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B1 #qfb1



EMPOWERING PRIMARY CARE TO LEAD QUALITY IMPROVEMENT

Thursday 28th March
13.15 – 14.30

Sean Manning & Simon Bricknell

Productive General Practice Quick
Start / Time for Care

Sustainable Improvement Team

NHS England



**RELEASING
TIME IN
GENERAL
PRACTICE:
PRACTICAL
SUPPORT
AS A
CATALYST
FOR
CHANGE**

“

‘This has given us hope. We were stuck before. Felt overwhelmed. Now we can see that we can make a difference.’

PRACTICE MANAGER



What Works?

1

Structured engagement assessing will and ability.

2

A structured systematic time bound approach.

3

Hands-on help – simple tools.

4

Focus on their pressing issues.

5

Local strategic ownership.

6

Power of sharing

Context = Pressure

GENERAL PRACTICE FORWARD VIEW



Time for Care

Our aim is to support primary care to:

- implement a change
- save time
- develop QI skills and confidence
- improve collaboration

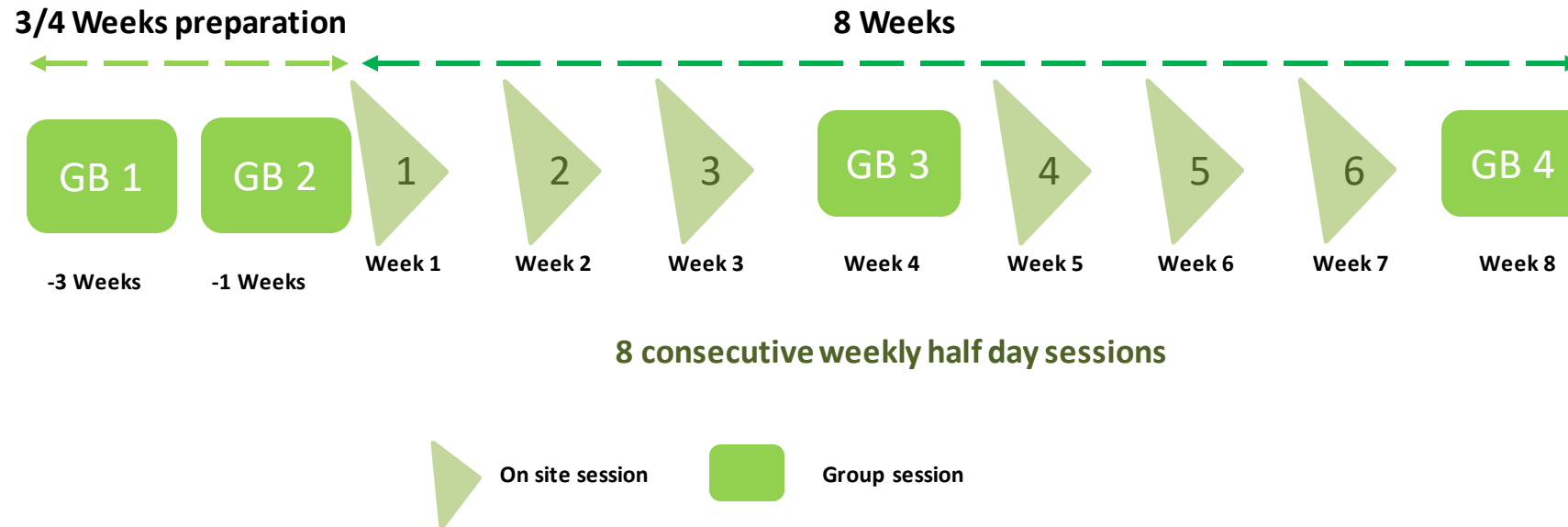


More information: <https://bit.ly/2u1KhG7>

The Delivery Model

Hands-on, practical, facilitation support in practice. Building capability and confidence, driving out waste and releasing time.

Supporting inter-practice learning, sharing and collaboration.





Engagement

- Will and ability
- Peer examples
- Face to face
- Choice
- Over 90% completion rate

What we focus on



24 year old home care assistant

1

Sore throat since previous evening. I had tonsillitis six months ago. I was really poorly and needed antibiotics and I don't want to end up like that.



62 year old lorry driver

2

Frustrated disempowered patient. Been to see the surgeon about my knee replacement and they have said I need to lose weight before they let me have the op.



28 year old nurse

3

Failure to conceive for eight months. Come to get blood results.



53 year old male with high blood pressure

4

Going on holiday to Tenerife tomorrow and needs a repeat prescription for Ramipril.



37 year old teacher

5

Has seen your GP partner two weeks ago and has not heard anything from the hospital yet.



84 year old lady

6

Two weeks after hip operation a district nurse was supposed to remove sutures. No one turned up.



18 year old female

7

First presentation with dry skin on her elbows.



84 year old lady

8

Caught her arm on a door handle yesterday. Small cut.



69 year old male taxi driver

9

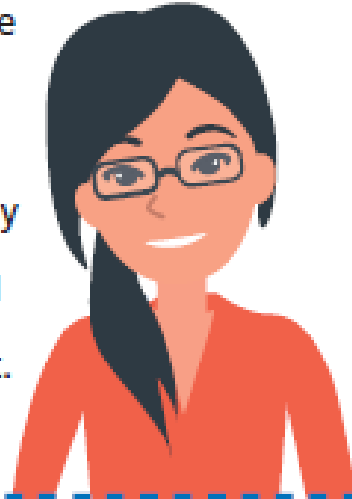
Has had severe chest pain – on and off with exertion for the last two days.



24 year old home care assistant

1

Sore throat since previous evening. I had tonsillitis six months ago. I was really poorly and needed antibiotics and I don't want to end up like that.



53 year old male with high blood pressure

4

Going on holiday to Tenerife tomorrow and needs a repeat prescription for Ramipril.



Eight categories

1. **Appropriate** – patient should **see a GP**.
2. **Inappropriate** – patient could have had a **telephone consultation**.
3. **Inappropriate** – patient should see **another clinician in the practice**.
4. **Inappropriate** – patient should see **another service** or organisation external to the practice, for example pharmacy, counselling.
5. **Inappropriate** – patient should be dealt with by **non-clinical staff**, for example reception/admin.
6. **Inappropriate** – patient should have managed condition themselves (**self care**).
7. **Inappropriate** – consultation is a result of a **missed opportunity** in the system previously.
8. **Inappropriate** – patient **did not need to be seen at all**.

Impact



PGP Quick Start gave us the tools and support to design a simpler and streamlined process that is fit for purpose and allows us to work more efficiently as a team.

Adaptability

*An excellent programme, expertly delivered,
practices have loved the individual bespoke
support provided by the coaches*

BUSINESS MANAGER - FEDERATION

Collaboration



“The programme has built relationships with staff across practices. Staff have been able to share best practice with each other and have had an open and trusting environment where frustrations and concerns can be voiced”

The Challenges

- Time
- Practice dynamics
- Sustainability
- Measurement



“It has begun to move the surgery along, things had become slightly stagnant and this has begun a movement for change”

GP

“PGPQS has helped us identify the stars in our team we never knew we had”

Practice Manager

“It’s made our lives better and happier”

Admin team member

B1: Empowering primary care to lead Quality Improvement

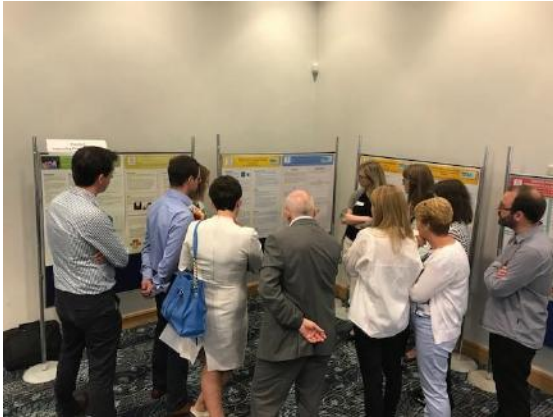
EQUIPping GPs to be leaders in improvement

Dr Nigel Hart

Queen's University Belfast &
Northern Ireland Medical and Dental Training Agency



EQUIP Day of Celebration – 1st June 2017



| My own back story...before medicine



*..where the culture & ethos was
all about:
"Continuous Improvement"*

A promise to learn - a commitment to act

Don Berwick - August 2013



“The NHS should become a learning organisation”

Batalden and Davidoff's tell us....that.....



“everyone in healthcare really has two jobs.....: to do their work and to improve it”



equip

Education Experience Excellence

UK Primary Care – Well placed for QI....

- Reputation for committed patient-focus
- Strong learning ethos in GP community
- GP Practices: Small enough to be agile
- Excellent appraisal process: focuses on Appraisee's insights for improvement
- Freedom to innovate:
 - General Practice – Contracted Service
 - Few admin barriers to service improvement & service re-design
- Existing Quality ethos:
 - QOF
 - Significant Event Analyses
 - Audit

What about the next generation...?



QUALITY IMPROVEMENT SCOPING EXERCISE

This is a short exercise to consider your current role and future aspirations within healthcare.

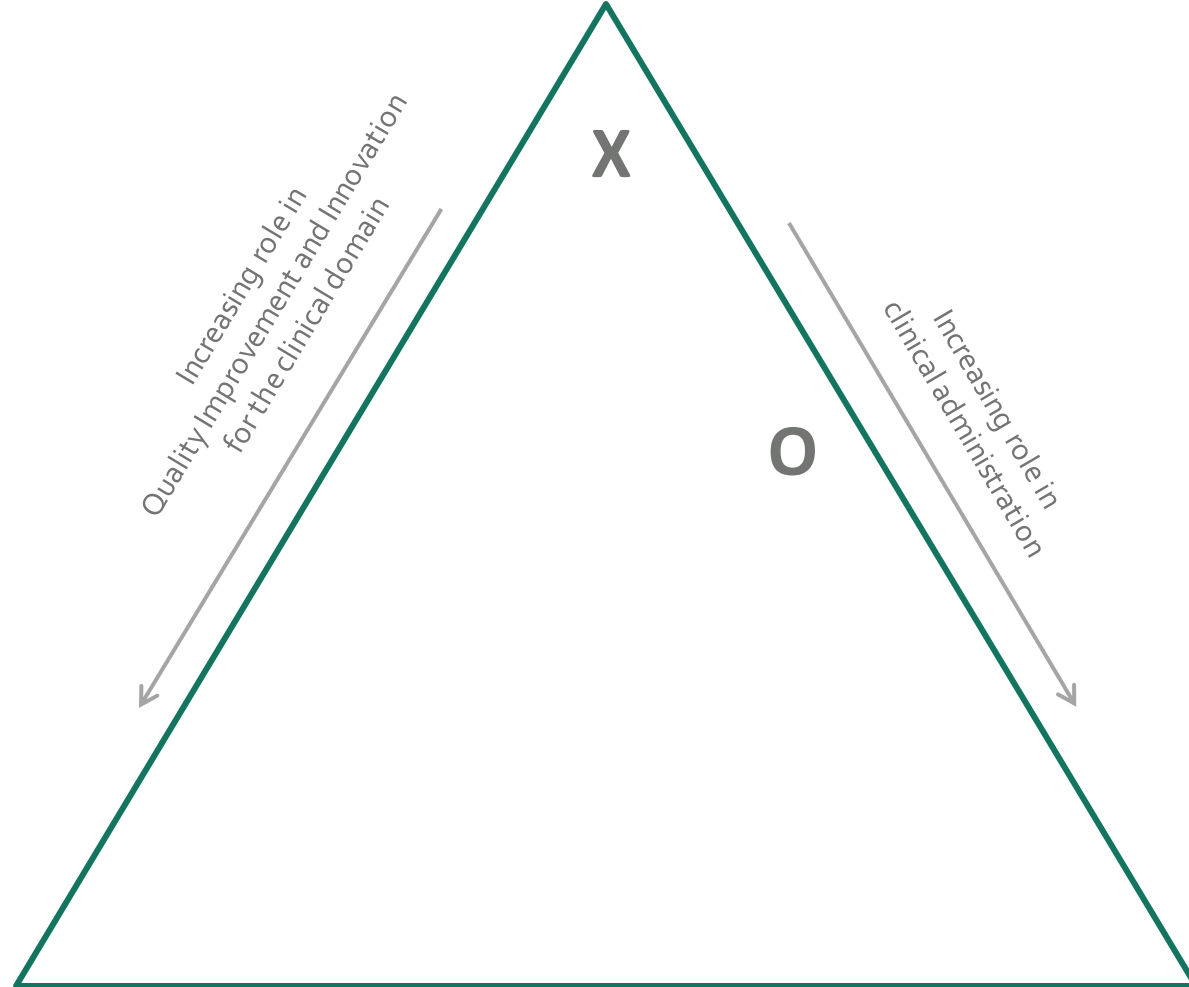
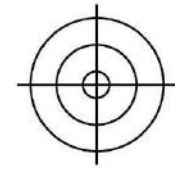
The triangle to the right maps out the main roles of 'Clinical Duties', 'Administrative Duties' and 'Quality Improvement & Innovation'.

INSTRUCTIONS

Within the triangle

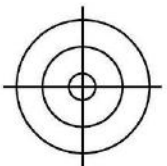
- Locate an 'x' where you think you currently are
- Locate an 'O' where you would like to be in 2 years from now

Clinical Duties



Quality Improvement & Innovation

Administrative Duties



QUALITY IMPROVEMENT SCOPING EXERCISE

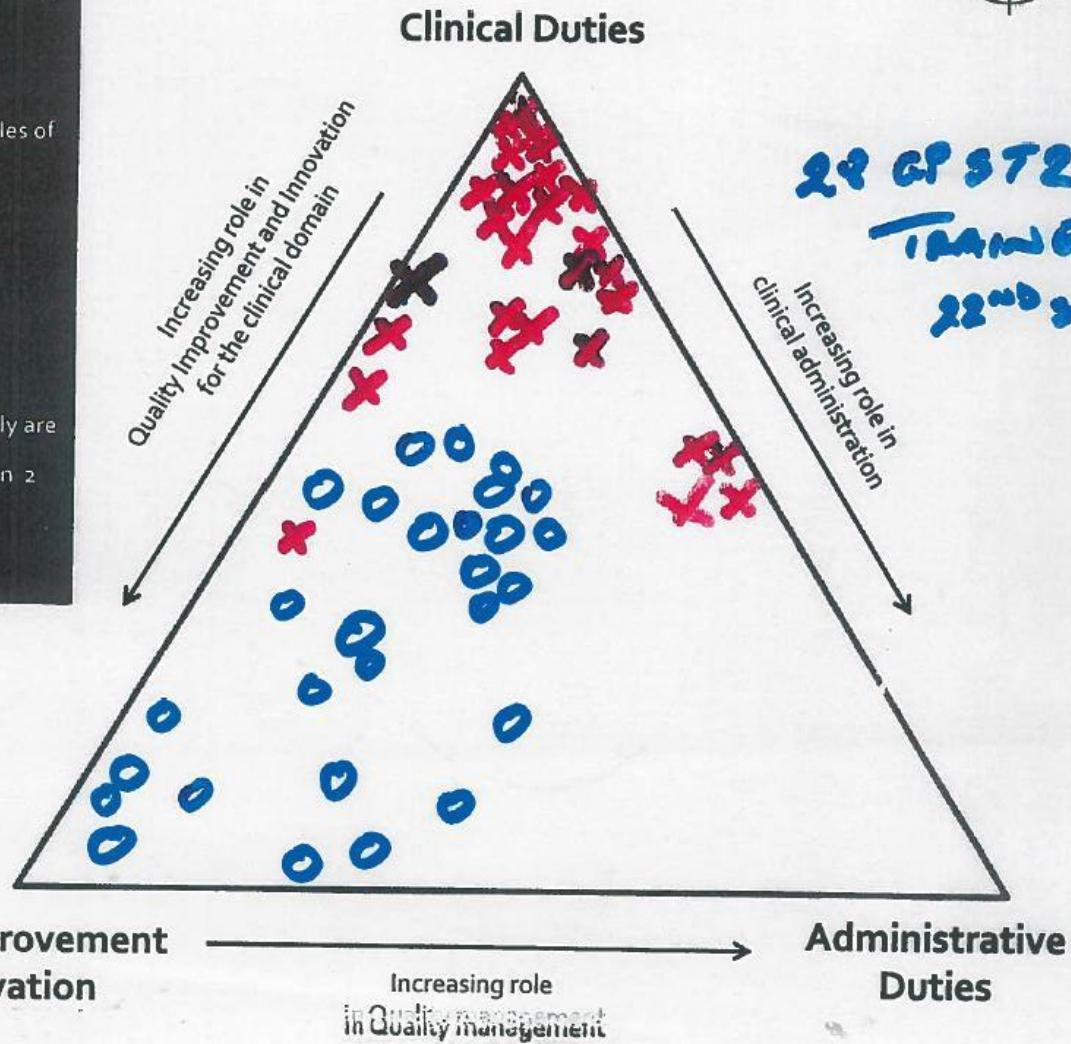
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ST2 → 2nd March 2017



QUALITY IMPROVEMENT SCOPING EXERCISE

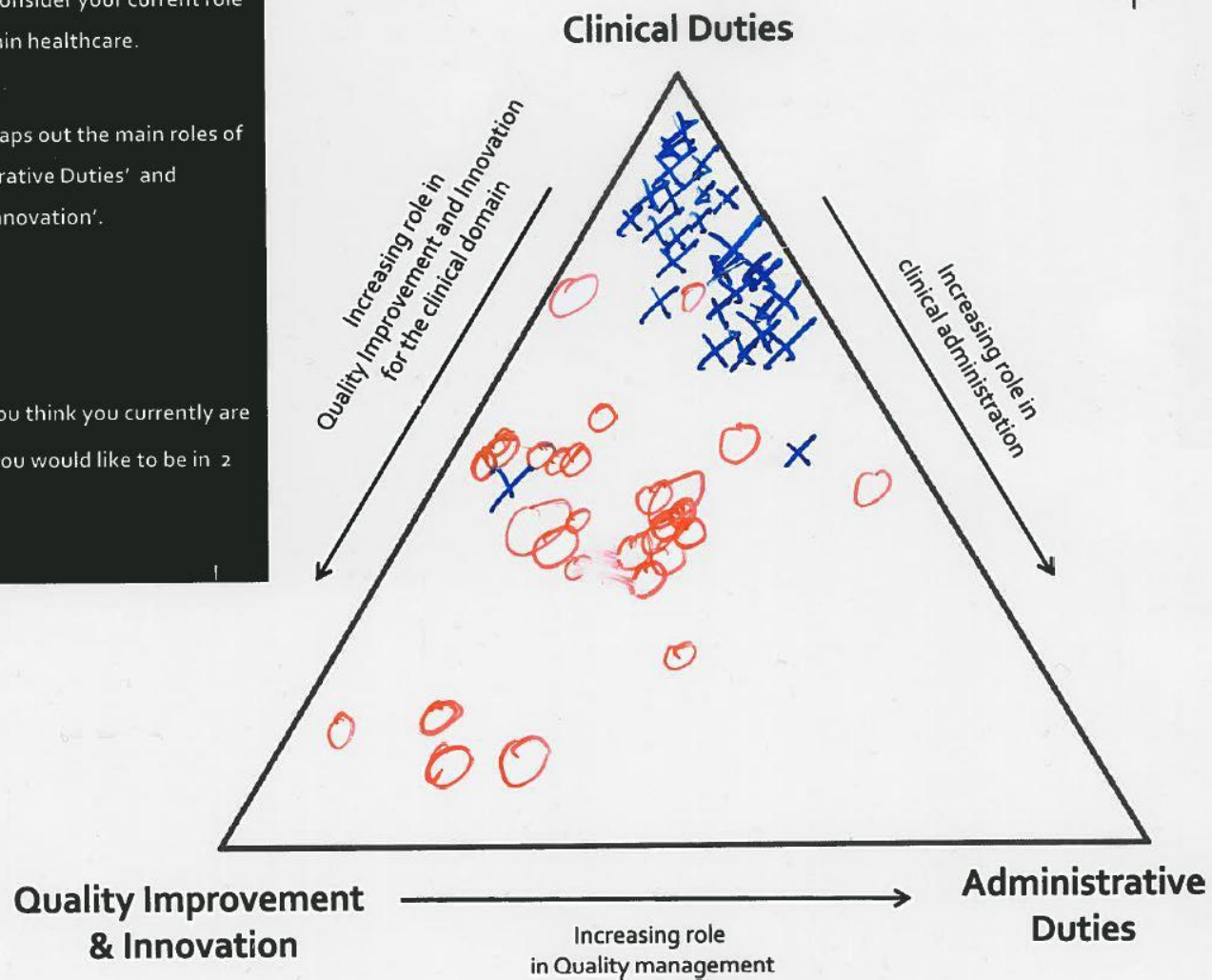
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Challenges to building capacity...

- Short GP Training Programme – competing demands e.g. Prof. exams
 - AKT – written exam
 - CSA – clinical exam
 - ePortfolio
- Trainers / Training Practices
 - Limited expertise available / trainees feeling lost
 - Displeasing the Trainers (taking trainees away from ‘real’ work)
 - Cynicism in the training system about QI
 - Trainer limited insight to concepts of QI and confusing trainees (conflicting advice)
- “Audit”, “Audit”, “Audit”

Audit & Re-audit



EQUIP AIM:

By the end of GP Training to give all our GP Trainees some of the Language, the Tools & some Experience in Quality Improvement

EQUIP





equip
Education Experience Excellence

+



1. Why ECHO?....Case-based Learning...



2. Why ECHO?...Wisdom of crowds & Vicarious Learning



3. Why ECHO?.....Supporting one another...



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All Teach

All Learn

All Improve

Do-How

Know-How

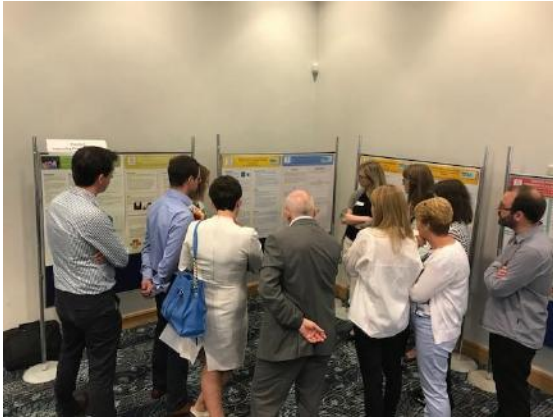




EQUIP Elements:

- 1. Each trainee chooses an improvement project**
- 2. Undertake in ST3 in their Practice**
- 3. Supported through 6 ECHOs:**
 - Short didactic teaching**
 - Use RCGP QI Guide**
 - Everyone gets to share their project & discuss**
 - Vicarious Learning**
- 4. 'EQUIP+' session for 1-to-1 support**
- 5. Group of QI Mentors for advice and support**
- 6. Resources available on Moodle Platform**

EQUIP Day of Celebration – 1st June 2017



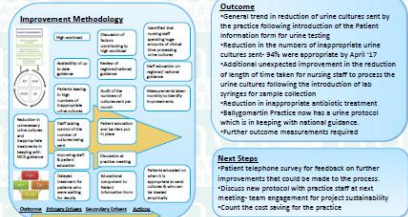
Developing a protocol for the diagnosis and management of UTIs at Ballagraney Group Practice

Catherine Hegan
Trainer: Dr Simon Hutchinson
Northern Ireland Medical and Dental Training Agency

Background
The urine testing protocol in Ballagraney was updated to reduce the number of cultures that were being sent unnecessarily. Changes to the protocol were made in line with NICE guidance on the management of UTIs in men (Oct 2014) and women (July 2015), NI Management of Infection Guidelines (2016), and Public Health England guidance on diagnosis of UTI (2014). We introduced a new Patient Information Form for urine samples for patients to complete when providing samples for culture. Later we asked patients to provide samples in tea syringes instead of traditional sample collection containers.

Aim
80% of urine cultures sent by the practice should be in keeping with NICE guidance on management of lower UTIs. The confirmed urine infections should also be appropriately treated in line with the NI Management of Infection Guidelines (2016).

Reduced number of inappropriate urine cultures
Provide clinicians with clear guidance on UTI management
Reduce unnecessary costs to the practice



Outcome measures
Identify quantitative measurement of the number of urine cultures sent per month. Number of inappropriate cultures, number of tea cultures, number of cultures of E. coli, Klebsiella pneumoniae, Pseudomonas aeruginosa and other organisms.
*Initial staff feedback regarding the impact of changes on staff

Process Measures
*Initial staff feedback about how protocol could be improved
*Completed new patient & NICE guidance on UTI management at practice meeting
*Updated Patient Information Form for further improvements

Outcome
*General trend in reduction of urine cultures sent by the practice following introduction of the Patient Information form for urine testing
*Reduction in the numbers of inappropriate urine cultures sent - 84% were appropriate by April '17
*Additional unexpected improvement in the reduction of length of time taken for nursing staff to process the urine cultures following the introduction of tea syringes for sample collection
*Reduction in inappropriate antibiotic treatment (Ballagraney Practice now has a urine protocol which is in keeping with national guidance)
*Further outcome measurements required

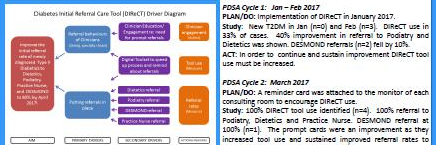
Next Steps
*Patient telephone survey for feedback on further improvements that could be made to the process
*Discuss new protocol with practice staff at next meeting- team engagement for project sustainability
*Count the cost saving for the practice

A DiReCT approach to Diabetes Care

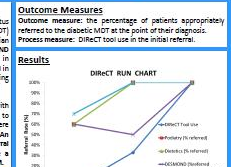
Diabetes Initial Referral Care Tool
Dr JF Johnson, Oriel Surgery, Dr J Jayaparakash
Northern Ireland Medical and Dental Training Agency

Background
Good clinical care of individuals with Type Two Diabetes Mellitus (T2DM) requires a sustained multidisciplinary team (MDT) approach from the point of diagnosis. This requires the clinician to coordinate referrals to Dietetics, Podiatry, DESMOND Structures Education and the Practice Nurse. Variation in referral patterns between clinicians was noted which resulted in some patients being referred at a later date (or others having their referral deferred) to some members of the broader MDT.

Aim
To improve the reliability of the initial referral rate of newly diagnosed type two diabetics in our practice to specialist services (Dietetics, Podiatry, Practice Nurse, DESMOND Course) to 80% by April 2017.



Improvement Methodology
QI methodology was applied to this project. The main change was the introduction of an electronic workflow (DiReCT tool) to provide prompts for referrals and automatic printing of Practice Nurse referral letters and T2DM PILs. Data was collected monthly from January to April 2017. Two PDSA cycles were achieved. Patient records with new T2DM were reviewed to identify if the DiReCT tool was used and if referrals were made (see Run Chart).



PDSA Cycle 1: Jan - Feb 2017
PLAN/DO: Implementation of DiReCT in January 2017.
Study: New T2DM in Jan [n=10] and Feb [n=10]. DiReCT use in 33% of cases. 40% improvement in referral to Podiatry and Dietetics was shown. DESMOND referrals at 100% [n=1]. The prompt cards were an improvement as they increased tool use and sustained improved referral rates to Podiatry, Dietetics and the Practice Nurse.

PDSA Cycle 2: March 2017
PLAN/DO: A reminder card was attached to the monitor of each consulting room to encourage DiReCT use.
Study: 100% DiReCT tool use identified [n=10]. 100% referrals to Podiatry, Dietetics and Practice Nurse. DESMOND referrals at 100% [n=1]. The prompt cards were an improvement as they increased tool use and sustained improved referral rates to Podiatry, Dietetics and the Practice Nurse.

The Pill - On time and up-to-date?

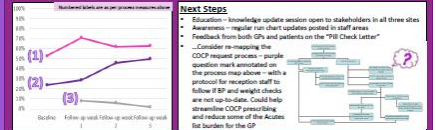
Dr Stephanie Connor
Western Rural Healthcare, Castlegregg
Dr Linda King / Dr Paula O'Brien
Northern Ireland Medical and Dental Training Agency

Background
Prescribing the COCP is a common task in general practice on the Acute list. However when scripts are requested, it can be tedious checking notes for BP and weight, then free-text typing off check requests on scripts. There was a recent update of the UNIMC guidance in 2016 from the Ffde. As our practice has expanded, it has become evident COCP prescribing habits vary across our three sites, with varying compliance with best practice guidance.

Aim
The aim is to improve and standardise the issuing of the COCP across the three sites in the practice, with the aim of achieving 100% compliance in reporting and maintaining annual BP and weight checks for our COCP users, to ensure safe and efficient prescribing.

Process Measures
After implementing the changes, I measured and monitored:
(1) % of COCP scripts prescribed with up-to-date annual BP and weight measurements
(2) % of COCP scripts requesting a BP and weight check when appropriate

Results
The run chart shows modest improvement towards our target of 100% up-to-date annual BP and weight checks for COCP users, with greater improvement noted in the percentage of appropriate all check requests. As anticipated a proved difficult working across three different sites, in terms of the IT, sharing information and maintaining established treatment. The biggest challenge was the IT aspect and this accounted for some of the slow uptake of the "PB Check Letter" due to accessibility issues.



Reducing the antibiotic prescribing in nursing home patients with asymptomatic bacteriuria

Dr Simon Hutchinson
Northern Ireland Medical and Dental Training Agency

Background
The updated 'Northern Ireland Management of Infection: Guidelines for Primary Care 2016' reinforced specific guidelines on the management of UTIs in nursing home patients. They specify that asymptomatic bacteriuria increases with age and is common in nursing home patients. Treating asymptomatic bacteriuria does not reduce mortality or prevent symptomatic episodes, but increases the chance of side effects and antibiotic resistance. Therefore, asymptomatic bacteriuria should not be used to diagnose a UTI in 80 patients aged 65 years of age or older in this group should be made on the basis of urinary symptoms and signs of sepsis identified as part of a full clinical assessment, then an MSU sent and GP informed.

What are we trying to accomplish?
How well we know if a change is an improvement
What changes can we make that will result in an improvement

Aim
To reduce the antibiotic prescribing in nursing home patients who are asymptomatic.
Audit how urine samples/MSUs. Antibiotic requests are sent with from nursing homes to find out the extent of the problem.
To decide on a change that might result in an improvement and implement it. Then re-audit.

Improvement Methodology
AUDIT: All MSU results/results, consultations, OOH letters between January 2016-December 2016 in our site population were audited as a better idea of the extent of the problem.

DISCUSSION WITH STAKEHOLDERS
Results were discussed at staff training day in January, comprised of district nurses, admin staff, practice nursing staff, my supervisor and the other GPs from a neighbouring practice. Guidelines and results also discussed with Nursing Home managers/nurses who were equally concerned about overprescribing in this group.

PLAN A STRATEGY
Print out guidelines for NH treatment rooms, inform staff. Provide a symptoms sheet to BP in before sending off MSU.

Next Steps
Do NH staff actually use the symptoms sheet?
Re-audit after 3-6 full year of the implemented change. Positive reinforcement of guidelines

Results of initial audit
33 phone call requests for antibiotics for NH
X2 treated with antibiotics over the phone.
*Based on dipstick urinalysis and very vague symptoms in letters, 'not themselves', 'confused', 'not eating'.
*2 treated based on positive MSU sent behindhand AMO placed regarding continued symptoms.
*4 treated based on vague symptoms - No dipstick or MSU result available.
*Of the 13 patients given antibiotics, only 9 had positive MSUs. MSU results alone generated and extra 33 phone calls on top of the antibiotic requests.
*3 prescribed an antibiotic based on MSU alone with no symptoms recorded.

Outcome Measures
*Identify measures that there is an improvement in. Are the guidelines adhered to in symptom recording, MSU sent and antibiotic prescribed appropriately?
*Process Measures: Are the guidelines being used and adhered to? Is the recording of symptoms, antibiotic prescribing, consulting.

Re-Audit/Outcome
February 2017-May 2017.
X3 phone call requests for antibiotics based on urine dipstick 'leaky symptoms'. Patient assessed as 'home visit' - general decline and frailty. NH protocol. Guidelines reinforced here.
X1 patient treated for UTI based on accurate symptom recording and positive MSU result.
X2 extra MSUs sent to lab based on patient being unwell. Both patients were treated for pneumonia - not UTIs as they had other symptoms.
No extra phone calls have been generated so far for random MSU results.

Compared to February 2016-May 2016
X4 phone call requests for antibiotics, poor symptom recording and antibiotic prescribed.
X4 extra phone calls alone for MSU results sent in.

Nitrofurantoin in Elderly Patients with Reduced Renal Function

Una Deehan, Woodstock Medical Centre,
Trainer: Dr M E Rea

Background
Nitrofurantoin is one of our first line antibiotics used in treatment of urinary tract infections.
It's antibacterial effect occurs when it is excreted into the urinary tract, therefore efficacy is reduced in people with renal failure.
It is linked with treatment failure in people over 65 years with eGFR <45 hence now contraindicated in this group as per current guidelines.

Results
The results showed that 15% of patients over age 65 yrs who were prescribed nitrofurantoin had an eGFR <45.
85% compliance with guidelines.
**Of these 15% - 10% needed another antibiotic despite a sensitive MSSU.

Outcome Measures
* % of staff with increased knowledge of guidelines
* Is the prescribing target meeting 100% adherence to current guidelines re: prescription of nitrofurantoin in reduced renal function.
Process Measures
* Is staff attending the practice meeting and education session
* Do all consultations rooms have guidelines displayed?
* Is staff with intranet/phone app

Aim
To audit how many patients over the age of 65 years have been prescribed nitrofurantoin with an eGFR <45.
To see if practice is meeting prescribing target of 100% adherence to current guideline criteria.

Current Northern Ireland Management of Infection Guidelines for Primary and Secondary Care 2016:

Primary Care (GPs)	Secondary Care (Hospitals)
First line: Nitrofurantoin (Macrobid)	First line: Nitrofurantoin (Macrobid)
Second line: Trimethoprim + Folic Acid	Second line: Trimethoprim + Folic Acid
Third line: Ciprofloxacin	Third line: Ciprofloxacin

Improvement Methodology
EMIS search parameters:
-prescription of nitrofurantoin in last 6 months
-in patients aged >65

From the results:
How many had eGFR <45? (and of these how many needed further treatment despite MSSU sensitive to nitrofurantoin?)

Present the findings to practice meeting
All prescribers are present. This will include education about current guidelines and nitrofurantoin prescribing.
Ensure prescribers display the current guidelines visible on all walls. Or that prescribers have the app - allows easy access to guidelines at all times.

Next Steps
* Re-audit in August - 6 months following the practice meeting
* If still not meeting target: plan to liaise with microbiology department to implement other changes:
* Perhaps different guidelines or treatment pathways for UTI treatment in renal impairment can be introduced. This could be incorporated into the "nitrofurantoin" mobile phone app and also distributed via the NI Formulary



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Improving gout monitoring - the forgotten and neglected arthropathy

Dr Simon Baxter ST3, Victoria Surgery, Larne



Northern Ireland Medical and Dental Training Agency



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Thanks for listening.....

e: n.hart@qub.ac.uk