

**SEVEN STEPS**  
TO PATIENT SAFETY IN GENERAL PRACTICE



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# QUICK REFERENCE GUIDE TO THE SEVEN STEPS TO PATIENT SAFETY IN GENERAL PRACTICE

## STEP 1: BUILD A SAFETY CULTURE

- Carry out an audit to assess your team's safety culture.
- Highlight successes and achievements in improving safety, and be open and honest when things go wrong.
- Apply the same level of rigour to all aspects of safety, including incident reporting and investigation, complaints, health and safety, staff protection, significant event auditing and clinical quality assurance.



## STEP 2: LEAD AND SUPPORT YOUR PRACTICE TEAM

- Talk about the importance of patient safety and demonstrate you are trying to improve it by including an annual patient safety summary in your practice report or your Practice Quality Report.
- Include patient safety in in-house staff training, including the use of improvement methods, and ask for it to be part of continuing education outside of the practice.
- Promote safety in team meetings by discussing safety issues and making it a standing agenda item.



## STEP 3: INTEGRATE YOUR RISK MANAGEMENT ACTIVITY

- Regularly review patient records (e.g. using casenote review tools) so that areas of common harm such as delayed or missed diagnoses/treatment can be identified.
- Keep a good significant event audit record that can be used for the General Medical Services contract, clinical governance, appraisals and revalidation.
- Involve wider primary healthcare team members in improving patient safety and use information from as many sources as possible to measure and understand safety issues in the practice.



## STEP 4: PROMOTE REPORTING

- Share patient safety incidents and Significant Event Audits (SEA) with the National Reporting and Learning Service (NRLS) so that learning can be disseminated nationally.
- Record events, risks and changes, and include them in your annual practice report.
- Cascade safety incidents and lessons learned to all your staff and other practices through your primary care organisation.



## STEP 5: INVOLVE AND COMMUNICATE WITH PATIENTS AND THE PUBLIC

- Seek patient views, especially on what can be done to improve patient safety, and use complaints as a vital part of a modern, responsive practice.
- Encourage feedback using patient surveys and websites such as NHS Choices.
- Involve your practice population via patient groups, open meetings or by inviting patient representatives to patient safety meetings.



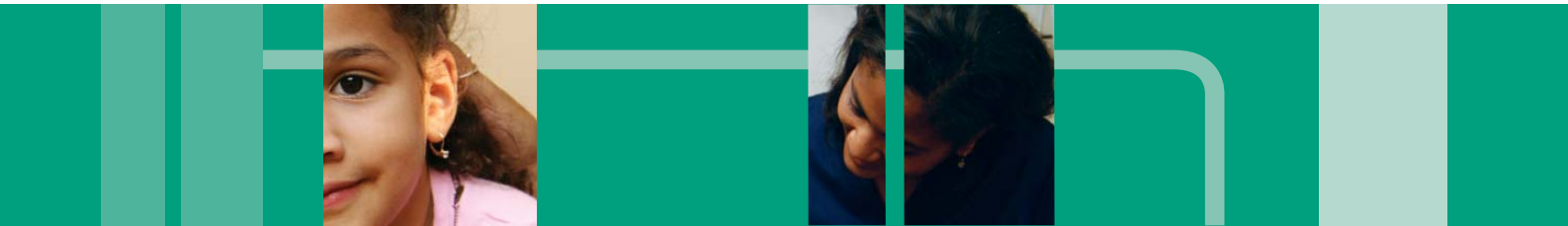
## STEP 6: LEARN AND SHARE SAFETY LESSONS

- Hold regular significant event audit meetings, reflecting on the quality of your care, patient safety and lessons for the future.
- Make the discussion of significant events and the national analyses of patterns of risk everybody's business, including the wider primary healthcare team as appropriate, and act on your findings.
- Share experiences with other practices by making your patient safety lessons widely available.



## STEP 7: IMPLEMENT SOLUTIONS TO PREVENT HARM

- Ensure that agreed actions to improve safety are documented, actioned and reviewed, and agree who should take responsibility for this.
- Use technology, where appropriate, to reduce risk to patients.
- Involve both patients and staff as they can be key to ensuring proposed changes are the right ones.



## INTRODUCTION

General practice is the largest speciality in the NHS: each year, in England alone, there are approximately 300 million<sup>1</sup> consultations with nearly 800 million prescriptions dispensed in the community.<sup>2</sup>

Every day, doctors, nurses, practice managers, healthcare assistants and reception staff (together with the wider primary healthcare team) work hard to provide high quality care to their local communities. As more complex care is delivered closer to home,<sup>3</sup> and as patients move through primary, secondary and social care sectors, the potential for patient safety problems inevitably increases.

Studies have identified that medical error occurs between five and 80 times per 100,000 consultations, mainly related to the processes involved in diagnosis and treatment.<sup>4</sup> Prescribing and prescription errors have been identified to occur in up to 11 per cent of all prescriptions, mainly related to errors in dose.

It has always been a key maxim of professionalism to 'first do no harm', and patient safety must therefore be the highest priority.<sup>5</sup>

### **About the *Seven steps to patient safety***

The *Seven steps to patient safety in general practice* describes the key steps for a general practice to take to avoid harming the patients they care for.

This guide is based on the full reference document, *Seven steps to patient safety in primary care*, and adapted specifically for general practice. It is one of a series of seven steps publications from the National Patient Safety Agency (NPSA). Go to [www.npsa.nhs.uk/sevensteps](http://www.npsa.nhs.uk/sevensteps) for details.

Alongside each step is a set of activities that can be taken to develop policies, strategies and action plans. There are also practical hints and techniques that can be used to promote quality care. Further tools, techniques and guidance are available at [www.npsa.nhs.uk/sevensteps](http://www.npsa.nhs.uk/sevensteps)

Following the steps set out here will help ensure that the care you provide is as safe as possible and, if things do go wrong, that the right action is taken. They will also support you in meeting clinical governance standards, accreditation processes and contractual requirements.<sup>6</sup> We encourage all staff who work in general practice to use this guide as a means to developing action plans for improving patient safety.

The steps described are based on a comprehensive literature review, and have been adapted to general practice through a series of focus groups. This has been supported by consultation with GPs, nurses and practice managers from across England and Wales.

This guide is endorsed by the Royal College of General Practitioners (RCGP), the Royal College of Nursing (RCN), the Queen's Nursing Institute (QNI), the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR) and the Institute of Healthcare Management (IHM).

The activities outlined in this guide are aimed at all staff working within the range of practices that currently exist and are continuing to evolve across the country (traditional partnerships, single-handed practices, nurse-led services, federations, as well as private and third-sector providers).



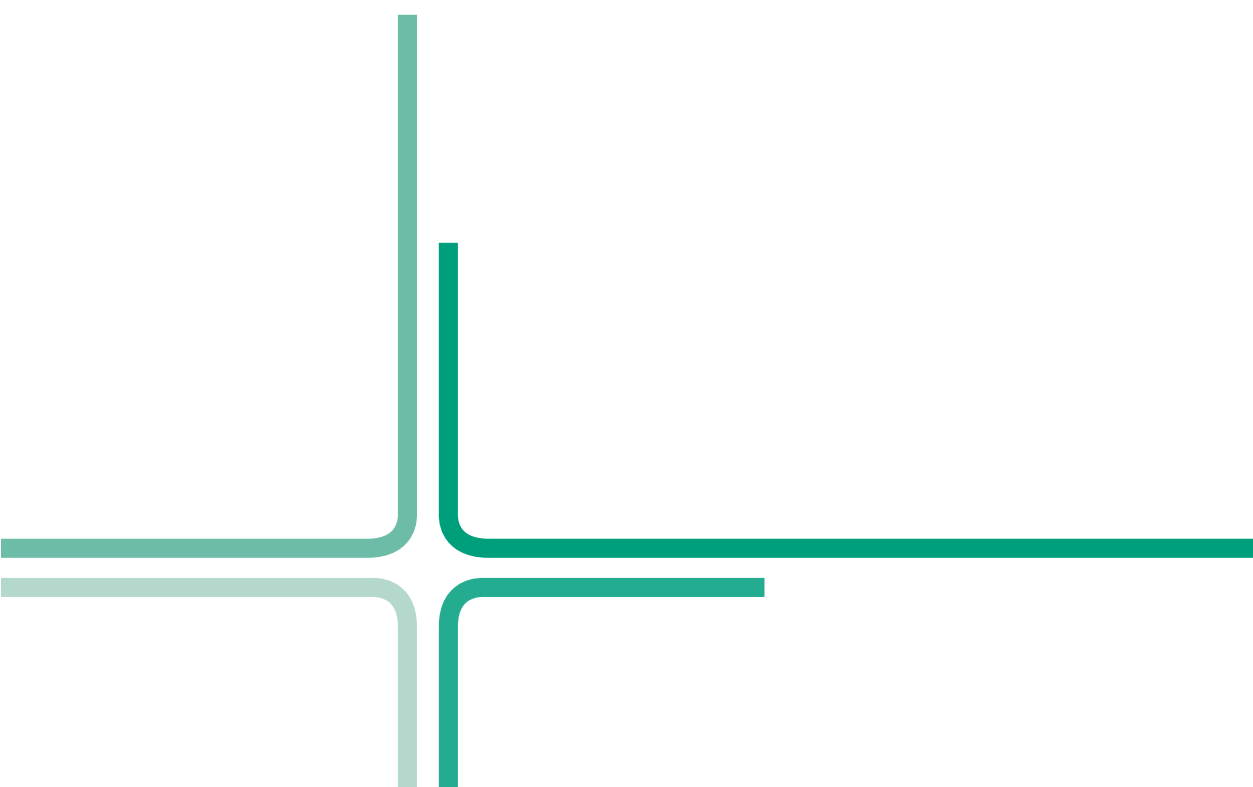
## About the NRLS

The National Reporting and Learning Service (NRLS) is a division of the NPSA that aims to identify and reduce risks to patients receiving NHS care, and leads on national initiatives to improve patient safety.

Through its national reporting system, the NRLS collects confidential reports of patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts help analyse these reports to identify common risks and opportunities to improve patient safety.

Feedback and guidance are provided to healthcare organisations to improve patient safety. These include alerts to address specific safety risks, tools to build a strong safety culture and national initiatives in specific areas such as hand hygiene, surgical safety, design, nutrition and cleaning.

Further information: [www.npsa.nhs.uk/nrls](http://www.npsa.nhs.uk/nrls)





## STEP 1: Build a safety culture

A good safety culture is one where staff have a constant and vigilant awareness of the potential for things to go wrong, are able to identify and acknowledge mistakes, learn from them, and take action to put things right in order to make patient care safer.<sup>7,8</sup>

Practices with a strong safety culture are those that engage with patient safety proactively: reporting and learning from incidents (including reporting to the NPSA so that other practices can learn from their experiences).

A strong safety culture requires:

- **Leadership** – the whole practice team to show that they believe in a good safety culture and are prepared to take ownership when things go wrong.
- **Teamwork** – the role of every practice member in promoting safety to be recognised and valued.
- **Accountability** – fair responsibility for your actions and accountability on four levels: professional, legal, ethical and contractual.
- **Understanding** – moving on from blaming the individual to recognising the role of system factors in patient safety.
- **Communication** – not assuming staff have understood the importance of patient safety and of recognising risks; remind them and applaud good practice. Make it commonplace and easy for all members of the team to speak up about concerns, taking care to reduce the impact of hierarchical relationships.
- **Awareness of workload pressures** – when times are busy, risks increase.
- **Safety systems** – robust systems to be put in place to prevent common errors.

### TOWARDS BEST PRACTICE

- Carry out an audit to assess your team's safety culture.
- Highlight successes and achievements in improving safety, and be open and honest when things go wrong.
- Apply the same level of rigour to all aspects of safety, including incident reporting and investigation, complaints, health and safety, staff protection, significant event auditing and clinical quality assurance.

### Key question for your practice:

How strong is your safety culture, and how can it be improved?

### Resources:

- Manchester Patient Safety Framework (MaPSaF) team safety culture assessment tool: [www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/mapsaf/](http://www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/mapsaf/)
- 1000 Lives Campaign, Wales: [www.wales.nhs.uk/sites3/home.cfm?orgid=781](http://www.wales.nhs.uk/sites3/home.cfm?orgid=781)
- Teamwork for safety: [www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/teamworking/](http://www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/teamworking/)



## STEP 2: Lead and support your practice team

Improvements in patient safety don't just happen. They need the right culture (see step 1), good leadership,<sup>9,10</sup> well-trained and supported staff, and the right systems.

The whole practice team need to commit to improving the safety of the patients in their care. All staff can make mistakes, and solutions to risks can come from any part of the practice. Effective change requires strong leadership and this demands leading by example – senior members of the practice team must be the first to put up their hands when something goes wrong.

In addition to everyday discussions, patient safety can be a regular part of annual staff performance reviews or appraisals, and GP annual appraisals; it can also be discussed at staff and practice meetings.

When something goes wrong, all staff should have the confidence to be open; focusing on the 'what', 'how' and 'why', rather than necessarily 'who'. Responses should be supportive of individuals, proportionate and robust, and focus on the learning that is to be gained from the incident.

Leaders should ensure agreed actions are clear and simple,<sup>11</sup> and should monitor changes by asking whether actions have been implemented and checking for intended and unintended effects.

### TOWARDS BEST PRACTICE

- Talk about the importance of patient safety and demonstrate you are trying to improve it by including an annual patient safety summary in your practice report or your Practice Quality Report.
- Include patient safety in in-house staff training, including the use of improvement methods, and ask for it to be part of continuing education outside of the practice.
- Promote safety in team meetings by discussing safety issues and making it a standing agenda item.

### Key question for your practice:

Can I demonstrate clear and visible leadership for patient safety?

### Resources:

- Leadership for patient safety (Patient Safety First Campaign):  
[www.patientsafetyfirst.nhs.uk/Content.aspx?path=/interventions/Leadership/](http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/interventions/Leadership/)
- Analysis of levers and forces:  
[www.systemsthinking.co.uk/3-2-0-4.asp](http://www.systemsthinking.co.uk/3-2-0-4.asp)
- NPSA Leadership checklist:  
[www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/7steps/leadership-checklist/](http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/7steps/leadership-checklist/)
- The Productive Leader:  
[www.institute.nhs.uk/theproductiveleader](http://www.institute.nhs.uk/theproductiveleader)



## STEP 3: Integrate your risk management activity

Risk management is built into many aspects of a practice's work: complaints handling, infection control, monitoring environmental risks, protecting vulnerable children, protecting staff, insurance and reviewing repeat prescriptions before they are signed.

In addition, clinical risks are managed through clinical governance, significant event auditing, conventional audit and other quality assurance activities. Thinking about all these activities in an integrated way helps a practice to focus on patient safety.

A key element of risk management is prevention. A safer practice:

- includes patient safety considerations in every decision the practice makes;
- has complete and accurate medical records;
- uses computerised decision support and responds appropriately to computer warnings, but doesn't let the computer stop them being alert;
- uses regular systematic casenote review to identify and measure adverse events (for example, using the Global Trigger Tool);
- does regular audits looking for avoidable acute admissions (many of which in the elderly are due to medication), interactions and patients lost to follow up (on anti-coagulation for example);
- regularly reviews patient safety incidents reported to the NPSA;
- tries to anticipate risks (e.g. double-checking drugs before injection).

### TOWARDS BEST PRACTICE

- Regularly review patient records (e.g. using casenote review tools) so that areas of common harm such as delayed or missed diagnoses/treatment can be identified.
- Keep a good significant event audit record that can be used for the General Medical Services contract, clinical governance, appraisals and revalidation.
- Involve wider primary healthcare team members in improving patient safety and use information from as many sources as possible to measure and understand safety issues in the practice.

### Key question for your practice:

What have you learnt from trends and patterns in your significant events, casenote review, complaints or reported patient safety incidents, and how have these been used to improve patient safety?

### Resources:

- The Global Trigger Tool – a new approach to using rapid casenote review to detect and measure harm: [www.institute.nhs.uk/safer\\_care/primary\\_care/improving\\_safety\\_in\\_general\\_practice.html](http://www.institute.nhs.uk/safer_care/primary_care/improving_safety_in_general_practice.html)
- There are various sources of guidelines for best practice: the National Institute for Health and Clinical Excellence (NICE), the RCGP, the Scottish Intercollegiate Guidelines Network (SIGN) and the National Prescribing Centre (NPC). If in any doubt, a practice should consult its primary care organisation.
- NPSA Rapid Response Reports: [www.npsa.nhs.uk/rrr](http://www.npsa.nhs.uk/rrr)
- The NHS Institute for Innovation and Improvement's Thinking Differently tool: [/www.institute.nhs.uk/building\\_capability/general/building\\_capability.html](http://www.institute.nhs.uk/building_capability/general/building_capability.html)



## STEP 4: Promote reporting

Learning from what happens in one practice can prevent harm to patients in other practices.<sup>12</sup> Only if we share our experiences can others learn from us and can we learn from others.<sup>3</sup>

The key to learning is not only in analysing large quantities of data at a national level, but also through local analysis at practice and primary care trust (PCT) level. This allows learning from reported incidents to be applied in a way that is relevant to local practices. This can only happen if incidents are reported in the first place.

Your practice's activity in patient safety, such as Significant Event Audits (SEA), risks identified and changes implemented, should be shared with your patients, the public, other practices, your primary care organisation and nationally via the NPSA's Reporting and Learning System (RLS). The RLS is a confidential system and it is your choice whether or not you share these reports with your PCT.

Less than 0.5 per cent of incidents reported to the RLS are from general practice (about 2,500 reports a year), despite this being a high-risk environment with emergency care, prescribing, early discharge, increased community care and the diverse nature of the workload.<sup>13</sup>

This low level of reporting is likely to be because practices don't have the staff, systems or culture to report regularly, or when necessary. A revised electronic reporting form, developed by the NPSA, makes it easier to report and also allows uploading SEAs to the NRLS.

While reports of significant event audits are owned and developed by the practice, they should be written so that they can be used for the new GMS contract and clinical governance reports, for submission to the RLS to assist in national learning, for staff appraisals, GP and nurse annual appraisal and, in time, GP and nurse revalidation. A summary of these reports and safety activity should be included in a patient safety section in your practice annual report.

### TOWARDS BEST PRACTICE

- Share patient safety incidents and SEAs with the NRLS so that learning can be disseminated nationally.
- Record events, risks and changes, and include them in your annual practice report.
- Cascade safety incidents and lessons learned to all your staff and other practices through your primary care organisation.

### Key question for your practice:

When did you last share the learning from a significant event with someone outside the practice?

### Resources:

- Incident report form: [www.npsa.nhs.uk/nrls/reporting/](http://www.npsa.nhs.uk/nrls/reporting/)
- Upload SEAs to the NRLS: [www.npsa.nhs.uk/nrls/reporting/gp-reporting-pilot](http://www.npsa.nhs.uk/nrls/reporting/gp-reporting-pilot)
- How to improve reporting: [www.npsa.nhs.uk/nrls/reporting/](http://www.npsa.nhs.uk/nrls/reporting/)
- NPSA incident data: [www.npsa.nhs.uk/nrls/patient-safety-incident-data/](http://www.npsa.nhs.uk/nrls/patient-safety-incident-data/)



## STEP 5: Involve and communicate with patients and the public

Your practice team comprises experts in health and healthcare; however each of your patients is an expert in their own health, what they want to achieve, how they wish to live and how they want to ensure quality of life and well-being.

Self-care is a vital part of modern medicine: informed patients should be supported to take decisions to protect and enhance their health. Patients have a key role to play in diagnosis, treatment, choosing their care provider, ensuring their treatment is appropriately administered, monitored and adhered to, and in identifying adverse events.<sup>14</sup>

If something goes wrong, a prompt, full, honest and compassionate explanation with an apology can help patients cope better with the after-effects of when things have gone wrong.<sup>6,15</sup> The NPSA Safer Practice Notice, *Being open when patients are harmed* gives guidance on explaining what happened to patients and/or their carers who have been involved in a patient safety incident.<sup>16</sup>

Patients and the public can be important allies in improving your services and those of other healthcare providers. Some practices involve patient representatives in some of their quality assurance meetings, and use a patient participation group to advise on service design and improvement.

### TOWARDS BEST PRACTICE

- Seek patient views, especially on what can be done to improve patient safety, and use complaints as a vital part of a modern, responsive practice.
- Encourage feedback using patient surveys and websites such as NHS Choices.
- Involve your practice population via patient groups, open meetings or by inviting patient representatives to patient safety meetings.

### Key question for your practice:

How does your practice respond when a patient makes a suggestion on how you can improve your care?

### Resources:

- National Association for Patient Participation: [www.napp.org.uk](http://www.napp.org.uk)
- The Patients Association: [www.patients-association.org.uk](http://www.patients-association.org.uk)
- Being Open: [www.npsa.nhs.uk/nrls/alerts-and-directives/notices/disclosure/](http://www.npsa.nhs.uk/nrls/alerts-and-directives/notices/disclosure/)
- NHS Choices: [www.nhs.uk](http://www.nhs.uk)



## STEP 6: Learn and share safety lessons

When something goes wrong (or could have gone wrong) the important issue is not to apportion blame but to understand what you can do to prevent it happening again.<sup>17</sup> For this you need to know what happened, how, why and what can be done to stop it from happening again.

A good practice is one that learns from mistakes or gaps in care and turns a potentially negative event into a positive one of improved, safer care.

In general practice, this can be achieved through recording and reporting patient safety incidents and through SEA, which most practices do regularly.

SEA is a key piece of evidence in GP annual appraisals, is recognised in the Quality and Outcomes Framework of the new GMS contract and will be a requirement in revalidation. In some complex cases, an SEA highlights the need for a more intensive investigation (a root cause analysis<sup>18</sup>). The NPSA has published SEA guidance for general practice which will help practices use SEA more effectively.<sup>19</sup>

A comprehensive view of safety in the practice can be built through using SEA alongside other methods. These include tools which measure harm (e.g. casenote review, routine data about key risk areas) and those which give understanding of the cause of safety incidents (e.g. interviews with staff and patients regarding areas of concern).

The actions taken by one practice may be highly relevant to other practices. Try to find ways to share lessons through local networks such as educational events, practice manager forums, commissioning consortia, and the Local Medical Committee. Also link with the clinical governance team in your primary care organisation.

Consider uploading your SEAs to the NRLS so that others can share in your learning.

### TOWARDS BEST PRACTICE

- Hold regular significant event audit meetings, reflecting on the quality of your care, patient safety and lessons for the future.
- Make the discussion of significant events and the national analyses of patterns of risk everybody's business, including the wider primary healthcare team as appropriate, and act on your findings.
- Share experiences with other practices by making your patient safety lessons widely available.

### Key question for your practice:

How confident are you that actions agreed at a SEA meeting are carried through?

### Resources:

- Root cause analysis:  
[www.npsa.nhs.uk/rca](http://www.npsa.nhs.uk/rca)
- SEA:  
[www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/significant-event-audit/](http://www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/significant-event-audit/)
- The Global Trigger Tool:  
[www.institute.nhs.uk/safer\\_care/primary\\_care/improving\\_safety\\_in\\_general\\_practice.html](http://www.institute.nhs.uk/safer_care/primary_care/improving_safety_in_general_practice.html)
- Upload SEAs to the NRLS:  
[www.npsa.nhs.uk/nrls/reporting/gp-reporting-pilot/](http://www.npsa.nhs.uk/nrls/reporting/gp-reporting-pilot/)



## STEP 7: Implement solutions to prevent harm

All practices should aim to embed any lessons learnt into their everyday work. There can be many reasons for not acting on learning, for example, lack of time, lack of a safety culture, dysfunctional relationships.

An SEA may recognise and congratulate good care. Others show up areas for improvement and actions needed. All team members, whether they were present or not when the decision was made, need to know why an action has been agreed.

All actions, where possible, need to be simple, appropriate, easy to achieve, measurable, sustainable and effective. Set a timescale and agree who will be responsible for carrying it out. Agreed actions should be reviewed to be sure that they are being implemented. The key steps are:

1. Raise awareness of the risk or issue.
2. Measure the size of the problem where possible.
3. Increase understanding of the problem and the potential solution.
4. Identify the best solution to the problem.
5. Try to find solutions which design out the problem so that it is difficult to get it wrong.
6. Introduce the solution that fits and explain to everyone why.
7. Test it using small-scale change methods and keep checking until you feel it is fully implemented.
8. Review the actions after a period of time to see if they have worked.
9. Keep finding new solutions until the data shows acceptable improvements.

### TOWARDS BEST PRACTICE

- Ensure that agreed actions to improve safety are documented, actioned and reviewed, and agree who should take responsibility for this.
- Use technology, where appropriate, to reduce risk to patients.
- Involve both patients and staff as they can be key to ensuring proposed changes are the right ones.

### Key question for your practice:

Have you ever experienced a significant event, or a 'near miss' similar to one that had happened before, and found that nothing had changed?

### Resources:

- Institute for Healthcare Improvement: [www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/](http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/)
- NHS Institute Leading Improvement in Patient Safety programme: [www.institute.nhs.uk/safer\\_care/leading\\_improvement\\_in\\_patient\\_safety\\_programme/leading\\_improvement\\_in\\_patient\\_safety\\_programme\\_%28lips%29.html](http://www.institute.nhs.uk/safer_care/leading_improvement_in_patient_safety_programme/leading_improvement_in_patient_safety_programme_%28lips%29.html)
- NHS Institute Plan-Do-Study-Act method: [www.institute.nhs.uk/building\\_capability/building\\_improvement\\_capability/pre-registration\\_education\\_phase\\_1.html](http://www.institute.nhs.uk/building_capability/building_improvement_capability/pre-registration_education_phase_1.html)

## USEFUL LINKS

1000 Lives Campaign, Wales	<a href="http://www.wales.nhs.uk/sites3/home.cfm?orgid=781">www.wales.nhs.uk/sites3/home.cfm?orgid=781</a>
Analysis of levers and forces	<a href="http://www.systemsthinking.co.uk/3-2-0-4.asp">www.systemsthinking.co.uk/3-2-0-4.asp</a>
Anticipate risks	<a href="http://www.fmeainfocentre.com">www.fmeainfocentre.com</a>
Being open	<a href="http://www.npsa.nhs.uk/nrls/alerts-and-directives/notices/disclosure/">www.npsa.nhs.uk/nrls/alerts-and-directives/notices/disclosure/</a>
Decision Support	<a href="http://www.connectingforhealth.nhs.uk/newsroom/worldview/protti3">www.connectingforhealth.nhs.uk/newsroom/worldview/protti3</a>
General Medical Council	<a href="http://www.gmc-uk.org">www.gmc-uk.org</a>
Global Trigger Tool	<a href="http://www.institute.nhs.uk/safer_care/primary_care/improving_safety_in_general_practice.html">www.institute.nhs.uk/safer_care/primary_care/improving_safety_in_general_practice.html</a>
Hand hygiene	<a href="http://www.npsa.nhs.uk/cleanyourhands">www.npsa.nhs.uk/cleanyourhands</a>
Manchester Patient Safety Framework	<a href="http://www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/mapsaf/">www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/mapsaf/</a>
National Institute for Health and Clinical Excellence	<a href="http://www.nice.org.uk">www.nice.org.uk</a>
NHS Institute for Innovation and Improvement	<a href="http://www.institute.nhs.uk">www.institute.nhs.uk</a>
National Patient Safety Agency	<a href="http://www.npsa.nhs.uk">www.npsa.nhs.uk</a>
National Reporting and Learning Service	<a href="http://www.npsa.nhs.uk/nrls/">www.npsa.nhs.uk/nrls/</a>
Patient Participation Group	<a href="http://www.patient.co.uk/showdoc/26740205/">www.patient.co.uk/showdoc/26740205/</a>
Plan-Do-Study-Act method	<a href="http://www.institute.nhs.uk/building_capability/building_improvement_capability/pre-registration_education_phase_1.html">www.institute.nhs.uk/building_capability/building_improvement_capability/pre-registration_education_phase_1.html</a>
Practice Based Commissioning	<a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453">www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453</a>
Rapid Response Reports	<a href="http://www.npsa.nhs.uk/rrr">www.npsa.nhs.uk/rrr</a>
Root cause analysis	<a href="http://www.npsa.nhs.uk/rca">www.npsa.nhs.uk/rca</a>
Royal College of General Practitioners	<a href="http://www.rcgp.org.uk">www.rcgp.org.uk</a>
Safety climate	<a href="http://www.npsa.nhs.uk/nrls/improvingpatientsafety/teamworking/tcam/">www.npsa.nhs.uk/nrls/improvingpatientsafety/teamworking/tcam/</a>
Seven steps to patient safety	<a href="http://www.npsa.nhs.uk/sevensteps">www.npsa.nhs.uk/sevensteps</a>
SIGN	<a href="http://www.sign.ac.uk">www.sign.ac.uk</a>
SEA guide	<a href="http://www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/significant-event-audit/">www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/significant-event-audit/</a> (click on 'SEA Guidance for Primary Care teams')
SEA - upload to the NRLS	<a href="http://www.npsa.nhs.uk/nrls/reporting/gp-reporting-pilot/">www.npsa.nhs.uk/nrls/reporting/gp-reporting-pilot/</a>
Sustainability guide	<a href="http://www.institute.nhs.uk/sustainability_model/introduction/find_out_more_about_the_guide.html">www.institute.nhs.uk/sustainability_model/introduction/find_out_more_about_the_guide.html</a>
Thinking Differently	<a href="http://www.institute.nhs.uk/building_capability/new_model_for_transforming_the_nhs/thinking_differently.html">www.institute.nhs.uk/building_capability/new_model_for_transforming_the_nhs/thinking_differently.html</a>
World Class Commissioning	<a href="http://www.dh.gov.uk/en/Healthcare/Highqualitycareforall">www.dh.gov.uk/en/Healthcare/Highqualitycareforall</a>

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