MEETING NOTES

Meeting:	Primary Care Patient Safety Expert Group		
Date:	12th June 2014		
Attendees:	• Martyn Diaper, Chair • Joan Russell, Head of Patient Safety, NHS England • Caroline Lecko, NHS England Patient Safety Lead • Jean Goffin, PPV representative • Tony Alcock, PPV representative • Maria Ahmed, GP Specialty Trainee • Marc Wittenberg, Clinical Fellow • Paul Gardner, GP • Berenice Lopez, Clinical Advisor to RCGP &Consultant Chemical Pathologist(metabolic medicine) • Ash Soni, Vice Chair RPS English Pharmacy Board • Nigel Sparrow, CQC • Christopher Connor, RCGP trainee representative • Donna Forsyth, NHS England Head of Patient Safety • Christine Johnson, RCGP In attendance: • Jit Patel, NHS England Deputy Director Patient Safety	**Apologies**:	• Tony Avery, RCGP • Mike Bewick, Deputy Medical Director, NHS England • David Geddes, NHS England – Head of Primary Care Commissioning • Sunil Gupta, CCG Accountable Officer • Peter Holden, BMA General Practitioners Committee • Anita Rolfe, Chief Nurse and Director of Quality Assurance at Manchester Mental Health and Social Care Trust. • Myra Upton, President AMSPAR • Ivan Benett, Clinical Director – Central Manchester CCG • Stephen Campbell – Principal Investigator: Greater Manchester Primary Care Patient Safety Translational Research Centre • Barbara Ross, AvMA • Bruce Warner, NHS England – Deputy Director Patient Safety • Jane Povey, Deputy Medical Director, Faculty of Medical Leadership and Management, NHS Shropshire CCG • James Nicholls, NHS England Patient Safety Communications Manager • Susan Riley- Kent Community Health NHS Trust

ITEM	KEY DISCUSSION	ACTIONS	ACTION BY + DUE DATE
A. Introduction and apologies			
	As above Martyn Diaper led the introductions, as chair, and then all introduced themselves for the benefit of new people that joined the group.		

B. Accuracy check of last meeting notes and approval			
	No further queries were raised over the notes of the last meeting		
Running Record of outstanding actions			
	A meeting is planned with David Geddes on 22nd July to discuss potential opportunities for taking primary care research forward. The group was informed that the report 'Building a culture of candor: A review of the threshold for the duty of candour and of the incentives for care to be candid' has been circulated. Further discussion took place on primary care responsibilities in relation to Duty of Candour when incidents may not be identified until the patient is in secondary care. It was recognised that some of these issues would be clarified by CQC at a forthcoming meeting. Marc Wittenberg reminded members of the call for proposals for the Quality and Safety in Health Care conference in 2015. All other actions were complete	Nigel Sparrow to provide feedback on outcome of CQC meeting All to consider submitting a proposal	Sep 2014 16th June
D. New agenda items			
Patient Story (C)	The patient story was read out by Martyn Diaper – a patient was admitted into secondary care under the care of psychiatrists. In the context of the admission patient had an x-ray that was reported as abnormal. The main issues the story highlighted were: • Request in discharge letter for primary care to follow up on x-ray result was missed • The results were not appended to the discharge letter • The patient was subsequently identified as having a fracture • There was subsequent delay in diagnosis A bulleted task list at the end of discharge letters had been proposed as an option to decrease the risk of similar issues from occurring in the future. It was agreed that this should be taken forward as part of the work on discharge. It was also agreed that this issue would be raised at the next Patient Safety Steering Group meeting as	Joan Russell to include in work on discharge Martyn Diaper to raise	April 2015 July 2014

	this was also relevant to other specialties	issue at next Patient Safety Steering Group	
Feedback from Patient Safety Steering Group (D)	The last meeting was held on the 28th April. Martyn Diaper provided an overview of the issues discussed and notes of the meeting had previously been circulated. Particular points noted were the discussion on Duty of Candour. The actions from the report, being led by DH, will be live from Autumn this year which includes providing further clarity for GPs. Sign up to safety campaign was also highlighted at this meeting. Martyn Diaper and Christine Johnson had both attended a planning meeting. It is proposed that this campaign will increase reporting and potentially reduce avoidable harm by half. The campaign will go live on 24th June Concern was expressed over whether current safety initiatives will support GPs in the current transformation of care programme for primary care. The patient safety website which will go live on the 24th June was also discussed. Concern was expressed that this may create risks if checks on data to be published had not yet been undertaken before the go live date.		
NRLS Review (E)	Jit Patel gave a presentation on the development of NRLS. The NRLS is national database of patient safety incident reports. Incidents resulting in severe harm and death are routinely reviewed and action triggered, where appropriate. Most incidents result in low and no harm – these incidents are routinely reviewed but can be used by groups upon request for studies and investigations. It is proposed that the NRLS will be updated within 3 years. Jit then shared the results from the questionnaire about views on the future of reporting and learning system for patient safety incident data. Views raised from the group included: • Recognition that the NRLS technology is	Jit to share full set of results with group	

	outdated and that it is difficult to find the data that is required – therefore every incident that is reported cannot be utilised. The technology is now available to do automatic scanning of free text. • Any future version of the NRLS needs to have a long shelf life. • Needs to be fit for purpose for primary care – adapting a secondary care system doesn't work. • Needs to be quick as no resource in primary care to complete (even if practices federate). Taxonomy needs to be simpler • Needs to be responsive for community pharmacy • Needs to be able to respond to requirements for pathology as any incidents reported relating to primary care are reported within secondary care systems • Consistency in language required – e.g. significant event means something different to primary care and revalidation		
Update on Improving GP Reporting (F)	Donna Forsyth gave information on the development of the new test GP e-form. This e-form will potentially make NRLS reporting more user friendly for General Practice. The form is not yet available as further work needs to be undertaken to find out what can be added to the current system and there may be funding requirements to back this project. There will be the opportunity for GP reporting to form part of revalidation and to offer CPD credits to GPS who offer some learning as part of the reporting process. Feedback was provided by CQC that practice appraisal will form part of their inspections so there may be potential for double counting with regards to Significant Event (SEA) reporting. E.g The same SEAs shouldn't be used for both CPD and revalidation. The group agreed that the proposed e-form will be useful as they want to see learning as a result of what is happening in general practice.		

	The Royal Pharmaceutical Society and RCGP also offered to be involved in this work.	Martyn Diaper/Donna Forsyth to coordinate work on new GP e-form for NRLS	July 2014
Patient Safety Action Day (G)	Martyn Diaper stated that initial feedback received on the proposal for the Patient Safety Action Day is that it is a good idea and possible to do with minimal financial resource. The next step is to get support from the group. The group stated that the text message is a good idea, but it may be off putting if then asked to complete the current reporting form It was proposed that the Action Day should not go ahead until a new form has been developed, as the need to encourage GPs to report incidents and capture information is key to the day. Martyn Diaper proposed that planning for the event should continue and the next steps should be a brainstorming session of the sub group	Joan Russell to arrange next meeting	July 2014
Response to Current Issues Brought to the Agenda (H) **Coroner's Letter re Essential Equipment**	The PSEG had been asked to consider the recommendations in a recent Coroner's Letter with a view to considering national applicability. The issue relating to availability of pulse oximetry was discussed. The group agreed that it should be considered good practice for every practice to have a pulse oximetry as it is included in NICE Guidance. Non-compliance wouldn't be a breach of CQC Regulations but compliance would be recognised as good practice. The group considered options for promoting availability of pulse oximeters, including the option of a Patient Safety Alert or GP Bulletin. Resource implications would not be an issue as pulse oximeters are inexpensive but training on how to use the equipment would be required. The NPSA had previously done work around standardising the contents of the doctor's bag. It was agreed that having the opportunity to review this work may inform the decision on how we promote the availability of pulse oximeters. It was agreed that Donna Forsyth would circulate the work previously considered on the	Donna Forsyth to circulate relevant elements of the previous work undertaken by the NPSA on standardising contents of the doctor's bag	

Discharge Task List	doctor's bag. This issue will then be re-discussed at the next meeting The patient story summarised at the beginning of the meeting had originated from a letter from the Medical Protection Society. No additional actions were identified.		
Review of Never Events Framework (I)	Joan Russell updated the group on Never Events. The Patient Safety Leadership Team has agreed that the whole of the Never Events framework is going to be reviewed. This included the definition of a Never Event as well as the events that are included in the framework. The reviews are scheduled to be complete by Nov 2014. Fran Watts is leading on this task and would like feedback from the Primary Care PSEG with regards to the principle and definition of Never Events as well as those that should be fed into the framework for Primary Care. Fran Watts will be organising a webinar for the group in July	Date of webinar to be circulated by Fran Watts. As many of the group as possible to attend the webinar	June 2014 July 2014
Update on Safer Discharge (J)	Joan Russell asked the group for feedback on the updated draft Patient Safety Alert 'Risks arising from communication and subsequent failure to act on information when patients are discharged from secondary care'. Joan Russell also shared that a number of questionnaires were being developed as a means of gathering further information relating to discharge communication, one of these is for primary care staff. The group agreed that the Alert now reads much better and provides more clarity than the previous version. The group recognised the importance of the questionnaire and advised that the focus of priority should be on the development of the Stage 2 Alert. Joan Russell reported that they will also be running a number of webinars to promote local discussion and sharing of practice. Joan Russell also asked the group if they had any ideas of social care networks to circulate the Alert through.	All to share ideas for networks/contacts with Joan Russell	July 2014

AOB			
	Martyn Diaper provided a brief overview of the work that he was involved in in the wider NHS England Primary Care Strategy and how this group will be involved.	To be raised as an agenda item at the next meeting	September 2014
Next Meeting:	Thursday 11th September 14.00 – 16.00. Venue: Skipton House		