Quality Improvement Activity Portfolio.

Examples submitted for appraisal

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Contents

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Introduction

All doctors are required to submit examples of their engagement in quality improvement for appraisal. Audit is perhaps the most well-known format for quality improvement but there is a wide range of quality improvement activities which also take place in day to day work. This document combines recent examples of QIAs submitted by GPs in the north east and shared with their consent. The aim is to give GPs ideas of suitable QIAs in order to find ways to make appraisal a natural extension of our core day to day work and not a project in itself. Some examples have been edited (shortened, anonymised, etc.).

Organisations are required to demonstrate measurable improvements in the quality of patient care and this requires the engagement of individuals working together. Individuals working in a more isolated way (in Out of hours services, walk in centres or part-time without a leadership/management role) may not have any an influence or authority to improve systems however they can still demonstrate the necessary the skills and values which underpin systemic quality improvement by efforts focused on **reviewing the quality of their individual work.** These reviews enable reflection on their performance, the identification of areas for personal development and improvement in their personal practice.

"What is quality improvement? The term 'quality improvement' describes a commitment to continuously improving the quality of healthcare, focusing on the preferences and needs of the people who use services. It encompasses a set of ***values (which include a commitment to self-reflection, shared learning, the use of theory, partnership working, leadership and an understanding of context);*** *and a set of methods (which include measurement, understanding variation, cyclical change, benchmarking and a set of tools and techniques).*[1]*"*

With thanks to all those who have kindly agreed to share their work.

I hope to add to this portfolio with more good examples so if you have something a bit different which you think would add to this document do get in touch. I am also happy to be contacted for more up to date versions and with feedback. I am particularly grateful to North East Sessional GP group Members who have shared their examples drawn from working as locums, Out of hours or in walk in centres. These GPs make an important contribution to general practice and their involvement in quality improvement whilst sometimes seen as unconventional is nonetheless extremely valuable.

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[1] Quality Improvement in General Practice: A Guide for GPs and the whole team. 2015.

Review of two week wait referrals

No. patients referred	26
No. patients seen	25
Cancer diagnosis	4

Dermatology	2
Upper GI	6
Breast	3
Urology	5
Gynae	4
ENT	2
Respiratory	4

Description of the activity – e.g., review of telephone triage from OOH, review of referrals or prescribing or small scale quality improvement activities that are not full audit cycles
I looked at the number of 2 week referrals I made in the period from 21/6/13 to 18/4/14 whilst at Appleton medical practice. I also looked at how many of the referrals resulted in a cancer diagnosis and the breakdown of specialities I referred to.
Why did you pick this TOPIC/ DATA SET case (e.g. to reflect on your practice and identify learning needs, to demonstrate application of learning, to identify areas for improvement –SEA, other)
I have an interest in oncology. I also wanted to assess the sensitivity of the 2w referral in detecting an actual cancer diagnosis. I also wanted to see if I was over referring to certain specialities.
What have you learnt from this activity?
For yourself: I am making regular referrals under the 2week rule to a variety of specialities. Some of my referrals do result in a cancer diagnosis, emphasising the importance of being vigilant in referring patients promptly. The main specialities I referred to were the upper GI team and urology.
What changes or actions have arisen from review of this activity?
For yourself: To continue to be vigilant in assessing patients to see if they fit the criteria which requires a 2w wait. I have updated my knowledge in the specialities I refer most to. I updated my knowledge of the upper GI 2w rule by attending a CCG event on 12/2/14 which covered the triage process and frequently asked question with regards to gastroenterology. I updated my urology knowledge by doing an online BMJ module on the diagnosis of prostate cancer.

Have you reviewed these changes yet –if not when/how will you do so?
I will carry out a similar audit in my new practice over a 9month period and see if the numbers are similar. I will also audit other staff in the practice, if they consent to this, to compare referral rates.

Review of AF patients on aspirin

Description of the activity – A review of AF patients on Aspirin at Stoney Hill Group
Why did you pick this TOPIC: The choice of the topic is based on recent changes to NICE guidance CG180 – Atrial fibrillation
The aim was to find out the number of our AF patients on QOF register in Stoney Hill Group who are currently on Aspirin.
Are there any external bench marks/standards against which you can compare your activity/ performance in this area?
NICE guidelines stated a third of all AF patients (about 33%) would be on Aspirin before the recent guidance which found Aspirin unsuitable for AF.

What have you learnt from this activity?
For yourself: A broad revision of AF and I am now more familiar with the NOACs than before.

For the practice: There were 101 patients on our AF QOF register back in November 2014 when the Audit was carried out, 28 or (27.27%) of the patients were on Aspirin.

- 18 of whom are females and 10 are males. 14 of the patients are aged between 60 – 79 years, 11 patients between 80 – 89 years, 1 patient less than 60 years and 2 over the age of 90 years.
- Five of them are palliative care patients with diagnosis like Multiple Myeloma, Dementia, Breast cancer, colon cancer and prostate cancer.
- Most of the AF patients on Aspirin had a CHA2DS2Vasc score between 2 and 5, one patient has a score of 8.
- 23 of these patients have had an ECHO at some point while only 5 have not had an ECHO done.

What changes or actions have arisen from review of this activity?
For yourself: As the AF lead in my practice, I will invite the 28 patients in for discussion on anticoagulation therapy based on NICE guideline. Patient's choice would be promoted as advised by NICE and where appropriate a referral to Secondary Care would be made for a Cardiology opinion on the anticoagulation therapy.
For the practice: We aim to get all our AF patient off Aspirin on to either warfarin or any of the NOACs by the end of the summer 2015.

Have you reviewed these changes yet –if not when/how will you do so?
Winter 2015.

Implementation of prescribing system changes.

Description of the activity - eg review of telephone triage from OOH, review of referrals or prescribing or small scale quality improvement activities that are not full audit cycles

Changing prescriptions policy in the practice

I attended a CCG-organised event /organised by the MPS on safe prescribing and we all realised that our prescribing practice was out-with guidelines and that most of our colleagues were practicing much more in line with guidelines.
I had been aware that our practice could lead to errors. Previously patients would ring the prescribing staff or submit requests in other ways. If items were not on repeat the staff would print them out "from the back screen" and secure them with a bulldog clip. Each Gp would have a tray with lots of prescriptions to sign, and we would all meet in a coffee room at lunchtime and sign them whilst chatting. Laptops were available to check clinical records but rarely used. My personal practice was to put prescription I wasn't sure about to one side and check them later in my room. Letters coming in from secondary care etc. requesting new prescription were scanned onto docman. The Gp reading them would highlight medication changes and forward to the prescriptions team to be added.
It was challenging and dispiriting to realise that our system wasn't safe. Some of us had previously asked to have prescription requests sent to us electronically but our "pilot" rapidly failed due to perceived significant extra workload.
We met with the practice pharmacist, the prescriptions admin team and proposed several changes which the team debated one by one.
We proposed that:

1. All requests not for repeats had to go to a GP electronically. There were multiple objections including –
2. Lack of knowledge, patients won't like it, we won't be able to sit together and support each other.
3. That all medication items had to be added by a GP. Objections included – will take too long, will add delays to patients getting prescriptions done.
4. Pre-printed prescriptions needed removing from consulting rooms and doctors bags and that a record be kept of all usage.
5. A record be kept of prescriptions collected for controlled drugs – who had collected them and when. CD prescription to be highlighted.
6. We move where prescription to be collected were stored – out of reach of people standing at the front desk.

The meeting worked remarkably well despite initial anxieties about workload, and negative effect on time spent with the team, and patient convenience.
We agreed :

1. To blank an appointment each day to cover extra time adding meds etc.
2. To buy more laptops for the coffee room so GPs could look at med requests whilst sitting together.
3. The pharmacist took all our notes away and produced a clear and relevant policy which was circulated around the team.

Although there is significant extra work (because reviewing records often triggers further actions and on occasion patients object to having their requests turned down we are picking up prescribing issues which might have been missed previously e.g. overuse of topical steroids, patients requesting different opioid drugs at different times (codeine one week, tramadol the next) and patients requesting meds which had been discussed with a GP at an appointment and declined. Adding meds I when requested by secondary care allows me to stop other drugs as appropriate.

Why did you pick this TOPIC/ DATA SET case (eg to reflect on your practice and identify learning needs, to demonstrate application of learning, to identify areas for improvement –SEA, other)
Topic identified following educational session on patient safety.
Are there any external bench marks/standards against which you can compare your activity/ performance in this area?
Yes – Kings Fund paper 2011 re quality in Gp prescribing states, for example "Only appropriately qualified prescribers should be allowed to put medications on repeat prescription."
Referring to this was useful when team members were reluctant to pass this task to GPs.

What have you learnt from this activity? For yourself
I was very anxious to discover how far we were from accepted good practice.
I learned that, in effecting a big change, getting the whole team together to discuss, and taking advantage of proactive colleagues such as my salaried colleague and the practice pharmacist, helped to drive change that had previously been strongly resisted.

What changes or actions have arisen from review of this activity? We have entirely changed the way prescriptions are issued and repeats are added.

Have you reviewed these changes yet –if not when/how will you do so?
The policy is to be reviewed next year.

Review of consultation records

Description of the activity - e.g. review of telephone triage from OOH, review of referrals or prescribing or small scale quality improvement activities that are not full audit cycles
I reviewed 20 consecutive patient consultations on a standard (non on-call) day 27/08/2015. I reviewed my documentation using suggestions from the NHSE guidance; I also added 2 additional criteria which I felt were relevant.

- Patients account of problem (history)
- Examination
- Plan
- Safety netting
- Documentation of consent
- Chaperone offered
- Patient advice and use of PILS
- Red flags
- Read coded problem
- Presence of carer or guardian
- Use of appropriate template (if available)
- Other

After analysing the results I re-reviewed my documentation of 20 consecutive consultations on another day (4/9/15), again a standard non on-call day.
I reflected on the results and discussed the results of the evaluation with GP colleagues at the practice.

Why did you pick this TOPIC/ DATA SET case (e.g. to reflect on your practice and identify learning needs, to demonstrate application of learning, to identify areas for improvement –SEA, other)
I picked this data set in order to reflect on my practice and identify areas for improvement. I've had some good informal feedback about my documentation standards, however I've never formally assessed this.

Are there any external bench marks/standards against which you can compare your activity/ performance in this area? No strict benchmark. Criteria chosen for this review were based on North East Primary Care Services Agency suggestions – plus 2 criteria I added myself (use of template and 'other').

What have you learnt from this activity?
This activity highlighted several areas for improvement in my documentation.

1. Recording read codes. I found that my recording of read codes was poor. On SystemOne most of the read codes aren't linked to the diagnosis section – need to do this separately.
2. I need to remember to divide the consultation into a separate 'new' problem if more than one problem discussed.
3. I need to improve my awareness of what PILs are available and increase use of PILs for patient education.

Other areas for improvement:

- Use of templates- find out how to access contraception templates and also baby check template.
- Recording presence of carer/guardian- particularly relevant to paediatric consultations as safeguarding implications.

- Watch out for SystmOne automatically adding in read codes e.g.: O/E mouth ulcer instead of moist mouth.

After analysing the results of the round 2 evaluation, I demonstrated an improvement in my recording of: safety netting advice; documentation of advice and use of PILs; use of read codes; recording whether a parent/carer was present and documentation of red flag symptoms. However, there was 1 consultation which involved a breast examination and I had forgotten to record the offer of a chaperone and gaining consent.

What changes or actions have arisen from review of this activity?

As a result of this activity I am now more vigilant in my documentation. I have a post-it note stuck to my computer screen to remind me to record: read-codes; chaperone/consent; presence of carer/guardian and to use PILs.

I've also set up a folder on my desktop which contains useful PILs/website links and will gradually add to this in the future. I have started to use PILs much more during consultations.

I have spoken to the practice manager and arranged for relevant contraception and baby check templates to be included on my SystmOne home screen.

Have you reviewed these changes yet –if not when/how will you do so?

Changes reviewed after round 2 evaluation as discussed.

Care Homes project

Description of the activity - e.g. review of telephone triage from OOH, review of referrals or prescribing or small scale quality improvement activities that are not full audit cycles
Care Home Project: This involved doing weekly ward rounds involving staff and community matrons, review if documentation (DNACPR/ EHCPs) and medicines reviews and optimization.
Why did you pick this TOPIC/ DATA SET case (e.g. to reflect on your practice and identify learning needs, to demonstrate application of learning, to identify areas for improvement –SEA, other)
Some of the main reasons I volunteered to be included in this project are as follows:

1. To improve care of patients in care homes
2. To promote communication and to develop professional working relationships with care home staff and community health workers
3. To reduce the burden of avoidable hospital admissions
4. I considered it to be a very worthwhile activity

Are there any external bench marks/standards against which you can compare your activity/ performance in this area?
I was assigned to XZ Care Home and data was collated from all care homes and GP's who took part in the project.
Impact of intervention
Emergency admission rates fell from an average of 36 to an average of 20 per month- 45% reduction. Full year financial impact of £480000 saving
Accident and Emergency rates fell from an average of 56 to an average of 31 per month- 45% reduction. Full year financial impact of £27000 saving

- Reduction in emergency admission and A+E attendances
- Significant reduction in out of hours callouts and GP callouts
- Reduction in admissions for foot ulcers
- Pharmacy improvements
- Increase in the number of people supported to die in their preferred place
- Clinicians feel better equipped to care for the frail and elderly
- Improvements in clinical effectiveness and patient safety
- Vastly improved communication
- Patient experience and satisfaction improved.

What have you learnt from this activity?

1. GP input is essential
2. MDT integrated way of working helps improve decision making
3. EHCP and DNACPR significantly better documented
4. Increased engagement of patients and families

I am far more aware of the pressures which the care home staff have to face, which include change of staff including at managerial level, problems associated with managing bulk orders of medication,
Staffing levels in particular when dealing with challenging patients.
For the practice [if appropriate]:

At the heart of the care home project, regular visiting (usually weekly) accompanied by the Community Matron has significantly reduced the number of urgent visits to the care homes, improved drug safety, reduced the overall admission rate, improved relationships between health professionals and has allowed closer liaison with relatives of care home patients.

What changes or actions have arisen from review of this activity?

For yourself:

The activity reporting procedure required changing because the IT department, (on their own admission) had been using inappropriate data which gave no indication of the true reduction in hospital admissions. It was subsequently modified to accommodate this data correctly.

I have been involved with the design of the Emergency Health Care Plan, which forms a central part of the project.

For the practice [if appropriate]

The Care Home Project was a pilot project which was completed in October of this year. Carrying on from the success of the Care Home Project, an extended version is being developed as a pilot and the practice has decided to join the new project, (the Integrated Care Team Project) which embraces the features of the Care Home Project to include the care of similar patients at home, in particular those who are at risk of avoidable admissions.

Have you reviewed these changes yet –if not when/how will you do so?

A more effective way of collating data and modifications of the Emergency Health Care Plan has improved the review process.

Review of cancer diagnoses 2013

Who was involved in the audit?
(List of people including designation) Dr ,Data Manager,

Background
The September GP mentoring group heard a presentation from a member as feedback from an update in cancer care. In it we were challenged to audit out own data. There has recently been some criticism of GP's failure to diagnose cancer and I was very interested to know how we were doing and whether we needed to improve anything.
Aim of the Audit
(This should identify what you need the audit to tell you e.g. is current practice compliant with a particular piece of guidance i.e. NICE guidance/local PCO policy etc).
National Cancer Intelligence Network in 2007 found only 25% of cancers detected via 2ww and 23% cancers presented as emergencies. I was interested as to how we compared with this albeit we are now in 2014.
Criteria
How many present with classic symptoms?
How many sent via 2ww?
How many present as emergencies?
Where there any avoidable delays?
Would direct access to diagnostics have helped?
Preparation and planning
(Data search of all those who received a diagnosis of cancer during 2013 undertaken by our data manager. I then looked through all the records.
Initial standard setting
(What are you aiming for 100%, 90% etc)
I had no idea of how we would compare and was simply aiming for initial fact finding
Analysis and Findings
Number pts with diagnosis cancer within this time 17
Number presenting with classic symptoms 14
Number sent via 2ww 10 ie 59%
Number presenting as emergencies 0
Number of pts with delayed diagnoses 2, neither of which are delays on our part.
No changes to any of the outcomes would have been influenced by more direct diagnostic access.
Conclusions and reflections from the first cycle of the audit
(What changes are needed to meet the standards set in this audit? How will the changes be implemented and who will do this and when?
How was this communicated to the team if appropriate? When will the re-audit occur?)
I have presented this data to our team here. I aim to audit this again , perhaps in 2015 once all the changes to the team have settled down.

Cervical Screening

Description of the activity - eg review of telephone triage from OOH, review of referrals or prescribing or small scale quality improvement activities that are not full audit cycles

Review of cervical screening procedures performed from 17/3/15 to 29/10/15:

- Background: I attended a Cervical Screening Update course on 17/3/15 and so wished to analyse my clinical performance following this to confirm I was meeting good standards of clinical practice.
- Method: Using a combination of SystmOne analysis in October 2015 (patients identified by coding for cervical screening performed by me) and review of my own notes kept regarding when I had performed smear tests, the following data were identified.
- Results: I performed a total of 8 smear procedures during this working period.
  - All 8 samples were rated 'adequate'; 7/8 showed evidence of transformation zone (TZ) sampling
  - 6/8 were reported as HPV negative smears & put on normal recall
  - 1/8 reported as low grade dyskaryosis & HPV positive-> automatically referred to colposcopy & recalled for repeat smear with them
  - 1/8 reported as severe high grade dyskaryosis-> automatically referred to colposcopy (in addition to referral to gynaecology by me based on patients' symptomatology at time of smear/examination)-> ultimately diagnosed with early cervical cancer & received what appears to be effective curative treatment (please see reflective 'clinical audit' CPD log entry dated 29/10/15 for details & full reflection).

Why did you pick this TOPIC/ DATA SET case (eg to reflect on your practice and identify learning needs, to demonstrate application of learning, to identify areas for improvement –SEA, other)

- Identified as further learning/development action point on reflective CPD entry from clinical meeting (Cervical Screening Update course) 17/3/15; 'to review number of smears taken over coming year and effectiveness of taking them'.
- To reflect on my individual smear performance/ outcomes and interesting & unusual case of cervical cancer picked up on smear test.

Are there any external bench marks/standards against which you can compare your activity/ performance in this area?

- It is mandatory for cervical sample takers to undertake a minimum of one half day update every 3 years in order to maintain theoretical competence, hence I have met this requirement in this appraisal year.
- Newcastle Hospitals 'Guidance for Good Practice in Primary Care 2012' states less than 1-2% of samples are reported as inadequate, and my results show 0%, in keeping with this.
- I cannot find any national or local guidance for actual numerical value for ideal levels of TZ sampling, but documents do suggest that practitioners audit their own practice of this. It appears a colour-coded RAG rating as automatically generated as feedback to clinical lead in the Practice for individual smear takers once individual numbers are >20. My clinical lead kindly checked on my logged values for the last practice report audit (1/7/14-30/6/15) & it

appeared by TZ sampling rate at that point was 100% (for 6 patients), and so no concerns were raised within the feedback system.

- Review of literature suggests invasive cervical cancer is detected on <0.5% of cervical screening samples nationally, confirming that the case of my patient ultimately diagnosed with this is very rare.

What have you learnt from this activity? For yourself

- This post-update course review of my smear taking confirmed I have performed adequate sampling & TZ sampling numbers to meet with required levels of good clinical practice.
- This review also highlighted surprising and interesting case of 32 yr old female where cervical cancer was diagnosed as a result of offering a patient opportunistic smear test (patient had never attended for routine smear previously but presented with symptoms of post-coital and inter-menstrual bleeding). Please see CPD entry 29/10/15 for full reflections on this.

For the practice [if appropriate]

- The majority of routine recall smears are undertaken by our Practice Nurses and this is likely to remain so, with GPs usually performing more opportunistic smears at time of vaginal examination for symptomatic issues (& hence relatively low numbers of tests performed by us). However, this audit review of my practice was reassuring that I met the required standards of practice & that I can confidently continue performing such smear tests within our Practice.

What changes or actions have arisen from review of this activity?

For yourself

- I need to demonstrate maintainance of these skills & performance through regular practice, audit review of smear sampling outcomes, and 3 yearly mandatory educational updates as appropriate (next due March 2018).

For the practice [if appropriate]

- Nil.

Have you reviewed these changes yet –if not when/how will you do so?

- No applicable.

Minor surgery review

Description of the activity - eg review of telephone triage from OOH, review of referrals or prescribing or small scale quality improvement activities that are not full audit cycles
Review of minor surgery procedures performed & post-operative complications:

- Background: Since working at Marine Medical Group, Blyth, as a salaried GP (1/7/14 onwards), I have been the principal clinician performing minor surgery. One other colleague also performs small numbers of occasional ad hoc minor surgery. As yet, we do not have regular sessions allocated, but we have an allocated admin worker & I have set up a waiting list system to which I add patients, until we have a full session of 5 allocated patients for minor surgery.
- Method: SystmOne analysis in November 2015 (audit report run- 'JSL minor surgery') identified patients coded as having minor surgery performed by me since July 2014. I reviewed every case to see if there had been any documentation (by in-house GP colleagues, out-of-hours colleagues or secondary care providers on SystmOne or scanned letter format) in order to identify if there had been any unexpected histology results, wound infections or other complications within 4 weeks of having minor surgery. The following data were identified.
- Results (wound infection): I performed a total of 62 minor operation procedures during this working period, including 9 joint injection procedures during minor operation sessions (6 shoulder injections, 3 knee injections). No cases of wound/joint infection or other complication to wound healing was identified.
- Results (unexpected histology): No patients had unexpected or malignant histology results. Histology confirmed diagnoses for the number of cases as follows (please note, some patients had more than one lesion removed during an appointment): 17 benign intradermal naevi; 16 seborrhoeic keratoses; 11 cysts (10 epidermal, 1 pilar); 7 viral warts; 6 fibro-epithelial polyps/skin tags; 1 actinic keratosis; 1 small skin haemangioma; incision & drainage of 4 cysts or abscesses.

Why did you pick this TOPIC/ DATA SET case (eg to reflect on your practice and identify learning needs, to demonstrate application of learning, to identify areas for improvement –SEA, other)

- Identified topic as action point on appraisal 2013/14; performed first cycle review on data from minor operation procedures whilst working at Coquet Medical Group for appraisal 2014/15 & this is second cycle review for comparison now I am working at Marine Medical Group.
- To reflect on my individual minor surgery performance/ outcomes.
- To identify any areas for targeted action to reduce potential negative outcomes from surgery, particularly inappropriate surgery and post-operative infection rates or unexpected/malignant histology results.

Are there any external bench marks/standards against which you can compare your activity/ performance in this area?

- NICE Clinical Guideline 74, 'Surgical Site Infection: Prevention and treatment of surgical site infection', issued October 2008, quotes, "At least 5% of patients undergoing a surgical procedure develop a surgical site infection".

What have you learnt from this activity?

For yourself

- I am very happy to demonstrate further decrease in levels of wound infections/post-operative complications rate (0%) compared to my last review which was also well below acceptable levels (2.4%), plus no evidence of unexpected or malignant histology results. However, I am aware that I am only performing approximately 1/3 of the levels of minor surgery procedures that I had been doing at my previous practice (62 vs 168), so lack of numbers of complications may simply be reflected by this. I am confident that my thorough analysis methods would have detected all of cases of adverse outcome. However, I will strive to continue minimising potential for adverse outcome by continuing to use good surgical practice techniques for wound preparation, tissue handling & dissection, and advising patients on post-operative wound care.

For the practice [if appropriate]

- This review again re-enforced importance of appropriate case selection for minor surgery in Primary Care by in-house practitioners (e.g. suspicious lesions referred to Dermatology service, large lesions for secondary care referral).

What changes or actions have arisen from review of this activity?

For yourself : - No new actions required but need to maintain skills & performance through regular practice and educational updates as appropriate.

For the practice [if appropriate] : - No changes.

Have you reviewed these changes yet –if not when/how will you do so?

Antibiotic Prescribing in Respiratory Tract Infection

Background

New NICE guidance on antibiotic prescribing in respiratory tract infections was published in January 2011. Working in an Out of Hours setting, I encounter a lot of patients with respiratory tract infections. At this time the NICE guidance was published, I was one maternity leave. I returned to work in April 2011 having had 13 months off work. In May 2011, I decided to undertake the audit in order to check whether my clinical practise was up to date. Although I had been aware of the guidance, I had not read the recommendations at the time of collecting me data.

Aim

To see if my clinical practice is in line with that of NICE guidance with regard to prescribing in respiratory tract infections.

Method

I retrospectively viewed the notes for patients that I had seen in a face to face consultation during a 1 week period in May 2011. I requested the notes for all the patients whom I had coded as having upper respiratory tract infection (URTI), lower respiratory tract infection (LRTI), otitis media, sore throat or tonsillitis. I noted whether the patients had been given antibiotics or not and the circumstances around this. I then read the NICE guidance and checked to see if my clinical practise was in line with the guidance.

Standard Setting

Ideally I should always be working within the guidance set by NICE although sometimes patient demands etc. mean this is not possible. I decided to set a standard of 90%. However, I expected myself to have documented the reasons I have prescribed antibiotics outside NICE guidance.

Results

I saw 17 patients who I considered to have a respiratory tract infection:

- URTI – 6 patients
  - No antibiotics prescribed
- LRTI – 2 patients
  - Both given antibiotics. Both had signs to suggest consolidation – 1 in right mid zone and the other had decreased air entry on left side
- Otitis media 6 patients
  - 2 patients given advise and no antibiotics
  - 2 patients given delayed scripts to start on day 3/4 – seen on day (2/3) – ie asked to persevere over next 24 hours
  - 2 given antibiotics – 1 patient had symptoms for 5 days, the other had for 12 days with some ottorhoea.
- Sore throat – 2 patients
  - No antibiotics prescribed
- Tonsillitis – 1 patient
  - Given penicillin – noted to have bilateral swollen tonsils with exudate

Discussion

URTI

My prescribing is in accordance with guidelines – this reflects my usual clinical practise

LRTI

Both patients had signs of consolidation and therefore prescribing antibiotics is in accordance with the guidelines. I know that sometimes I prescribe in patients with less obvious signs, but these patients usually have other underlying conditions ie COPD etc.

Otitis Media

Both patients who were given immediate antibiotics had symptoms for > 4 days usual duration cited in guidelines, therefore appropriate. For those patients I gave delayed scripts to, as opposed to no script, mainly depended upon patients/parents expectations and previous experiences. Overall my clinical practise is in line with NICE guidance.

Sore throat

I did not prescribe antibiotics and this is my usual clinical practise – in line with guidelines

Tonsillitis

This patient had very enlarged tonsils and exudate. I feel that it was appropriate to prescribe in this case. I do not always prescribe in tonsillitis but I also do not usually use the centor criteria (tonsillar exudate, tender anterior cervical lymph nodes, absence of cough, history of fever) so perhaps I do over prescribe.

Conclusion

Overall the study shows that I am prescribing antibiotics appropriately in respiratory tract infections. In the future I will aim to use the centor criteria more. I could also try negotiating less delayed scripts for otitis media but this may be difficult, especially if patients have received antibiotics before.

Review of Walk-In-Centre consultation records.

Description of the activity -

Random case analysis 20 cases from OOH & WIC

Why did you pick this TOPIC/ DATA SET

To reflect on my practice and identify learning needs

Are there any external bench marks/standards against which you can compare your activity/ performance in this area?

I looked at Northern Deanery- Guidance on supporting information for non-standard GPs (Drs Wright and Blades). This included some brief details of what data/ possible focus/ reflection to consider: further guidance in link to SOAR (Scottish Online appraisal resource)

What have you learnt from this activity?

For yourself

The value in placing emphasis on both exploring patient concerns, and also the value in explaining + documenting safety netting in OOH scenario

In addition, identifying a number of learning needs from the documentation

What changes or actions have arisen from review of this activity? For yourself

As a routine I will routinely seek patient concerns (if not already doing this)

Have you reviewed these changes yet –if not when/how will you do so?

Not yet- could undertake repeat RCA IN 6 months time

Random case analysis

20 consecutive consultations in OOH and WIC settings

Areas of focus (identified at earlier informal discussions of cases at Self-directed learning group)

1. Appropriate history in particular patient ideas, concerns and expectations
2. Prescribing- appropriateness, within guidelines
3. Safety netting- with particular reference to characteristic of one-off OOH/WIC consultation

Age/sex	Presentation	History with focus on expectations	Prescribing- did it meet guidelines (if relevant)	Safety netting OOH/WIC
23, M	6 days cough, due at work	Y Were antibiotics needed, was he fit for work	Y None prescribed- not clinically indicated/ advice re work	Y Expected course of illness/ what to do if deterioration
6 week, M	Father proxy repeat prophylactic cephalexin for UTI	Y Clear understanding of father request	Y Old bottle available; dose appropriate.	Y Seen near 10pm; explanation that missing one dose acceptable if pharmacy shut
22, F	Bleeding early pregnancy	Y Miscarriage and risk of ectopic	Y None indicated	Y Clinically ectopic remote; patient fully counselled if deterioration + follow up GP

				Learning point- ectopic pregnancy
42, F	Palpitations	Y Awaiting 24hr tape; did increase sx herald new or undiagnosed illness	Y None indicated	Y Follow up plan clear, including urgent steps if new symptoms
2, F	Rash, fever, otitis media	Y Did worsening fever herald undiagnosed/ dangerous illness	Y None indicated; open discussion re antibiotics in OM and agreement easily reached	Y Explanation of warning signs and options for review
17 months, F	Fever, URTI	Y To rule out serious illness requiring medical intervention	Y None indicated; open discussion and agreement	Y Explanation of warning signs and options for review **Learning point- RASCAL**
41, M	Chest pain, anxiety	Y TO reassure serious illness not being missed	Y None indicated	Y Planned follow up in place; options if significant deterioration
66, F	Dry eyes, family stress	Y Second opinion wanted; discussion about daughters MH + alcohol illness	Y Hypromellose + lacrilube	Y Follow up with GP or Optician
27, F	Heartburn in pregnancy	Y Relief of symptoms	Y Gaviscon **Learning point- other options?**	Y GP or midwife
3, F	Fever, conjunctivitis; mum stress?	Y Reassurance not missing serious illness	Y None indicated	Y Warning signs and advice. **Support for mother re stress?**
22, F	Headaches? Migraine	Y Diagnosis & symptom control	Y Sumitriptan 2nd line for treatment of acute attacks	Y Advice if deterioration; advice re general follow up
30, F	Breathing problems, anxiety	Y Reassurance not missing serious illness	Y None indicated (already has beta blocker)	Y Advice to follow up
74, M	Vertigo? BPPV	Y Diagnosis + treatment	Y Buccal prochlorperazine	Y Advice re driving. Follow up assessment of BPPV
35, F	Bleeding PV/ PR Learning difficulty?	Y Not clear; 2nd opinion? Serious illness ruled out; limitations of WIC assessment	Y None indicated	Y GP for fuller assessment

3, F	URTI/ cough	Y Rule out serious underlying illness	Y None indicated; expectations met	Y Advice re steps to take if deterioration, or non-improvement
14, M	Infected IGTN	Y Treatment requested	Y Flucloxacillin; appropriate dose + formulation	Y GP or Chiropodist
22, F	Gingivitis	Y Diagnosis and treatment	Y Metronidazole; advice re side effects, alcohol, COC	Y Dental follow up
76, F, **telephone**	Post-op cystoscopy	Y Husband proxy; unwell post procedure	Y None indicated	Y Patient had recovered; agreement on what to do if recurrence/ deterioration
76, M, **interpreter**	Visitor from India, T2DM problems with glycaemic control	Y Advice on self management, medication, diet	Y No change to current regime	Y Contact family GP as temp resident if further problems
39, M	Dental pain	Y Diagnosis and treatment	Y Advice re analgesia. Antibiotics not issued till sees dentist	Y Dental follow up/ emergency numbers

Review of Triage/ Out of hours records

Description of the activity
Review of note keeping in out of hours settling. Looking at the notes made by myself and others in my SDLG – looking at notes for both telephone triage and face to face consultations. 10 sets of notes were picked for all of use – chosen at random. Consecutive notes for 6 triage calls and then 4 consecutive face to face consultations. We requested the notes from governance and they were all anonymised prior to us reading them.
Why did you pick this TOPIC/ DATA SET case (eg to reflect on your practice and identify learning needs, to demonstrate application of learning, to identify areas for improvement –SEA, other)
To reflect on the quality of my written notes both in terms of accuracy/lack of typing errors but also to make sure the notes made clinical sense to another GP and were felt to be safe and appropriate.
1 clear/relevant history
2 Recording other relevant information -pmh/dh/sh
3 For those seen face to face - appropriate examination/documenting obs
4 Appropriate management
5 Safety netting
6 Easy to follow thought process
Are there any external bench marks/standards against which you can compare your activity/ performance in this area?
There were no formal benchmarks but each set of notes were assessed by 3 GPs all experienced in working out of hours and reading other GPs notes (e.g. another doctors triaging notes when seeing someone face to face).

What have you learnt from this activity? For yourself
Generally my notes were felt to be good, clear and show a safe clinical thought process. It was noted that, after a triage and if a patient was going to be seen, I did not document about safety netting (although always do). It was felt that I should in case of a system failure.
For the practice [if appropriate]
We felt that reviewing the quality of notes would be a useful practise for NDUC to do on all doctors.

What changes or actions have arisen from review of this activity?
For yourself I now always document that I have safety netted a triage call
For the practice [if appropriate]
We fed back our thoughts about reviewing notes as an organisation to learn that they were already developing a tool and so 2 of us were invited to get involved with developing it further.
Have you reviewed these changes yet –if not when/how will you do so?
The notes review tool has now been developed and piloted by myself and 2 other GPs. I presented that tool at an educational meeting and it will shortly be used throughout the organisation.

Quality of Referrals : a review:

i) ***O****verall, is the letter message obvious?*
*ii) Is there **P**SO (Psycho-social-occupational) information included i.e. the way in which this is effecting the patient's life*
*iii) What is the **Q**uestion I am asking? (Diagnosis? Management?)*
*iv) Is the letter **R**elevant or are there statements or sections which are superfluous?*
*v) Say what has been tried **S**o far from GP point of view.*

*Points for potential improvement marked in **BOLD***

	Overall obvious	**P**SO	**Q** asked clear?	**R**el info?	'**S**o far'?
Letter 1 Vasectomy request	Yes	Yes	Yes	yes	**Could have said what wife uses egg COC**
Letter 2 Cheek lesion ?BCC	Yes	**Nil offered e.g. sun exposure risk**	yes	yes	**Nil done/said**
Letter 3 Physio & wheelchair	Yes (pt with MS)	**Work? (don't assume nil) Is his carer coping?**	yes	**Leg exam: no mention!**	Yes i.e. what was done in the past
Letter 4 Hepatobil; referral 'from urol letter'	Yes	No mention (but never met)	**'Input' (a bit general?!)**	Yes (CT scan info)	Yes - Urology
Letter 5 Paeds ENT (kid not met)	Yes Hyperacusis	Yes (ADHD autism)	Reasonably	Yes (incl letter from school)	Nil offered (apart from school)
Letter 6 ??BCC	Yes	Nil offered	Yes (BCC and removal request)	Yes (Known to derm)	Yes (cryo)
Letter 7 Knee pain to Dr Roberts	Yes	Yes	Yes	Yes	**No info offered e.g. exercises, nsaids**
Letter 8 Hand physio	Yes	Yes	Yes	Yes	**Nil mentioned i.e. why no physio so far (he DNA'd)**

Letter 9 Talk therapy	yes	**Yes (but work' – what is it?)**	**Not 100% clear! (i.e. that counselling is wanted)**	yes	Yes

Description of the activity –
Whilst in my trainer role, I was assessing my trainee in relation to several components of her practice - one of which was her referrals to secondary care. Whether as a Drs we are feeling guilt, heart sink or professional pride-related pressure from patients to 'take them seriously enough' to refer, or whether we are feeling financial pressure from GP partners or organisations we may work for, not to refer anyone unless absolutely necessary, there must be some middle ground. Rather than concentrate on pure numbers – as might be understood by for example in the 'hit rate' or 'conversion rate' judgement of referrals where a 'good' referral end us with an operation, and a bad one is discharged after a single OP appointment, I wanted to step back from these local and current peculiarities to ask – what actually makes a good referral? I had my own opinions, but asked my own trainee and after a 'brainstorm' on the topic we came up with our own criteria. This helped us feel ownership of the manner in which we assessed her, especially as I agreed to be submitted to the same scrutiny, as we both then performed the same review of practice for my referrals, selected at random from the past month.

Why did you pick this TOPIC/ DATA SET case (e.g. to reflect on your practice and identify learning needs, to demonstrate application of learning, to identify areas for improvement –SEA, other)
It is part of assessing a trainee doctor, but is useful at any stage of one's career. It was helpful to reflect on my own practice (in doing the review) and then get another person's view on it also (which picked up things I may not have otherwise noticed).

What have you learnt from this activity?
For yourself: I like more often to make the Question clear that I am asking the consultant, use PSO information i.e. linking this to the complaint and also more reliably mention what has been 'tried so far'.
What changes or actions have arisen from review of this activity? For yourself:
Make the link from PSO information gleaned to the way in which this effect the patient's life – helping the referral team understand 'why this, why now?'.

Have you reviewed these changes yet –if not when/how will you do so?
I have agreed to repeat this review in 6 months – and perhaps use this approach (of making an assessment 'tailor made' by way of increasing ownership) with my next trainee.

Review of video consultations for time management

Description of the activity:
A day of recording my consultations on video with the patients' consent on 2/3/15. I then reviewed the videos with my mentor, with a particular emphasis on my time management skills.

Why did you pick this TOPIC/ DATA SET
I had identified time management as one of my PDPs for the appraisal year 2015/16. As a relatively newly qualified GP, I feel that this is an area I need to develop. I recognized that I was often running up to 1 hour late by the end of my surgery. Although I have not received any complaints about this, I do worry about the impact on patients if they are waiting a long time to be seen. I also realized that running late during consultations leads to a longer working day and subsequently can have an impact on my personal life outside work.
My appraiser and my mentor had suggested that video consultations could be a useful way of reviewing my time management within consultations and identifying potential changes I could make.

Are there any external bench marks/standards against which you can compare your activity/ performance in this area?
We are required to provide 10 minute consultations in General Practice, and I therefore need to be able to see patients in this time frame on average.

What have you learnt from this activity? For yourself
This exercise has helped me to identify the following reasons why my consultations are lasting longer than 10 minutes:
1. Not setting an agenda at the start of the consultation and therefore having to deal with important issues raised by the patient later in the consultation.
2. Not being assertive enough to say to patients that I am unable to address all of their problems during one consultation.
3. Spending too long on history taking e.g. picking up on something which the patient may have mentioned in passing but was not concerned about.
4. Not delegating tasks to other team members where appropriate, such as checking a patient's blood pressure or urinalysis.
5. Difficulty dealing with uncertainty, which can lead to more time spent making decisions on management or devising complex management plans.
6. Lack of confidence in dealing with certain presentations particularly mental health problems, neurology and cardiology, or patients with comorbidities.
7. Extensive documentation which could be more succinct yet still include what is needed for any clinician who subsequently sees the patient.

For the practice [if appropriate]
I have learnt that having systems in place within the practice can help us to work more effectively as a team. For example, it's important to have same day appointments available with nursing staff or HCAs so that some tasks can be delegated when appropriate. I feel that patients should be reminded that we only have 10 minutes per appointment and therefore it is important that we only focus on one problem in order to address it fully. We also have an

alert system for more complex patients for whom it is appropriate to book a double appointment.

What changes or actions have arisen from review of this activity? For yourself

1. I am being more assertive in setting the agenda with the patient at the beginning and being realistic with the patient to ensure that their expectations of the appointment are managed. I also make it clear for complex patients what I can address, and that a further follow-up, or where necessary, double appointment, may be needed to ensure that their needs and concerns are dealt with effectively. I will also endeavor to remain focused on the presenting complaint, rather than allowing patients to digress too much.
2. When dealing with uncertainty about the diagnosis, I recognize that I sometimes need to simplify my management plan and use a step-wise approach. For example, it may be helpful to arrange one or two investigations and then review the patient, rather than arranging multiple investigations which may turn out to be unnecessary.
3. I am also trying to prioritize my time in other aspects of my job, for example by doing referrals immediately after seeing the patient while the information is still fresh in my mind.
4. I am addressing my clinical learning needs in those areas which I found were leading to longer consultations such as cardiology, neurology and mental health. I have attended lectures in these areas (see evidence in my learning log).
5. I have also read some guidance about time management and how taking control of my time results in reduced stress and better outcomes both personally and professionally. I am planning to attend a course on assertiveness and resilience, which I feel will also help me to work more effectively.

For the practice [if appropriate]

I have discussed areas for change with the practice management team. For example, I have arranged a 30 minute block in the middle of my evening surgeries which has been very helpful to allow me to catch up.

This exercise also highlighted the issue that I was being given more telephone consultations than my colleagues, which added to the length of my surgery. I have therefore spoken to reception staff about this and the number of telephone consultations I do has now been limited to four per session.

Have you reviewed these changes yet –if not when/how will you do so?

I completed a second round of video consultations on the 3/12/15. This demonstrated improvements in some areas such as setting the agenda, more succinct documentation during appointments and increased delegation of appropriate tasks. However I feel that it will be important to periodically review my consultation skills and reflect on any cases which I find are taking much longer than 10 minutes.

Review of Referrals

To study the quality of my clinic referrals (i.e. excluding emergency referrals, physio, ECG/ECHO USS referrals) over a 1-3 month period of 2012.

Referral letters need to provide information, which is relevant, complete, and inclusive of all factors which will allow the recipient to offer the best care. As a locum I am not included in practice reviews on referrals. A lot of my referrals get signed by regular practice GPs and in general I have had good feedback from them.

One of the GPs nevertheless suggested this as a useful audit. He had carried out an audit of his referrals several years ago and found it helpful. I based my quality criteria on his template –which had been based on some past LMC guides. Once I started scoring I separated FHx and social factors –which he had scored as one- into 2 separate items, which left me to quality check my letters against 10 criteria.

The criteria:

1. Essential background and patient details e.g. address, date of birth, National Health Number, hospital number.
2. Reason for referral-specified at beginning of letter
3. History of the complaint: incl. degree of urgency.
4. Past medical history – relevant and if not relevant this should be stated
5. Examination: sig negatives or positives
6. Drug history and actions taken so far.
7. Social factors
8. FHx
9. What patient knows / has been told.
10. Expectation of the referral

I assessed the adequacy of the information that I provided and in deciding whether that information was there, or not, I scored a Yes (Y) or a No (N). Occasionally a criteria did not apply to the type of referral in which case I scored n/a. I then awarded a point or not under each criteria and therefore arrived at a total for each referral x/10 or if a criteria did not apply x/9. I carried out and analysis of 50 elective referral letters.

I was quite stringent in the application of those criteria and even if e.g. information could be deducted from the context of the letter, unless I had specifically made reference to it, I did not score at all.

SCORING BY CRITERIA ()

			%
1	Patient Details	50/50	100
2	Reason for Referral	31/50	62

3	History of Problem	49/50	98
4	Past Medical History	42/50	84
5	Examination	45/48	94
6	Drug History / Medication	39/43	90
7	Social factors	19/50	38
8	Family History	15/48	31
9	What Patient Told / Knowledge	17/50	34
10	Expectation from Referral	43/50	86

DISCUSSION

1. **Patient information**: is provided automatically so 100% are scored with no effort form my part here.
2. **Reason for Referral**: Whilst the reason for referral would be clear from the context in my referrals, I have not always put this in the first sentence or as a headline. Further discussion with a colleague we both felt that this criterion is only achieved, if there is specific reference made to the reason for referral in the first sentence or even better highlighted as a problem heading, as this allows more immediate tuning into the letter. I have scored this accordingly. This does not mean that the letters where I have not scored failed to convey what the problem is in some form.
3. **History of Problem**: was mostly covered well and seem to reflect a strength of mine of generally taking a very detailed Hx of the complaint
4. **Past Medical History**: is included nowadays in all referrals in the computer printout. However those can be difficult for secondary care physicians to read and take account of (*In fact I had one Consultant once criticise me for not including a diagnosis of Type 2 Diabetes, when it had indeed been included in the summary but not in the letter*) . This audit and discussion with my colleague highlighted for me the importance to make mention of any positive or negative PMHx, which is directly relevant to the presentation for which the referral is made, in the main letter. I have not achieved this in 16% and this could be improved
5. **Examination**: I achieve a relatively high score here. Some referrals do not need examination findings to be included, i.e. 2 weeks gynae referral for PMB. Hence it would be unrealistic to aim for a 100% and I would consider this score as acceptable.
6. **Drug History and medication**: a list of current medication is usually included in all referrals due to the computer print out summary. However again it is possible that Secondary Care Physicians are not as familiar with looking at the summaries and it is rather important to elaborate on any treatments tried and what effect a treatment has or has not had in relation to the presenting complaint for which a referral is made. There are potential safety issue, if e.g. medications which the patient has been intolerant too are tried again in secondary care. This is not good practice, may well be dangerous and is a potential

waste of patient and consultant time. Because of the safety issue, I would like to aim for a higher score than 90%.

7. **Social Factors**. 38% I score very low here as I do not routinely include details about patient's professions and life circumstances and styles. As a locum I often do not know that much of patients' backgrounds and would normally only ask about work when this is relevant to the consultation or comes up in conversations. I noticed that in those referrals where social factors are particularly relevant, i.e. psychiatry I include it. It is rather nice to know and be able to provide a bit more background about a patient as the relevance might only become apparent at later stages when further management is discussed. Since becoming aware of my omissions I make an effort to ask routinely about basic social factors/life circumstances and get a positive response to this from patients.
8. **Family History**: again it's a rather disappointingly low score –34%. As for PMx FHx is often listed in the summary, but this will not be immediately obvious to the recipient of the referral. I also do not report relative negative family history, which is another reason for the score to be so low. There is definitely scope to improve this and I should include relevant FHx both negative and positive in the bulk of the letter
9. **What Patient Told**: Again a low score 34%. This is low as I do not communicate in my letter how much information I have given to the patient. I realise this is very important as I myself often deal with patients who "claim they have not had anything explained" and it can then be difficult to know if that's actually true or if they have just not fully understood or are in denial. I generally spend a lot of time in sharing information with patients, e.g. explanations and issuing or pointing patient towards patient info leaflets and self help. I clearly need to communicate this better when making referrals so the Consultant can refer back to this as needed and add to the information rather than repeat it.
10. **Expectations:** I seem reasonably good at describing what I expect, although there is room to improve!! On reflection I also feel one might wish to include more specifically the ICE of the patient.

Summary

I thought this exercise has been well worthwhile, as it has highlighted clear areas of poor/less good performance which could easily be improved.

This insight has already changed my practice. I will concentrate on my areas of poorer performance and re-audit this in 1-2 years time.