

Delivering patient safety at scale - the Suffolk Primary Care experience

Suffolk Primary Care clinical safety team:

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Suffolk Primary Care clinical safety team provide support to the 8 practices in SPC covering 80,000 patients and supports Unity Health run by the Suffolk GP Federation covering 30,000 patients.

10 things that we have learnt:

1. Data drives change but not on its own

Professor Ben Goldacre from the University of Oxford says "data does not know what it's for and data just being available is not enough to turn it into working services" that has been our experience.

Practices have different strengths and weaknesses and the ability to compare practises and identify outlying activity is invaluable and can help challenging less appropriate prescribing and it also helps support conversations with patients.

2. Quality and safety is a team sport

The skills and expertise of the data teams are often overlooked in practices.

A combined approach of clinical, data and administrative expertise is vital in order to be effective. Clear presentation of the data drives change.

3. The clinical searches must be correct

- clinically relevant evidence based
- Accurate searches

It does not take many poor searches, identifying the wrong patients, for them to generate considerable work at practice level and then losing confidence in the search system.

For searches to be effective it is vital that data quality is good, and we regularly cleanse the system of unissued repeat medications to ensure focus on the correct patients

4. Digital First services / "industrial numbers "

Due to the numbers, it is essential to use digital systems text messages such as Accurx or SystmOne Comms Annexe to communicate with patients in numbers and those that allow messaging back can be very valuable ensuring patient buys in to the change requested for example PPI reduction discontinuation and inhaler changes and maintains that individual approach.

The clinical safety process acts as a backstop for long-term conditions which are increasing in number giving clinicians' assurance that they don't have to address every issue at every consultation.

5. Working with patient participation groups (PPGs)

Working with the PPG's is helpful in explaining the rationale behind the system. Sharing the prevalence data of LTC review and medication monitoring requirements can be eye opening. Efficiencies here can lead to clinicians to spending more time with patients.

6. Timescales

Adding a small extension to the review, e.g. 15 months for 12 months, 8 months for 6 months, 4 months for 3 months, ensures we are not contacting patients who are already in the system just a little delayed.

Excluding frail and palliative patients from searches requires appropriate practice coding.

7. Messaging out to patients should be clear but can be robust

Where there are patient safety messages most patients will want to do what is safest.

It is riskier to continue to issue medication for a patient that is overdue monitoring than to withhold the medication until monitoring tests are completed and it's important that staff are supported in this by senior clinicians.

The opportunity to give patients information with links can be very powerful. There is evidence that where patients are given this support, they are more likely to engage in the changes.

Clinicians should not feel under pressure continue to prescribe something that current guidance suggests is less appropriate, for example, Dosulepin an old-fashioned antidepressant with an unacceptable safety profile and sometimes the clinical practise must just say no, stop.

It is important that where there is a change in guidelines for example around Asthma inhalers, Opioid overuse and Dosulepin patients are informed of that and that's very clear this is not something that they have done wrong as it were but that should not support unsafe prescribing. Patients do have choice, but clinicians also have professional obligations and choice.

Repeat messaging is appropriate as due to busy lives initial texts may be overlooked and lost. Repeat messaging tends to lead to response rates of 15-30%.

These systems only work where there are good patient access systems for patients to contact the practice to discuss and queries.



8. Clinical Support

It is important clinicians have senior support in difficult conversations, though in our experience most patients who want an explanation are happy to take the safe first approach.

9. Focused actions

"Everything, Everywhere, All at once" it's a great title for a film, but not great approach to change management.

Over the years we have focused on certain areas some as one-off actions, for example the discontinuation of quinine and vitamin B. Others are completed over a period of time, e.g. inhaler change and non-steroidal reduction. See chart below:

	2020				2021				2022				2023				2024				2025				2026			
Drug group																												
HRDM																												
NOACS																												
Gastro protection Metoclopramide/domperidone																												
Teratogenic drugs																												
SABA DPI																												
Valproate (M)																												
Topiramate																												
Antidepressant R/V																												
NSAIDS/Renal/ACE																												
Quinine																												
Non-preferred NSAIDS																												
Dosulepin																												
Antibiotics on repeat																												
Asthma																												
Opioids/PDD																												
Metformin - No B12																												
PPI																												
Add GLP-1 for weightloss																												
Tiding GLP-1 for weightloss																												

10. Robust communication channels

Working at scale means that we need confidence that actions recommended by the central clinical team are implemented in practice. Practice pharmacists and technicians are a vital component to make this system work. Our system of having a clinical lead supported by pharmacists and practice admin staff can support this. Dissemination of information to the care navigators who are very front line of primary care is vital so that they are aware of any messaging out to patients. We provide a monthly meeting for practice teams to attend.