Online supplementary file 2: the top 60 research priorities

1	What is the role of the receptionist in patient safety; i.e. facilitating access to urgent appointments?
2	Do GP practices keep patient records up to date to ensure safety when a patient is seen by a different GP?
3	Do patients have thoughts on what is safe and unsafe practice and would they know how and where to escalate any concerns?
4	Does seeing a named GP who knows an individual have safer care than seeing a GP who doesn't know me?
5	How does continuity of care influence patient safety?
6	How is patient safety and patient harm monitored in primary care?
7	How many patients actually know what medication they are taking; what for and what the potential side effects are?
8	What can be done to make polypharmacy safer?
9	What is the impact of pharmacy input in the GP surgery?
10	Do GPs and other health care professionals record patients who are vulnerable/at risk in the patient notes?
11	Do patients referred to their community pharmacist by their hospital pharmacist for post-discharge support with their medicines have improved levels of medicines safety and medicines adherence?
12	How can patient safety be assured for the most vulnerable in society (e.g. people who are frail; have mental health problems; cognitive impairments; learning difficulties; disabilities; and poor health literacy)?
13	How frequent are the misdiagnosis of symptoms by GPs resulting in patient safety incidents?
14	How safe are phone consultations compared to face to face with one's GP?
15	How well trained are receptionists as acting as gatekeepers to GPs and prioritising patients?
16	In what ways does work intensity; hours worked & staffing levels affect patient safety/near misses?
17	What can be done to improve access to GP surgery for someone with mental health problems?
18	What can Primary Care do to identify and support people who may be at risk of suicide?

19	What do patients understand about when they should or shouldn't contact a GP; and who they should see instead?
20	What team working methods/cultures promote a safer approach?
21	What types of prescribing errors are occurring in GP prescribing practice and how often are they occurring?
22	Would a co-ordinated / holistic / overview approach to individual patients and families improve patient safety?
23	How can we encourage a culture that learns from patient safety incidents?
24	How can we encourage patients and clinicians to be more open about patient safety incidents; within a culture of learning rather than blame?
25	What tools could help practitioners balance safety/costs/workload/accessibility/quality?
26	Are difficulties in contacting doctors and/or making appointments associated with more delays or errors in diagnosis; or other failures of care?
27	Do clinicians ask patients if they understand the questions they are being asked and if they feel safe?
28	Do the actions of receptionists have potential ramifications for patient safety?
29	Does safety consciousness lead to anxiety and over compensation i.e. too much risk averseness?
30	Does the provision of detailed blood test data to patients lead to them managing their condition better?
31	How can communication between health care professionals be improved for people with multiple long term conditions?
32	How can information within patient medical records be made available to patients and care providers in a way that protects privacy and improves safety and quality of care?
33	How can patient safety reporting be made simple and action on reporting made effective?
34	How can patients best be informed about GPs with special interests in the practice they attend; in order to direct them to the most suitable doctor or nurse for consultation?
35	How can risks be mitigated to allow for safe; complex care at home?

36	How can we enable individual Practices to share their significant event audits and outcomes with each other in a way which promotes patient safer care?
37	How can we improve safe communication and co-ordination of care between Primary and Secondary care?
38	How can we make sure that the whole patient is treated; not just one condition and with mental health and physical health both being treated together?
39	How do GPs inform their patients of the side effects and potential risks when prescribing a new medication?
40	How well do patients understand the information that has been conveyed to them during the consultation?
41	In the backdrop of health and social care devolution; what are the risks to patient safety as services transform and the system transitions?
42	Is lack of continuity of care by a single doctor in a joint practice associated with more delays or errors in diagnosis?
43	Is there a clear understanding of patient safety in general practice?
44	What are the diagnostic success rates of GPs when compared to their final diagnosis for a patient?
45	What are the safe frequencies of medication review?
46	What can be done to help GPs or nurse practitioners decide when the use of antibiotics is necessary?
47	What kinds; seriousness; and frequency; of harms happen to patients in primary care?
48	What proportion of national guidelines and National Institute for Health and Care Excellence recommendations are followed and monitored?
49	What proportion of patients tell their GPs about anything else they may be taking (e.g. homeopathy; cannabis etc.) that may conflict with medications?
50	What steps can be taken to improve patient safety in out of hours care?
51	Which type practitioner (GP; advanced nurse practitioner; practice nurse; etc.) is safest to see which types of patients (acute illnesses; acute on chronic; multi-morbid; long-term illness)?
52	Why do some patients not engage with their healthcare and so not attend all/some of their health checks?
53	Why is it that doctors do not listen to carer's concerns?

54	Why is there such a time lag between seeing the hospital consultant and the GP getting information about a medication change?
55	Are patients with a disability particularly vulnerable to unsafe primary care and; if so; how can this be improved?
56	Are their harmful outcomes form excessive attention to safety?
57	How are medical errors in primary care prevented and recorded?
58	How can GP practices appointment systems (e.g. telephone; online) be improved?
59	How often do GPs report side effects; what is the level of under-reporting and how can it be improved?
60	How safe is treatment in out of hours care if patient notes are not available?