Editorial

Researching patient safety in primary care: Now and in the future

If we were to paraphrase Voltaire's quote on God, we could certainly say that in respect of patient safety it is a circle whose centre is everywhere and whose circumference is nowhere. Over the past 10 years, there has been a huge volume of data collected on medical error and harm to patients. With many tragic cases of healthcare failure and a growing number of major government and professional reports on the need to make healthcare safer, there has been a recognition that patient safety should be at the centre of healthcare. However, if we were to ask whether patients were any safer than they were 10 years ago, the answer would be elusive. We certainly have not been able to put a circumference around the circle of patient safety.

This supplement, like much research, raises more questions than it answers. What it does achieve is to identify the key challenges facing researchers seeking to understand the complexity of patient safety in the primary care setting and map out a possible future research agenda. However, it is also worth asking some searching questions on the key issues facing us today.

There are five key questions that we need to ask when considering whether a healthcare organization in primary care is safe. Has patient care been safe in the past? Are our clinical systems and processes reliable? Is care safe today? Will care be safe in the future? Are we responding and improving? These questions have been developed into a framework of five dimensions to help understand how we can measure and monitor safety in the healthcare setting: past harm, reliability, sensitivity to operations, anticipation and preparedness and integration and learning (1). How relevant are these dimensions to primary care?

We clearly need to understand a lot more about the definition, epidemiology and type of patient safety incidents that occur in primary care because this will be essential to understanding past harm and determining whether we are improving (2). This remains a challenge for the patient safety research agenda and primary care researchers need to address this deficit in their countries because the heterogeneity of primary care systems in Europe means that results will probably only be applicable locally.

The emphases on strengthening systems and on learning are highlighted in several papers in this supplement. Unfortunately, reliability and sensitivity to operations requires an infrastructure that is absent from most areas of primary care—the examples in this supplement of the tasks facing GPs in Poland (3) and Greece (4) are examples where there is almost a total lack of infrastructure support for primary care. The use of tools like the Manchester patient safety framework (MaPSaF) highlighted in this supplement (5) seem to have a wide resonance in a diverse range of countries with very differing primary care infrastructures and provides a useful means of assessing anticipation and preparedness. Critically, understanding and measuring culture allows primary care organizations to be proactive in shaping their responses. The emphasis on integration and learning has a strong history of development in primary care. Although it remains a relatively evidence-free zone, the impact of significant event auditing could play an important role in assessing the reliability of organizational systems, especially if we can agree on consistency in its use and on using prospective methods to embed the learning from this (6). As the researchers from Denmark point out, there is still a huge challenge in understanding what patients perceive and want from primary care in relation to patient safety (7).

It is also worth reflecting on some key principles as we decide on what needs to be done. First, the concept of trying to identify a single measure of safety is a fantasy—it has not worked in secondary care and will not work in primary care. Measuring safety is complex and will need to rely on different metrics recognizing the complexity of clinical care in the primary care setting. Second, there is a challenge to allow those who work in primary care to monitor what is happening in their organizations. GPs and their colleagues do have the capacity to monitor and intervene in situations when things go wrong and they need to make the time to understand the problem and intervene. We need to invest in technology and analyse the vast amount of data that is already collected in primary care and assess its relevance to safety metrics (8). These metrics will need to be customised to local settings and local circumstances and be developed with clinicians – there have been too

many initiatives where the needs of clinicians have been subsumed into regulatory requirements.

From the perspective of patient safety research, we are in a much better place than we were 10 years ago. A lot more funding has been directed to patient safety both in the UK and by the EU. It is a good time, to paraphrase Paulo Freire so that tomorrow we can do what we are unable to do today.

REFERENCES

1. Vincent C, Burnett S, Carthey J. The measurement and monitoring of safety. London: The Health Foundation; 2013.
2. Verstappen W, Gaal S, Bowie P, Parker D, Lainer M, Valderas JM, et al. A research agenda on patient safety in primary care. Recommendations by the LINNEAUS collaboration on patient safety in primary care. *Eur J Gen Pract.* 2015;21(S1):72–77.
3. Godycki-Cwirko M, Esmail A, Dovey S, Wensing M, Parker D, Kowalczyk A, et al. Patient safety initiatives in Central and Eastern Europe: A mixed methods approach by the LINNEAUS collaboration on patient safety in primary care. *Eur J Gen Pract.* 2015;21(S1):62–68.
4. Skalkidis Y, Manoli A, Evangelos D, Nikolaos T, Sekeri Z, Dantsi F, et al. First experiences with patient safety initiatives in Greek rural primary care. Action research by the LINNEAUS collaboration on patient safety in primary care. *Eur J Gen Pract.* 2015;21(S1):69–71.
5. Parker D, Wensing M, Esmail A, Valderas JM. Measurement tools and process indicators of a patient safety culture in primary care. A mixed methods approach by the LINNEAUS collaboration on patient safety in primary care. *Eur J Gen Pract.* 2015;21(S1):26–30.
6. Verstappen W, Gaal S, Esmail A, Wensing M. Patient safety improvement programs for primary care. Review of a Delphi procedure and pilot studies by the LINNEAUS collaboration on patient safety in primary care. *Eur J Gen Pract.* 2015;21(S1):50–55.
7. Trier H, Valderas JM, Wensing M, Martin H, Egbert J. Involving patients in patient safety programs: A scoping review and consensus procedure by the LINNEAUS collaboration on patient safety in primary care. *Eur J Gen Pract.* 2015;21(S1):56–61.
8. Nurek M, Kostopoulou O, Delaney B, Esmail A. Reducing diagnostic errors in primary care. A systematic meta-review of computerized diagnostic decision support systems by the LINNEAUS collaboration on patient safety in primary care. *Eur J Gen Pract.* 2015;21(S1):8–13.

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