OPEN ACCESS

University of BRISTOL

Early version, also known as pre-print

License (if available):
Other

Link to published version (if available):
10.3399/bjgp19X702629

Link to publication record in Explore Bristol Research
PDF-document

University of Bristol - Explore Bristol Research
General rights

Is the future of general practice safe for patients?

Understanding the risks presented by the rapid transformation of general practice

Ian Bennett-Britton [a] *NIHR Academic Clinical Fellow in Primary Care*

Chris Salisbury [a], *Professor of Primary Health Care*

[a] Centre for Academic Primary Care, Bristol Medical School, University of Bristol, 39 Whatley Road, Bristol, BS82PS

Word Count: 1200

Reference Count: 13

Introduction

General practice is changing rapidly, driven by policy demands for new models of care to address an expanding, aging and increasingly medically complex population.[1] Such change presents opportunities to improve all aspects of care, however questions remain about the risks to patient safety. These risks can be grouped into (1) those related to changes in workforce and workload, (2) those related to changes in infrastructure and models of care, and (3) those related to limitations of existing mandatory patient safety systems in general practice.

1. Risks of changes in workforce and workload

The GP Forward View[1] (GPFV) set out NHS England's strategy for general practice up to 2020, committing to 5000 additional doctors and a minimum of 5000 other staff, including mental health therapists, clinical pharmacists and physician associates. The roles of new and existing staff are expanding to more efficiently use general practitioner capacity. Whilst investment in general practice is welcomed, there is uncertainty regarding safe limits of delegation and supervision of staff in existing and new roles.

Some of the risks surrounding the workforce changes are illustrated by the GPFV's commitment to increasing physician associate (PA) numbers, from 31 known to be working in general practice in 2016, to 1000 by 2020[2]. PAs are presently regulated on a voluntary basis despite commitments to rapid expansion of the role since 2016. Fortunately, in October 2018, the Department of Health committed to developing statutory regulation for PAs,[3] however the value of this will be defined by its terms. The clinical governance arrangements under which PAs may work remain ill-defined, despite warnings that these are of "critical importance in ensuring the quality and safety of their work."[4] Such uncertainty risks inappropriate utilisation of staff in stretched general practices.

2. Risks of changes in infrastructure and models of care

Amongst other drivers, advances in technology are transforming general practice infrastructure and models of care, enabling the growth of a range of services from artificial intelligence facilitated patient triage to video-call consultations.[5] Such developments are compelling, however concerns remain that interventions are being applied to patients without adequate evidence of safety.[5]

Examples of this are summarised in the Care Quality Commission's (CQC) report on independent online primary health services.[6] Initial inspections found 30 of 35 providers to not fully meet criteria consistent with safe care,[6] with failures across prescribing, safeguarding, patient identification and information sharing. Such failures highlight the risk of harm in an environment where, by the CQC's own admission, "the pace of advancement in technology has outpaced the evolution of the regulations."[6]

3. Risks of limitations of existing mandatory patient safety systems in general practice

The absence of clear limits of task delegation and supervision of new and existing staff, and evidence of failures in the provision of online medical services, illustrate the risks presented by the transformation of general practice. The lack of consistent evaluation to identify and mitigate such risks, coupled with the pace and disparate nature of such changes, leads one to question what systems are already integrated into general practice that would highlight when patient safety is at risk?

The following section provides an overview of the mandatory 'safety-net' systems in general practice today, categorising by those at the (i) organisational, (ii) clinician and (iii) patient level.

(i) Organisational level

The principal mechanism to ensure patient safety at the organisational level is CQC regulation. CQC assurance processes[7] include data monitoring and targeted inspections to discern whether services are safe, effective, caring, responsive and well-led.

One of the key safety indicators described by the CQC is the propensity to report safety incidents and learn from them.[7] Reporting of incidents resulting in severe harm is mandatory, but the CQC advises that all incidents, including near misses, should be reported to a national database, the National Reporting and Learning System (NRLS). NRLS data indicate that only 8383[8] general practice incidents were reported to have occurred between October 2016 and September 2017, an average of one incident per GP practice annually. Variation in patient safety incident reporting was explored in an interview study of primary health care staff in London.[9] Participants described inadequate time to engage in these activities, and

"disincentives for responding to and acting on safety issues and concerns, with few reported benefits."[9] Such evidence suggests incident reporting systems are unlikely to consistently identify and ameliorate sources of patient risk.

(ii) Clinician level

Professional regulation is the principal clinician level "safety-net" mechanism. It functions primarily through revalidation, which aims to ensure clinicians are "not just qualified, but safe."[10]

The extent to which revalidation of doctors improves patient safety is debated, with the principal evidence coming from the research of the UK Medical Revalidation Collaboration.[11] Only 20% of surveyed doctors thought revalidation improved patient safety, the minority (23%) thought revalidation would identify failing doctors, and most (58%) "made no change to their clinical practice, professional behaviour or learning activities as a result of their most recent appraisal."[11] As a consequence of this, and other assessments of the impact of revalidation,[10] the GMC has committed to improvements.

A future of increasingly blurred professional boundaries,[1] requires that regulatory regimes of staff working in similar spheres are consistently detailed. However, the disparity in revalidation intensity between doctors and registered nurses,[12] and only recent commitment to developing mandatory professional regulation of physician associates,[3] highlights an increasingly relevant inconsistency (Table 1).

Uncertainty over the ability of clinician level safety mechanisms to ensure patient safety today, raises doubts over their suitability for monitoring future models of care.

(iii) Patient level

Patient level "safety-net" mechanisms function through accountability and feedback to help identify areas of risk. These consist of surveys, written complaints and online review systems.

As an overview, patient level safety mechanisms are undermined by low levels of engagement, which coupled with the asymmetry of information that defines the doctor-patient

relationship, limit their usefulness for identifying risks to patient safety, now and in the context of the future of general practice.

Is the future of general practice safe for patients?

Questions regarding the safety of future models of care draw attention to what is known about the safety of existing models of general practice. The presented overview of existing mandatory safety assurance systems highlights challenges that are likely to be exacerbated by the future of general practice. This underlines the need for research to consider alternative approaches to ensure the safety of existing and future models of care.

Alternative patient safety mechanisms may move away from the present regimes of infrequent, resource-intensive assessments of mostly self-collated evidence - often with perverse incentive structures; towards independent and continuous assessments based on triangulation of a wide range of variables. In the context of increasingly blurred professional boundaries, more sophisticated assessment regimes may place greater emphasis on situational competence and appropriate supervision, rather than professional status. The development of such safety systems may be facilitated by strategic moves towards larger organisational general practice units[1] and advances in machine learning technology.

The future of general practice is reliant on the ability of services to continuously evolve to respond to new challenges. The safety of this future depends on corresponding investment and innovation in patient safety assurance mechanisms and, crucially, incentive structures that support meaningful and consistent engagement with them.

References

1. NHS England. General Practice Forward View. London: NHS England, 2016.
2. Ritsema T. Faculty of Physician Associates: Census Results 2016 [Report]. London: Faculty of Physician Associates; 2016 [Available from: http://www.fparcp.co.uk/about-fpa/fpa-census accessed 19th Sept 2018.
3. Rimmer A. Physician associates will be regulated along same lines as doctors and nurses. *BMJ* 2018;363 doi: 10.1136/bmj.k4320
4. Primary Care Workforce Commission. The future of primary care: Creating teams for tomorrow. London: Health Education England, 2015.

5. Marshall M, Shah R, Stokes-Lampard H. Online consulting in general practice: making the move from disruptive innovation to mainstream service. *BMJ* 2018;360 doi: 10.1136/bmj.k1195

6. Care Quality Commission. The state of care in independent online primary health services. London: Care Quality Commission, 2018.

7. Care Quality Commission. The state of care in general practice 2014-2017. Newcastle upon Tyne: Care Quality Commission, 2017.

8. NHS Improvement. NaPSIR quarterly data summary: October to December 2017 [Data Report]. London: NHS Improvement; 2018 [19/09/18]. Available from: https://improvement.nhs.uk/resources/national-patient-safety-incident-reports-21-march-2018/ accessed 19th Sept 2018.

9. Samra R, Bottle A, Aylin P. Monitoring patient safety in primary care: an exploratory study using in-depth semistructured interviews. *BMJ Open* 2015;5(9) doi: 10.1136/bmjopen-2015-008128

10. Pearson K. Taking revalidation forward: Improving the process of relicensing for doctors. Cardiff, Wales: General Medical Council, 2017.

11. The UK Medical Revalidation Collaboration. Shaping the future of medical revalidation: Interim Report. London: The UK Medical Revalidation Collaboration,, 2016.

12. Nursing and Midwifery Council. Nursing and Midwifery Council: Revalidation: What you need to do London: Nursing and Midwifery Council; 2017 [19/09/18]. Available from: http://revalidation.nmc.org.uk/what-you-need-to-do accessed 19th Sept 2018.

13. Faculty of Physician Associates. Physician Associate Managed Voluntary Register (PAMVR) [Webpage]. London: Royal College of Physicians; 2018 [cited 2018 19/09/18]. Webpage]. Available from: http://www.fparcp.co.uk/employers/pamvr accessed 19th Sept 2018.

	General Practitioners[10]	**Registered Nurses**[12]	**Physician Associates**[13]
Regulation	Mandatory: General Medical Council	Mandatory: Nursing & Midwifery Council (NMC)	Presently voluntary**: Faculty of Physician Associates (FPA)
Appraisal	Mandatory: Annually	Recommended: Annually	Recommended: Annually
Revalidation freq.	5 yearly	3 yearly	6 yearly for voluntary register
Individual responsible for recommending revalidation	Independently allocated: "Responsible officer"[10] (97%) or GMC approved "suitable person"[10] (<1%). Otherwise for GMC assessment (2%).	Individual nurse choice: "Confirmer"[12] – normally line manager or NMC registered individual. Otherwise, any regulated healthcare professional.	FPA checks compliance for those that are voluntarily registered.
CPD (Annual)	50 hours[b]	11.7 hours[b]	50 hours for voluntary register
Feedback requirements	Once every 5 years: Patient & colleague surveys	Once every 3 years: 5 pieces of patient or colleague feedback "formal or informal; written or verbal"[12]	No requirement
Additional revalidation requirements	Reviews of: - Complaints & compliments - Significant events - Quality Improvement Activity - Reflective practice	- 5 written reflective accounts & discussion about these with someone registered with NMC - 450 hours of nursing practice	- Recertification Exam: 200 single best answer questions every 6 years. Exam not specific to specialty of practice.
** In October 2018 the Department of Health committed to developing mandatory regulation of physician associates[3] [b] Mandatory average (mean) annual commitment			

Table 1: Comparison of current regulatory regime by clinician group