### MEETING NOTES

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>Primary Care Patient Safety Expert Group</th>
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<tr>
<td>Date:</td>
<td>18th June 2015</td>
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| Attendees: | Martyn Diaper (Chair) – Head of Patient Safety, Primary Care, NHS England  
Sabina Khanom Patient Safety Lead, NHS England  
Joan Russell Head of Patient Safety, NHS England  
Nigel Sparrow National Professional Advisor for Primary Care, CQC  
Paul Gardner – GP  
Soni Ashok President RPS  
Bruce Warner- Deputy Chief Pharmaceutical Officer, NHS England  
Lance Sandle Vice President, Royal College Pathologists  
Chris Connor – Trainee representative, RCGP  
Jean Goffin PPV representative  
Ivan Benett Clinical Director, Central Manchester CCG  
Christine Johnson RCGP  
Gillian Champion – Nurse and managing partner  
Berenice Lopez Consultant Chemical Pathologist, Norfolk & Norwich UHT Teaching Hospitals |
| Apologies: | Dr Sunil Gupta, member of Governing Body Castlepoint and Rochford CCG  
Mike Bewick Deputy Medical Director, NHS England  
Maria Ahmed, GP Speciality Trainee  
David Geddes Head of Primary Care Commissioning, NHS England  
Tricia Woodward RCR Patient Safety Advisor, Royal College of Radiology  
Tony Avery Professor of Primary Health Care, RCGP  
Peter Lord Programme Delivery Lead, NHS England  
Andrew Green, Chair, GPC Clinical & Prescribing Subcommittee, BMA  
James Petter Head of Education and Professional Development  
South Western Ambulance Service  
NHS Foundation Trust  
Stephen Campbell, Principal Investigator: Greater Manchester Primary Care Patient Safety Translational Research Centre  
Myra Upton, President AMSPAR  
Susan Riley Kent Community Hospital Trust  
Dr Jane Povey Deputy Medical Director, Faculty of Medical Leadership and Management, NHS Shropshire CCG  
Cat Ohman-Smith  
David Gerrett, Senior Pharmacist, Patient Safety, NHS England  
Ghafur Saira, Clinical Advisor, NHS England  
Barbara Ross - AVMA |
| In attendance: | Helen Marlow, Lead Primary Care Pharmacist and NICE Medicines and Prescribing Centre Associate  
Ben Scott, Customer Services Manager MRHA  
Maria Root, Editor of Drug Safety Update MRHA  
Paul Aylin, Professor of Epidemiology and Public Health, Imperial  
Jane MacDonald MRHA |
<p>| Dr John Byrne |</p>
<table>
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<tr>
<th>ITEM</th>
<th>KEY DISCUSSION</th>
<th>ACTIONS</th>
<th>ACTION BY + DUE DATE</th>
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<td>A. Welcome, Introductions &amp; Apologies</td>
<td>Martyn Diaper (MD) led the introductions, as chair, and then all introduced themselves for the benefit of new people that joined the group. Martyn Diaper also acknowledged the apologies received.</td>
<td>Sabina Khanom to present at next meeting</td>
<td>September 2015</td>
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<td>Actions from last meeting: Sabina Khanom updated the group on the launch of the new GP eform and reporting from general practice. Sabina shared with the group data from the first few weeks of reporting which show an encouraging increase in reporting. The summary of feedback is received by the reporter as part of the bounceback email, which also includes an SEA template. The group discussed how GP’s can be encouraged to report and the importance of receiving feedback when reporting incidents. This will be presented in-depth at the next meeting. Due to lack of capacity on the agenda for this meeting the decision was taken to defer further discussions on the Five Year Forward View until the next meeting in September. Actions on glucose test strips have been deferred to next meeting as David Gerrett was unable to attend. All other actions were complete.</td>
<td>To be discussed further at next meeting</td>
<td>September 2015</td>
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<td>C. New agenda items</td>
<td>Alerts issued since the last meeting: Risk of death or severe harm due to inadvertent injection of skin preparation solution <a href="http://www.england.nhs.uk/wp-content/uploads/2015/05/psa-skin-prep-solutions-may15.pdf">http://www.england.nhs.uk/wp-content/uploads/2015/05/psa-skin-prep-solutions-may15.pdf</a> Managing risks during the transition period to new</td>
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ISO connectors for medical devices

Joan Russell asked the group were asked if they were aware of the two Alerts and it was confirmed that the group weren’t. The current communication routes for Alerts was discussed through the CAS system; Ben Scott informed the group that he is involved in a meeting with CAS who are now working with sub regions to address how communication with primary care can be improved. It was reflected that is essential for Alerts to be cascaded down to Practices and they need to be more specific to general Practice. Targeting of Alerts also needs to be improved to ensure they are going to the correct place. It was agreed that more work needs to be done with CAS. It was noted that the same issues applied to pharmacy and the other primary care independent contractors.

It was agreed that there was a role for the networks within the PSEG to support dissemination on relevant Alerts.

The draft Alert on ambulance dispatch and satellite navigation units which had been shared by email was also discussed and approved.

**D. Presentation of research from Imperial Patient Safety Translational Research Centre**

Martyn Diaper welcomed Paul Aylin to the group.

Paul provided an overview of research undertaken at Imperial relating to the monitoring of patient safety in north west London primary care. The aim of the study was to explore the data that is used to monitor patient safety and quality of primary care by professionals working or supporting primary care practices in north west London.

Paul explained that three main themes emerged:

- Vast amount of complicated data collected about GP’s and GP practice’s performance, however these did not inform about patient safety in a meaningful way.
- Lack of clarity over which aspects of patient safety are to be monitored and how this is to occur.
- It is not clear whose responsibility it is to act on patient safety information.

The research also highlighted the need for reliable feedback over patients missing appointments and
confusion over serious incident reporting.

A discussion took place about issues raised over reporting.

Martyn Diaper added the current priority for the PSEG has been around Culture and Infrastructure.

It was suggested that reporting should focus on five common incidents so GP’s would be more inclined to report.

Lack of feedback was also raised as a barrier.

It was also pointed out that incident reporting will need to reflect the change of delivery of primary care.

A paper is going to the RCGP Council in June written by Maureen Baker to address patient safety concerns. A funded project is also being undertaken by RCGP to identify avoidable harm in general practice through case note review.

**E. MHRA drug safety updates**

Maria Root gave a presentation on MHRA drug safety updates / yellow card reporting system.

Maria Root shared with the group examples of topics covered within the Drug Safety Update. She informed the group that the yellow card system is now being integrated into software systems. There are currently over 230,000 subscribers to the update with only 34,000 of these being from primary care. The group was asked for suggestions to increase readership and how to increase yellow card reporting.

Suggestions included incorporating yellow card system into GP systems as well as GP eform with the two integrated and the development of an app to download the bulletin as well as report incidents.

Currently, incidents reported to the NRLS are shared with the MHRA if they are related to medications.

It was clarified that electronic subscribing to the bulletin is free.

**F. Draft standards ‘Communication of essential test results at discharge’**

Berenice Lopez provided an update on this work programme.
Since this group was established a number of additional related areas of work had been identified with the proposal that they are included in the standards. These include the need for more detail around specific types of tests, inclusion of other transfer of care circumstances, the role of IT and the role of diagnostic services.

It was recognised that inclusion of these additional areas would significantly increase the scope and complexity of this work programme.

It was stated that the Royal College of Pathologists is preparing a document on the communication of critical pathology results.

It was agreed that the subgroup should be asked to review scope and identify those areas that can be achieved in the short term to achieve the original aim of ensuring essential information is communicated effectively and responsibilities for this clarified.

### 6. Feedback from the Patient Safety Steering Group - to include MBRRACE Report and discussion

Christine Johnson provided an overview of the last Patient Safety Steering Group and fed back in more detail on the MBRRACE Report and discussion.

The report identifies that the number of indirect maternal deaths has gone up significantly and in higher proportion to other countries. Key causes of indirect maternal death are epilepsy, sepsis and influenza.

The group has been asked to consider its potential role in reducing these potential deaths and feedback to the next steering group.

Martyn Diaper is chairing the Out of Hospital Sepsis meeting and will take this forward at this meeting.

It was felt that the group needed a greater understanding of the data and where the deaths are occurring. It was agreed that MBRRACE should be approached to provide more detail.

### H. Follow up of patients who did not attend (DNAs)

Joan Russell fed back that a joint meeting had taken place with Mental Health PSEG where this issue was discussed. It was proposed that a Patient Safety Alert should be considered to promote the follow up of patients who DNA.

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<th>Berenice Lopez and Joan Russell to discuss at next Workstream Sub Group meeting and feedback to next Primary Care PSEG meeting</th>
<th>July 2015</th>
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<td>Joan Russell to invite a representative from MBRRACE to the next meeting</td>
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On discussion it was felt the scope for an Alert was too big and more work needs to be done on understanding the patients most at risk and the reasons for DNA's.

It was agreed that further work should be undertaken outside of this meeting bringing interested people together.

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<th>I.</th>
<th>Reg 28 letter - Prioritisation of home visits</th>
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<td>A Reg 28 letter has recently been circulated identifying that a patient deteriorated while waiting for a home visit and later died. Martyn Diaper read out the reg 28 letter and the group discussed the practicality of telephoning every patient in advance of a home visit. Some members of the group informed that this routinely takes place in their practices; however the workload implication of this should also be noted.</td>
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<td>It was agreed that systems should be in place to assess and prioritise home visits and this was appropriate to be taken forward by CQC. It was queried whether commissioners could also have a role in ensuring systems are in place.</td>
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<th>K. Repeat prescribing and administrative staff smart cards</th>
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<td>Helen Marlow, Lead Primary Care Pharmacist and NICE Medicines and Prescribing Centre Associate attended the meeting to discuss some work undertaken at surrey Downs CCG. This related to repeat prescribing and administrative staff smart cards. The work undertaken in the area was to develop standards which included administrative staff not being able to add new medicines to a patient’s medication record. However, one of the difficulties is that the national smart card profile for administrative staff allows this to take place, therefore resulting in some practices feeling that this is national authority for this group of staff to undertake this role.</td>
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<td>On discussion it was identified that CQC already have similar standards. A member of the group also stated that within her practice staff are not allowed to undertake this role and their smart card profile does not allow this as they have been able to change this locally when setting up.</td>
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It was agreed that Helen Marlow to liaise directly with the CQC via Dr John Byrne regarding standards in the first instant to undertake a gap analysis between standards. This should then be brought back to the group to consider whether the group could produce a revised standard.

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<tr>
<th>J. Reviewing TOR for PSEGs</th>
<th>Helen Marlow and Dr John Byrne to undertake gap analysis</th>
<th>September 2015</th>
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**Any Other Business**

| Martyn Diaper updated the group regarding his meeting with Keith Ridge, Chief Pharmaceutical Officer and the work being undertaken around medicines use in learning disabilities mainly around the use of powerful medicines such as antipsychotics to manage challenging behaviour. Martyn also discussed his conversation with Mike Durkin, who is happy for the work up for a draft alert to be undertaken. Martyn asked the groups views about a draft patient safety alert relating to this. The group were in favour of this. Martyn agreed that he would share these views with Keith Ridge. | Martyn Diaper to discuss further with Keith Ridge | July 2015 |

**Date of next meeting:**

17th September 2015, Skipton House, 14:00 to 16:30, Room 124A