2.02 THE CONTEXTUAL STATEMENT ON

Patient Safety and Quality of Care

This statement is part of the curriculum produced by the Royal College of General Practitioners (RCGP) which defines the learning outcomes for the discipline of general practice and describes the skills you require to practise medicine as a general practitioner in the National Health Service (NHS) of the United Kingdom. Although primarily aimed at the start of independent work as a general practitioner, it must also prepare the doctor beyond the training period and provide support for a professional life of development and change.
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KEY MESSAGES

- The ‘purpose’ of the RCGP is to improve the quality of healthcare by ensuring the highest standards for general practice, the promotion of the best health outcomes for patients and the public and by promoting GPs as the heart and the hub of health services.
- As a GP you are in a strong position to influence your own care of patients, that of your practice and that of the wider healthcare community.
- Understanding how and when to apply tools and metrics to improve the quality of care is a key skill that can and should be learnt during your training, as well as enhanced in lifelong learning.
- Working in partnership with your patients and understanding their needs is vital to improving clinical care and reducing health inequalities.
- Patients, their families and carers have an important role in the assessment of health care; their views are therefore essential for the development of high-quality health care. Patients should be encouraged to be actively involved in planning their care and in the development of services at practice level and beyond.
- How we learn from and share lessons regarding clinical care is an important marker of our personal and collective professional development.
INTRODUCTION

The GMC *Duties of a Doctor* clearly states ‘you must make the care of your patient your first concern’, with quality and safety of healthcare being a key concern for the public.

General practitioners and practices do not work in isolation but are an integral part of *systems of care*. As a GP, understanding teams, interfaces, organisational relationships and care pathways is essential to the delivery and development of high-quality, safe patient care. Because of this there are many opportunities for you to have a positive impact upon healthcare and to improve the quality and safety of care for your individual patients, your registered population and for those patients within your locality.

As such all GPs need to make sure that their practice has good systems in place to monitor the quality of care that they provide. This requires leadership, team working and good information systems. GPs increasingly need to be able to demonstrate that they keep up-to-date and are fit to practise, and can account for the standard of care they are providing.

Techniques to look at patient safety and to begin to compare quality of care is a relatively young field and, whatever your age and experience, you will require ongoing training to introduce and enhance your skills. Clinical audit, significant event audit and improvement methodology are key tools to improving the quality of care. There are a variety of definitions of ‘quality’, most encompassing clinical effectiveness, patient safety and awareness of the patient experience. All GPs should have a thorough understanding of clinical governance and contribute actively to creating a practice culture which is conducive to learning, team working and the promotion of clinical excellence, focused on meeting patients’ needs.

There are a variety of measures that capture different pieces of information. Looking across a broad spectrum of data is important and helps healthcare organisations to triangulate impressions. No one source is perfect and because of the diversity of practices and the variation in patient demographics it is essential to take a broad, balanced view. Patient safety incidents, near misses and complaints are part of a jigsaw of information that can be used to ‘share and learn lessons’. How we share lessons is key to our personal and collective professional development. Clinical governance aims continuously to improve the quality of healthcare and to ensure equality of standards, as well as to demonstrate accountability to the public. In addition, it includes identifying and responding to poor practice. As a GP you need to understand the principles underpinning clinical governance by demonstrating the appropriate knowledge, skills and attitudes. In addition to providing annual summaries of complaints received by the practice, *Seven Steps to Patient Safety* for general practice encourages reflecting on safety and quality development within the practice, including benchmarking and other comparator measures of outcomes (www.npsa.nhs.uk may change).

The role of information technology (IT) has changed substantially over the past few years, as well as during the clinical lifetime of most working doctors. General practice in the UK has especially embraced computerisation. Understanding what opportunities and risks this introduces is an important part of your experience in general practice. In particular, prescribing and monitoring of medication needs to be understood, developed and explored to ensure high-quality, safe care. Understanding what contribution reliable design and human factors play in helping this can be a useful transferable skill and
understanding human factors and its impact on both practitioners and systems offers opportunities to identify risks in healthcare and possible ways to reduce them.

Dealing with feedback to patients and carers in an open and transparent way is another feature of a ‘safety culture’ within a practice that values a quality service. Also, working in partnership with your patients and understanding their needs is key to improving clinical care and governance and to tackling health inequalities.

Increasingly different parts of the NHS within England, Scotland, Wales and Northern Ireland are influenced by devolved organisations, so understanding their contribution and comparing their impact can be a useful learning experience. The National Institute for Health and Clinical Excellence (NICE) affects England as does the Care Quality Commission (CQC). In Scotland the role of the CQC is fulfilled by the Care Inspectorate (www.careinspectorate.com) and in Wales by the Care Standards Inspectorate for Wales (www.cssiw.org.uk). In Northern Ireland, the role is carried out by the Regulation and Quality Improvement Authority (RQIA) (www.rqia.org.uk), which includes registration of providers including GP practices. The RQIA seeks to formally explore quality and variation. How we deal with such variation is important.

The requirements for appraisal and revalidation are being developed by the RCGP and GMC. As a GP you need to understand the requirements and collect the relevant supporting information as part of your professional development, including links to the quality and safety domain within the GMC’s Good Medical Practice.
CASE ILLUSTRATION

A patient, Juliet Brown, asked for a home visit for her frail elderly mother, Mrs Jones, who had come to stay with her. Dr G visited that afternoon and found that Mrs Jones had atrial fibrillation and was on warfarin. She had no patient-held record but her daughter Juliet reported that each day she was taking 3 mg of warfarin. Dr G advised her to continue with this dose and that he would arrange for an INR (international normalised ratio) blood test.

On returning to the medical centre, he entered her medication on the clinical system and issued a prescription for 3mg warfarin tablets. He asked a receptionist to email the community nurses, requesting blood tests, including an INR. The email was never sent and the INR was not done.

A week later Mrs Jones was admitted to hospital in the middle of the night and died six hours after admission. After a postmortem the primary cause of death was recorded by the coroner as a haemorrhagic CVA. A few days following the death of Mrs Jones, her daughter Juliet phoned the practice manager to say that a junior doctor at the hospital had said Mrs Jones had a bleed in the brain, which can occur when people are on warfarin. A blood test done soon after admission had shown her INR was ‘a bit high’.

Juliet asked the practice manager why the blood test had not been done as Dr G had said it would be; whether the warfarin might have been a cause of her mother’s death; and whether the blood test might have saved her mother’s life. She also wanted to know if her mother’s own general practice had been at fault because it appeared that her INR had not been done for about six months. The practice manager explained that she didn’t have the answers straight away, but would come back to Juliet soon.

The practice held monthly significant event audit meetings. Dr G presented the case of Mrs Jones at their next meeting. All present shared their distress at what had occurred, as well as their view that it could easily happen again. They then got down to a frank discussion of what might have gone wrong, agreeing that:

- Home visits presented particular risks for clinical care
- If the patient had carried a patient-held record then the previous INR would have been available
- There was a well-established system for communicating with the community nurses, which generally worked well; but on this occasion human error had occurred
- The originating clinician remains responsible for delegated actions/commissions
- There might be some other patients in their practice not having regular INR reviews and such patients might also have raised INRs

Actions from the meeting included the following points:

- Undertaking an audit of all patients on long-term warfarin
- The message-taking and message-passing systems in the practice would be a major subject for the practice’s next internal protected learning time event for the whole team
• The dosing regimen was likely to lead to confusion (it was actually a 3mg tablet on one day and a tablet and a half alternate days), but it is often safer to continue with such a regimen short term while waiting for an INR in a temporary residence
• Dr G was under high time-pressure that afternoon because he had had a minor surgery session after morning surgery, a teaching session with the registrar at lunchtime, and was fitting in two visits before the mid-afternoon surgery session. This particular day in the four-week cycle was always known to Dr G as his ‘black day’
• The practice manager was to look at the timetabling issues, not just for Dr G but for other partners, to minimise the risks of such predictable time pressures occurring. This was to be a root cause analysis (RCA). A letter would be written to Juliet Brown telling her what the practice had discussed and what it was doing, and inviting her to a meeting with Dr G and the practice manager

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Primary care management</th>
<th>What are the systems and processes that a practice puts in place to ensure simple blood tests and tasks are carried out and how would I ensure these processes continue to function?</th>
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<tr>
<td>Person-centred care</td>
<td>What are the particular issues I need to consider when visiting a patient, such as a temporary resident, for whom I have barely any preceding information?</td>
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<tr>
<td>Specific problem-solving skills</td>
<td>How would I use clinical audit and the team-based use of significant event audit to further understand the issues here? What validated service improvement tools could I also use to monitor improvement in the practice once changes have occurred?</td>
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<tr>
<td>A comprehensive approach</td>
<td>What are the clinical risk management issues of managing co-morbidity?</td>
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<td>Community orientation</td>
<td>How might I predict and meet the needs of a frail relative staying with a patient of the practice – thinking, in particular, of the interrelationship between health and social care?</td>
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<tr>
<td>A holistic approach</td>
<td>What way can I use to describe the complexity of a single home visit in my current system of healthcare, looking especially at the need to respect the values of patients and carers and whether these will influence the outcome of care?</td>
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<tr>
<td>Contextual features</td>
<td>In what ways do the contextual aspects of the doctor and seeing patients in a different setting, such as the home, on a busy day impact upon clinical care?</td>
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<tr>
<td>Attitudinal features</td>
<td>How would my approach change if, on reviewing the situation, the practice manager finds that staff have to chase Dr G constantly for reports and referral letters and that staff then say that, when on call, it can be hard to contact Dr G and sometimes his records are poor?</td>
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<tr>
<td>Scientific features</td>
<td>How might different approaches to the rota arrangements predict that a vulnerable time for patients and doctors might occur?</td>
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LEARNING OUTCOMES

This is one of four contextual statements (2.01 – 2.04) which explore in greater detail particular aspects of your work as a GP. They contain learning outcomes in the ‘areas of competence’ and ‘essential features’ relevant to their topic. These learning outcomes or objectives are in addition to those detailed in the core statement, Being a General Practitioner. The core statement and this statement should be used in conjunction with the other curriculum statements. In order to demonstrate the core competences in this contextual statement you will require knowledge, skills and attitudes in the following areas:

The RCGP areas of competence

1 Primary care management

This area of competence is about how you manage your contact with patients, dealing competently with any and all problems that are presented to you. (This area of competence is not limited to dealing with the management of the practice.)

This means that as a GP you should:

1.1 Build and enhance the safety culture in your general practice setting including attending meetings
1.2 Know how organisations and individuals can learn to improve systems by analysing patient safety incidents and near misses
1.3 Understand the principles of medical device management and the use of the adverse incident centre for reporting device-related adverse incidents
1.4 Describe how the analysis of patient safety incidents can enhance rather than undermine professional integrity and performance
1.5 Contribute to the regular significant event audit (SEA) meetings and describe the benefits of a multidisciplinary team, as well as feed back to colleagues about incidents
1.6 Comment on the participation of whole teams in significant event audits within the practice and give reasons for inclusion or exclusion of different team members
1.7 Write up an SEA from a patient that you were involved with during the general practice period of training (significant event analysis in the learning log of the RCGP ePortfolio)
1.8 Reflect on the learning and consider whether reporting locally and or nationally would be appropriate
1.9 Demonstrate the measures that the organisation takes to ensure that reports are dealt with fairly and that appropriate learning and implementation takes place
1.10 Know the elements that contribute to an appropriate infrastructure for risk management, such as: create a culture that is open and fair with systems and policies, helping staff understand what actions to take following an incident and the mechanism of investigation
1.11 Demonstrate an awareness in how changes in the IT structure of the NHS will both reduce and increase the chance of patient safety incidents
1.12 Demonstrate the use of call/recall systems within the practice to the benefit of patient care
1.13 Demonstrate an understanding of the connection between good data entry and improved patient health outcomes
1.14 Demonstrate how to use information management and technology (IM&T) to share information and co-ordinate patient care with other health professionals
1.15 Demonstrate an understanding of the need for information recorded in the practice clinical system to be fit for sharing with different health professionals in different organisations
1.16 Demonstrate how to use NHS electronic booking systems to tailor healthcare provision to the needs of the individual patient
1.17 Demonstrate the use of the practice’s computer system to improve the quality and usefulness of the medical record, e.g. through audit
1.18 Demonstrate effective use of interagency systems such as pathology links and GP-GP record transfer
1.19 Demonstrate an understanding of information governance, patient consent and privacy issues that relate to the sharing of electronic health records and the central storage of health information (e.g. as proposed by NHS Connecting for Health)
1.20 Demonstrate an understanding of the power of reporting from clinical systems for personal/practice audit and data analysis; and for comparisons with other practices that assist in setting the agenda for improving quality of care and recording of care
1.21 Demonstrate an understanding of the definition(s) of clinical governance and describe the standards used to assess the quality of health care, for example the seven domains of ‘Standards for Better Health’ used in England:
   • Safety
   • Clinical and Cost Effectiveness
   • Governance
   • Patient Focus
   • Accessible and Responsive Care
   • Care Environment and Amenities
   • Public Health
1.22 Describe the uses and abuses of clinical indicators and metrics such as benchmarking
1.23 Understand the concept of variation in clinical care, how it is determined and measured and what actions might need to be taken to address inappropriate variation, for example in referrals, prescribing, admissions
1.24 Describe when it is appropriate to raise concerns and policies for whistle blowing, and what action to take when a colleague gives you cause for concern, including what support is available
1.25 Describe the role of a practice clinical governance lead and their key relationships internally and externally
1.26 Describe the local clinical governance arrangements
1.27 Describe the relationship between clinical governance, appraisal and revalidation, including the requirements for revalidation and describe the process and roles of the GP, the responsible officer, the RCGP and the GMC
1.28 Compare Good Medical Practice as published by the GMC and the RCGP’s Good Medical Practice for General Practitioners
1.29 Be familiar with the RCGP guide to revalidation and the requirements for strengthened medical appraisal (www.rcgp.org.uk) and your revalidation portfolio
2 Person-centred care

This area of competence is about understanding and relating to the context of your patients as individuals, and developing the ability to work in partnership with them.

This means that as a GP you should:

2.1 Communicate openly, listen and take patients’ concerns seriously. Consider patient issues when reflecting on consultation experiences.
2.2 Tell patients and their families as soon as possible when incidents occur and do so fully, honestly and compassionately.
2.3 Describe the NHS complaints systems and optimal methods for learning from complaints and dealing with patients.
2.4 Describe the techniques for obtaining the views and feedback from patients, including both quantitative methods such as surveys and qualitative techniques such as focus groups.
2.5 Consider the benefits of involving lay people in the improvement of health services.
2.6 Understand what is involved in establishing a Patient Participation Group (PPG).
2.7 Consider the advantages and disadvantages of patients accessing their own records.

3 Specific problem-solving skills

This area of competence is about the context-specific aspects of general practice, dealing with early and undifferentiated illness and the skills you need to tolerate uncertainty, and marginalise danger, without medicalising normality.

This means that as a GP you should:

3.1 Compare the systems and processes in place in your practice to identify and manage risk in the primary care setting and compare these with other practices.
3.2 Decide the criteria for when the organisation should undertake a root cause analysis or significant event audit.
3.3 Be aware of the limitations of your own skills in risk management and illustrate that you understand when the skills of colleagues trained more extensively in risk management should be called upon.
3.4 Be able to conduct a clinical audit.
3.5 Describe when an improvement project would help patient care and consider undertaking an evaluation e.g. audit or PDSA cycle (plan–do–study–act).
3.6 Describe how practice systems can be used to analyse practice performance.

3.7 Appraise critically data about practice indicators (e.g. prescribing, referrals, chronic disease management, availability)
3.8 Describe the variation in GP and practice performance and the determinants of this
3.9 Locate information about standards, clinical guidelines, critical appraisal and databases

4 A comprehensive approach

This area of competence is about how you as a general practitioner must be able to manage co-morbidity, co-ordinating care of acute illness, chronic illness, health promotion and disease prevention in the general practice setting.

This means that as a GP you should:

4.1 Demonstrate an awareness of the all-encompassing approach to patient safety, for example by keeping a log diary of consecutive consultations for at least one day per month and commenting on any actual or potential patient safety incidents within those consultations
4.2 Reflect on the risks to patient safety in a care pathway in which a variety of healthcare professionals are involved, looking at interface issues and be able to comment on the ways in which, as a GP, you can work to minimise these
4.3 Describe the structures and processes for managing clinical and non-clinical risk, and how these are integrated with patient and staff safety, complaints, clinical negligence and financial and environmental risk
4.4 Explain the importance of good clinical governance and its key components in a practice
4.5 Understand principles of improvement methodology to facilitate change

5 Community orientation

This area of competence is about the physical environment of your practice population, and the need to understand the interrelationship between health and social care, and the tensions that may exist between individual wants and needs and the needs of the wider community.

This means that as a GP you should:

5.1 Be aware of the current pattern of patient comments through, for instance, the local patient representative body
5.2 Describe the ways in which general practice and community pharmacy can work together to minimise the potential for patient safety incidents
5.3 Know how patient groups may be put at increased risk of mishaps by virtue of their particular characteristics, such as language, literacy, culture and health beliefs
5.4 Know the new roles that have emerged in the community setting and give examples of how these new roles have impacted upon patient safety
5.5 Consider why patients from varied backgrounds that reflect the population of the area should be involved
5.6 Describe the problems resulting from inequalities in healthcare provision
5.7 Describe approaches to improving access to services for hard-to-reach groups
6 A holistic approach

This area of competence is about your ability to understand and respect the values, culture, family structure and beliefs of your patients, and understand the ways in which these will affect the experience and management of illness and health.

This means that as a GP you should:

- 6.1 Describe how the lessons of patient safety can be applied prospectively to doctor–patient interactions, especially through the identification and discussion of risk
- 6.2 Help facilitate the implementation of solutions to prevent harm, by embedding any lessons learnt in the practice processes and systems
- 6.3 Share lessons from the analysis of patient safety incidents within the team
- 6.4 Identify which other elements of patient services may be affected in future and share learning more widely on the basis of this
- 6.5 Involve patients and carers in their care, in decision-making and in quality improvement processes

The essential features of you as a doctor

The three essential features (EFs) below are concerned with the features of you as a doctor which may influence your ability to apply the core competences to real life in the work setting.

EF1 Contextual features

This essential feature is about understanding your own context as a doctor and how it may influence the quality of your care. Important factors are the environment in which you work, including your working conditions, community, culture, financial and regulatory frameworks.

Examples of this are:

- EF1.1 Showing that, as a specialty trainee (GP) within the team environment of general practice, your experiences gained in previous settings can be shared with colleagues. Recognise that the formal Patient Safety Agenda is relatively recent and may be unfamiliar to well-established colleagues
- EF1.2 Describing the impact of the working environment on the care the doctor provides and the likelihood of adverse incidents as a result of this
EF1.3 Commenting on the use of situational awareness theories

EF2 Attitudinal features

This essential feature is about your professional capabilities, values, feelings and ethics, and the impact these may have on your patient care.

Examples of this are:

EF2.1 Admitting when an error has occurred, apologising for failings in the delivery of care and communicating this openly to patients and their families, reassuring them that the appropriate lessons have been learned

EF2.2 Illustrating how a change in the behaviour and/or systems can influence patient safety

EF2.3 Discussing with colleagues in different practices how high-quality multi-professional working can benefit patient safety, and considering the steps needed to facilitate such co-working

EF2.4 Demonstrating a commitment to clinical excellence and patient safety, to monitoring the quality of care provided and to accounting for it to peers, patients and the NHS

EF2.5 Having an awareness of your own capabilities, values and ethics

EF2.6 Identifying ethical tensions inherent in governance processes and resource allocation

EF2.7 Describing the interaction of work and private life for oneself and others, and striving for a good balance between them

EF2.8 Helping to shape an organisational culture that prioritises safety and quality through openness, honesty, shared learning and continual incremental improvement

EF2.9 Describing your accountability as a GP

EF3 Scientific features

This essential feature is about the need to adopt a critical and evidence-based approach to your work, maintaining this through lifelong learning and a commitment to quality improvement.

Examples of this are:

EF3.1 Being able to describe the tools and principles that can be applied in risk management and patient safety issues

EF3.2 Being able to describe the basic principles of human error

EF3.3 Compiling a simple risk matrix

2 e.g. ‘The three bucket model’ proposed by James Reason (www.npsa.nhs.uk) where each bucket is variably filled according to the context, the domestic feelings of the doctor and the complexity of the task
EF3.4 Developing and maintaining an approach to continuing learning and quality improvement
EF3.5 Being aware of clinical guidelines and pathways and demonstrating their appropriate use
EF3.6 Preparing a folder for educational supervision and when appropriate revalidation containing relevant evidence
LEARNING STRATEGIES

Work-based learning – in primary care

It is important that the specialty trainee (GP) gains a good understanding of clinical governance in primary care before completing training. Primary care both inside and outside the practice is the ideal environment to learn about the principles and to engage in their application.

All specialty trainees should complete a clinical audit cycle relating to patients in their training practice and actively contribute to the practice’s significant event audit meetings. Recognising this as an opportunity for reflection as well as possible celebration of good care is a particular feature of primary care teams.

As a GP specialty trainee you should take the opportunity to visit the relevant local primary care organisation in order to understand the role of clinical governance leads, and observing a governance committee would help you in understanding their associated processes. This may change over time with the impact of practices working as federations and also within GP clinical commissioning groups.

Being part of a multidisciplinary team is a particular feature of primary care. It is important that you understand the influence of being a doctor in that team and the effect on the culture and systems within the practice. It is also useful for you to observe and be aware of the varying levels of influence arising from the different roles such as partner, sessional doctor and locum. This has clear links to leadership competencies.

Observing systems developed by each practice to manage its repeat prescribing system and decisions about how much risk to ‘tolerate’ in this process is unique to primary care. Considering the variation in impact and uptake of the National Prescribing Centre guidance is also worthwhile. Likewise, the processes that occur during a consultation when a decision to refer is made, as well as the practical systems in place to achieve the referral, are ideally explored within the primary care setting. Reflecting on cases that illustrate a delay in diagnosis using tools such as SEA can help in understanding the complex process of diagnosis, within both the primary and the secondary care setting.

Work-based learning – in secondary care

Learning about the differences between primary and secondary care will help the specialty trainee gain a broader understanding of the principles and practice of clinical governance and how to maximise benefit for patients. There should be opportunities to undertake clinical audits and critical event analysis with hospital colleagues.

Root Cause Analysis (RCA) is the standard risk tool used in secondary care and familiarity with its application can be best observed in this setting. Specialty trainees should be able to describe the particular role of risk managers in acute trusts and this is best appreciated while in this environment.
The primary/secondary care interface is especially vulnerable to patient safety incidents. Observing and understanding how different systems and processes influence this can be appreciated during a secondary care-based experience.

**Non-work-based learning**

There are many web-based sites that offer educational modules in patient safety and quality of care, in particular e-GP, which provides a free programme of e-learning courses covering the RCGP curriculum (www.e-GP.org)

**Learning with other healthcare professionals**

Primary care teams are highly sophisticated multi-professional groups. The opportunities for you to participate in shared learning with colleagues have expanded, particularly following the extension of non-medical prescribing and extensive collaborative working on long-term conditions.

In addition, you have many opportunities in primary care to discuss clinical governance with nurses, allied health professionals and managers, all of whom should be engaged in the practice’s education and clinical governance programmes.

Unscheduled care in the community, both in hours and out of hours, is provided by a variety of different contractors utilising the skills of practitioners such as paramedics, emergency care practitioners, urgent care centres, crisis mental health teams and walk-in centres. These are ideal places for you to see and understand skill-mixing in healthcare and to compare and contrast the benefits and disadvantages of each option.
Examples of relevant texts and resources

- Clinical Governance Support Team. *What is Clinical Governance?* Leicester: Clinical Governance Support Team, 2005
- General Medical Council. *Duties of a Doctor* London: General Medical Council, 2002
- Houghton G and Wall D. Twelve tips on teaching about clinical governance *Medical Teaching* 2000; 22(2): 145–53
- Kemper KJ. Holistic pediatrics = good medicine *Pediatrics* 2000; 105: 214–18
- Payne RA and Avery AJ. Polypharmacy: one of the greatest prescribing challenges in general practice *British Journal of General Practice* 2011; 61: 83-84
- Pietroni P. Holistic medicine: new lessons to be learned *Practitioner* 1987; 231: 1386–90
Web resources

Medical Defence Union
www.the-mdu.com/section_GPs_and_primary_care_professionals/index.asp

National Institute for Health and Clinical Excellence (NICE)
www.nice.org.uk

NHS Institute for Innovation and Improvement
The aim of the NHS Institute is to help transform healthcare for patients by developing leadership, new work practices and technology.
www.institute.nhs.uk

- Leading Improvement in Patient Safety Programme for General Practice (LIPS GP) is a training resource facilitated by clinical improvement experts. The tools and techniques learnt enable practices to improve quality and safety
- Medical Leadership Competency Framework (MLCF) has been jointly developed by the Academy of Medical Royal Colleges and the NHS Institute for Innovation
- Podcasts on various aspects of quality and safety improvement are available on the NHS Institute’s Safer Care/General Practice web pages
- Primary Care Trigger Tool is a web-based tool that uses rapid structured case-note review to measure harm in general practice and prioritise areas for improvement
- Productive GP modules will be available from April 2012
- The Productive Leader modular framework encourages leaders to be more efficient and reliable in the way they lead improvement
- Sustainability Guide provides self-assessment of the level of sustainability of improvement initiatives
- Thinking Differently tools utilise creative thinking in improvement initiatives

National Reporting and Learning Service
The National Reporting and Learning Service (NRLS) is working with healthcare organisations and royal colleges to improve how patient safety incidents from general practice are reported so that national learning can be developed.
www.nrls.npsa.nhs.uk/resources/healthcare-setting/general-practice

- www.nrls.npsa.nhs.uk/resources/?EntryId45=75355 (Root cause analysis)
- www.nrls.npsa.nhs.uk/resources/healthcare-setting/general-practice/?entryid45=61598 (Seven steps to patient safety in general practice)
- www.nrls.npsa.nhs.uk/resources/healthcare-setting/general-practice/?entryid45=61500&q=0%2acssignificant+event+audit%2ac (Significant event audit guidance)
- www.nrls.npsa.nhs.uk/resources/type/data-reports/?entryid45=69894 (Delayed diagnosis of cancer: thematic review)
- www.nrls.npsa.nhs.uk/resources/?entryid45=59796
Royal College of General Practitioners
The Royal College of General Practitioners (RCGP), the professional membership body for family doctors in the UK and abroad, is committed to improving patient care, clinical standards and GP training.

www.rcgp.org.uk
- For e-learning to support the curriculum statements: www.e-GP.org
- For news on GP federations: www.rcgp.org.uk/federations_toolkit/about_the_toolkit.aspx
- For information on revalidation: www.rcgp.org.uk/revalidation.aspx
- For information on GP commissioning: www.rcgp.org.uk/centre_for_commissioning.aspx
This curriculum statement is based on and replaces the following statements in the 2007 version of the RCGP Curriculum.

3.1 Clinical Governance
3.2 Patient Safety

It has drawn on various national guidelines and policies, current research evidence and the clinical experience of practising general practitioners.

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The 2007 version of the statement and subsequent updates can be found on the RCGP website. The Royal College of General Practitioners would like to express its thanks to all the individuals and organisations who have contributed so generously to past and present versions of this statement.