

Learning from International Networks about Errors and Understanding Safety in Primary Care (LINNEAUS EURO-PC)

The importance of primary care in health care systems and why we have to study patient safety in primary care

There is an increasing understanding of the importance of patient safety in the delivery of health care. Landmark studies (in the USA, Australia, the UK, Denmark and the Netherlands) assessing the contribution of adverse events causing harm to patients, have resulted in major initiatives for improving patient safety in many countries. However, in all EU countries, patient safety is still primarily focused on hospital and specialist care with little activity in primary/generalist care. Whilst there is also an increasing emphasis on safety culture, leadership and clinical governance, much of this activity is again concentrated on hospital and regional organisations and not on clinicians and teams working at the primary care level.

In many EU countries, access to specialist care occurs through primary or generalist care. For example, in the UK, 85% of contacts with the National Health Service take place in primary care and there are 300 million general practice (GP) appointments each year, which means that nearly 750,000 patients consult their GP each day. In Germany the rates are even higher – approximately 1.5 million visits per day to primary care physicians, with GPs and general internists issuing 550 million prescriptions per year. It is estimated that in the Netherlands, every citizen has 2.6 GP consultations per year. Clearly, primary care is a vast organised sector for health care with millions of interactions occurring every day throughout the EU. A literature review of the nature and frequency of error in primary care suggested that there are 5 to 80 safety incidents per 100,000 consultations which in the UK would translate to between 37 and 600 incidents per day. The vast majority of incidents can be categorised into 4 main areas covering diagnosis, prescribing, communication between health care providers and patients, and organisational / administrative problems. The potential for error is great, but analysis of medico-legal databases suggests that 50% are of no consequence, 20% result in non-clinically relevant delays in diagnosis and 10% result in upset patients, but 20% of errors could have serious consequences. Set within the context of a large number of healthcare interactions, this has the potential to become a significant problem.

Linneaus Euro PC (Learning from InterNational Networks about Errors And Understanding Safety in Primary Care) is a co-ordination action programme, financially supported (2.46m Euros) by the EC under the Framework 7 Programme for four years (2009-13). It currently involves 8 research groups in 6 EU countries (UK, The Netherlands, Germany, Austria, Denmark and Poland), although more countries are expected to become involved during the life of the project. It will address specifically issues related to improving patient safety, focusing on primary care and at the primary care/secondary care interface.

Aims and Objectives of the LINNEAUS-EURO-PC collaboration:

As a result of obtaining financial support through EU FP7, we are now in a position to extend and develop the collaboration at the European level. The Linneaus-Euro-PC collaboration co-ordination action will specifically address issues related to patient safety through:

- The development of a taxonomy of adverse events and errors and an instrument to assess safety culture and leadership in the primary care setting. This will enable the development of tools which are already being used at a national level for benchmarking and comparative analysis at the European level.
- Identifying best clinical practice and the way that it improves patient safety through an understanding of decision making and medication errors in primary care which we have already identified as a major area contributing to adverse events and errors.

- Achieve consensus on the measurement of safety culture in the primary care context and develop agreement on indicators which can be used to assess improvements in safety culture.
- Enhancing existing knowledge from quality improvement techniques which are widely used in the primary care setting (in which members of the collaboration have extensive experience) and applying these to learning cycles for improvements in patient safety.
- Building up an existing network into a pan European network which will extend the current knowledge and experience from countries where the importance of patient safety is nationally recognised to countries where it is less developed; sharing information through workshops and seminars, ensuring that there is an appropriate focus on primary care, and encourage co-operation and collaboration for future interventions through large scale trials.

Organisation:

The collaboration is divided into nine work packages, with a specific country taking a lead in addressing the functional areas.

1. Project management and coordination activities (Manchester, UK)
2. Developing a Taxonomy of Errors for Primary Care (Frankfurt, Germany)
3. Medication errors in primary care (Salzburg, Austria)
4. Diagnostic errors in primary care (London, UK)
5. Safety Culture and performance (Manchester, UK)
6. Learning for patient safety (Nijmegen, Netherlands)
7. Developing interventions for patient safety in nascent organisations (Lodz, Poland)
8. Patient involvement (Copenhagen, Denmark)
9. Dissemination (Manchester, UK)

Current members of the collaboration:

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2. Dr Barbara Hoffmann, Institute for General Practice at Johann Wolfgang Goethe University, Frankfurt am Main, GERMANY
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5. Dr Michel Wensing, Radboud University Nijmegen Medical Centre, Nijmegen, THE NETHERLANDS
6. Dr Maciek Godycki-Cwirko, Medical University of Lodz, POLAND
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