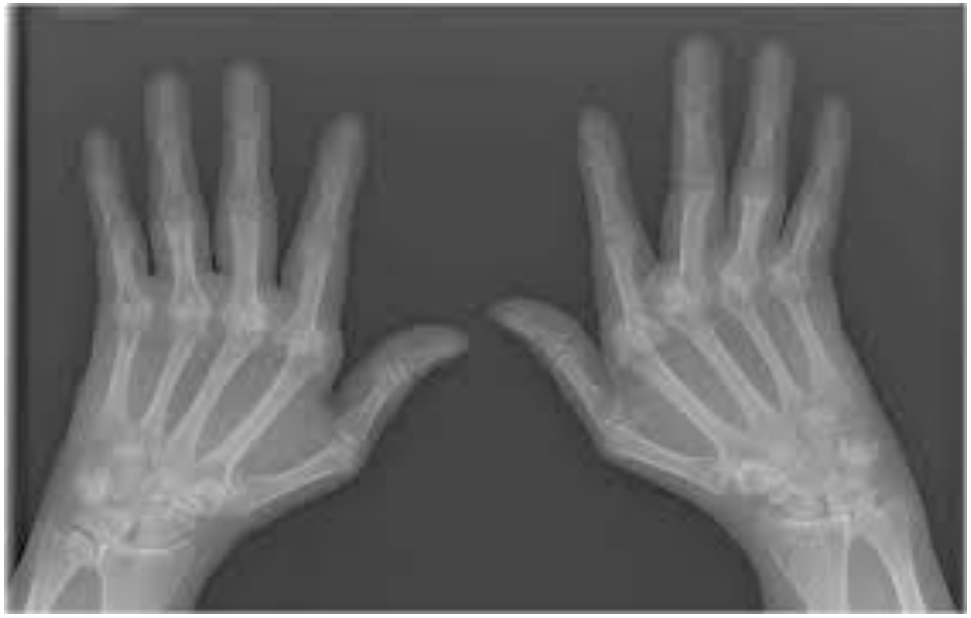
Quality, Service Improvement and Redesign (QSIR)

Your Toolbox

“Window of Opportunity”



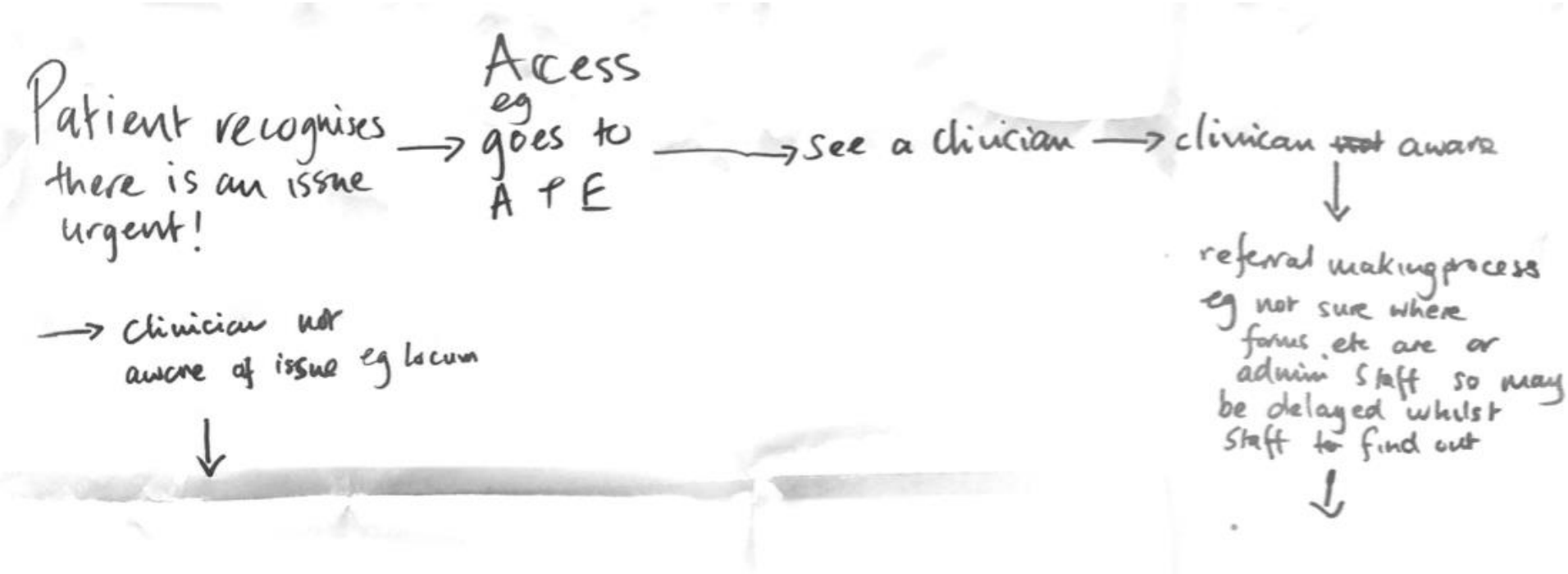
CCG Quality Committee in April and review Dec 2017

Diagnostic phase

- **Process mapping**
  - What is the starting point for the patient ?
  - What is end point … those diagnosed with dx treated with DMARDs (disease modifying drugs) within 6 weeks of referral
  - So where is it going wrong?
  - Where shall we start?

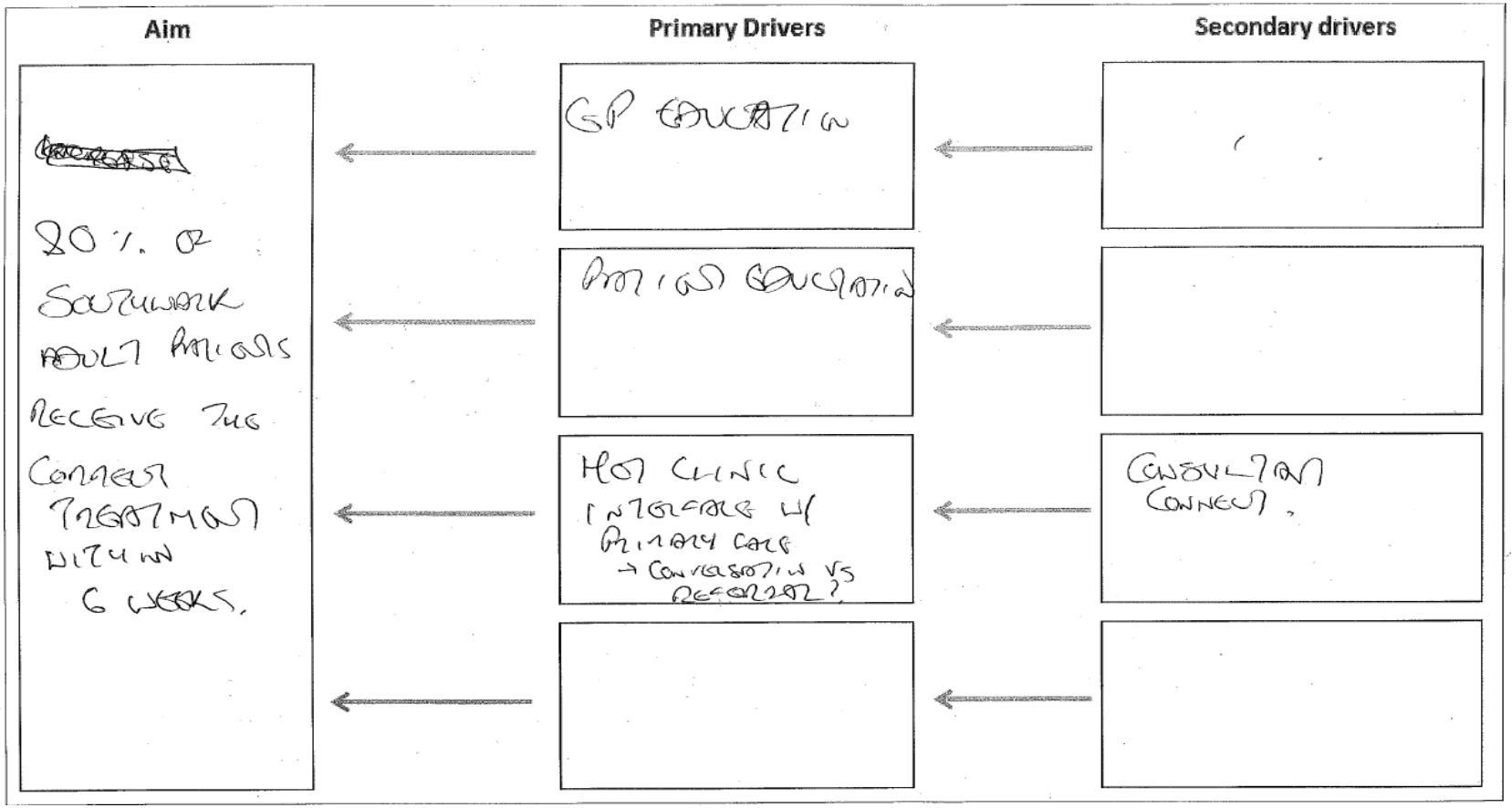
All change! The compelling case for change: changing the way we change
7–8 June 2019, Hallmark Hotel Derby Midland

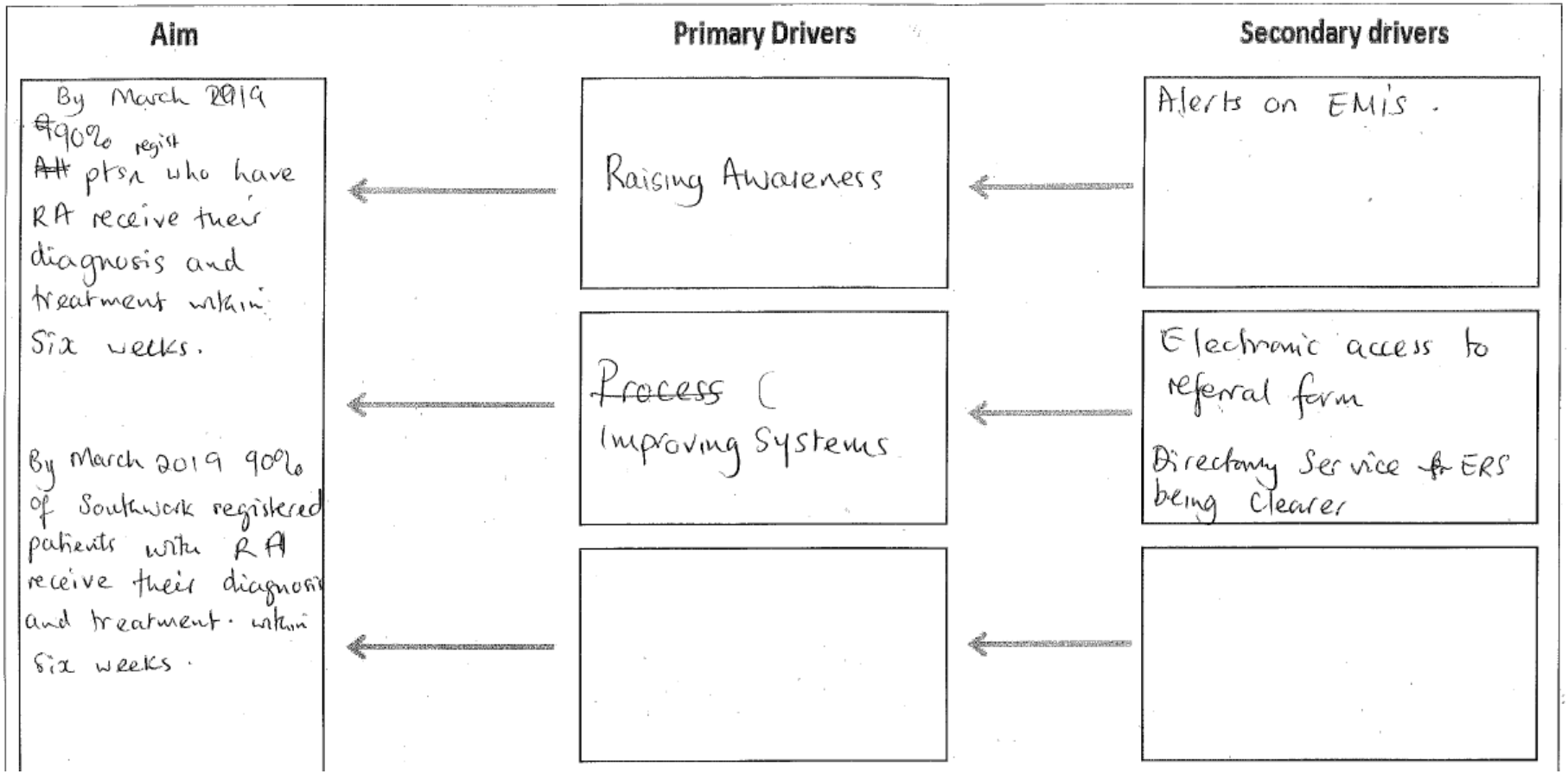
1. When does the patient decide to see GP
2. How long does it take to get appointment
3. @ appointment: History
   Tests.
   Assessment of symptoms.
4. Differential diagnosis + identification of need to refer.
5. [redacted] GP knowledge & up-to-date guidelines
   ↳ threshold to refer. Take the systems "bad" enough to justify pain + inconvenience.
   ↳ We need not & wait for tests.
6. Does the patient turn up for the blood test
7. e Referral
8. Clinic capacity + accessibility.

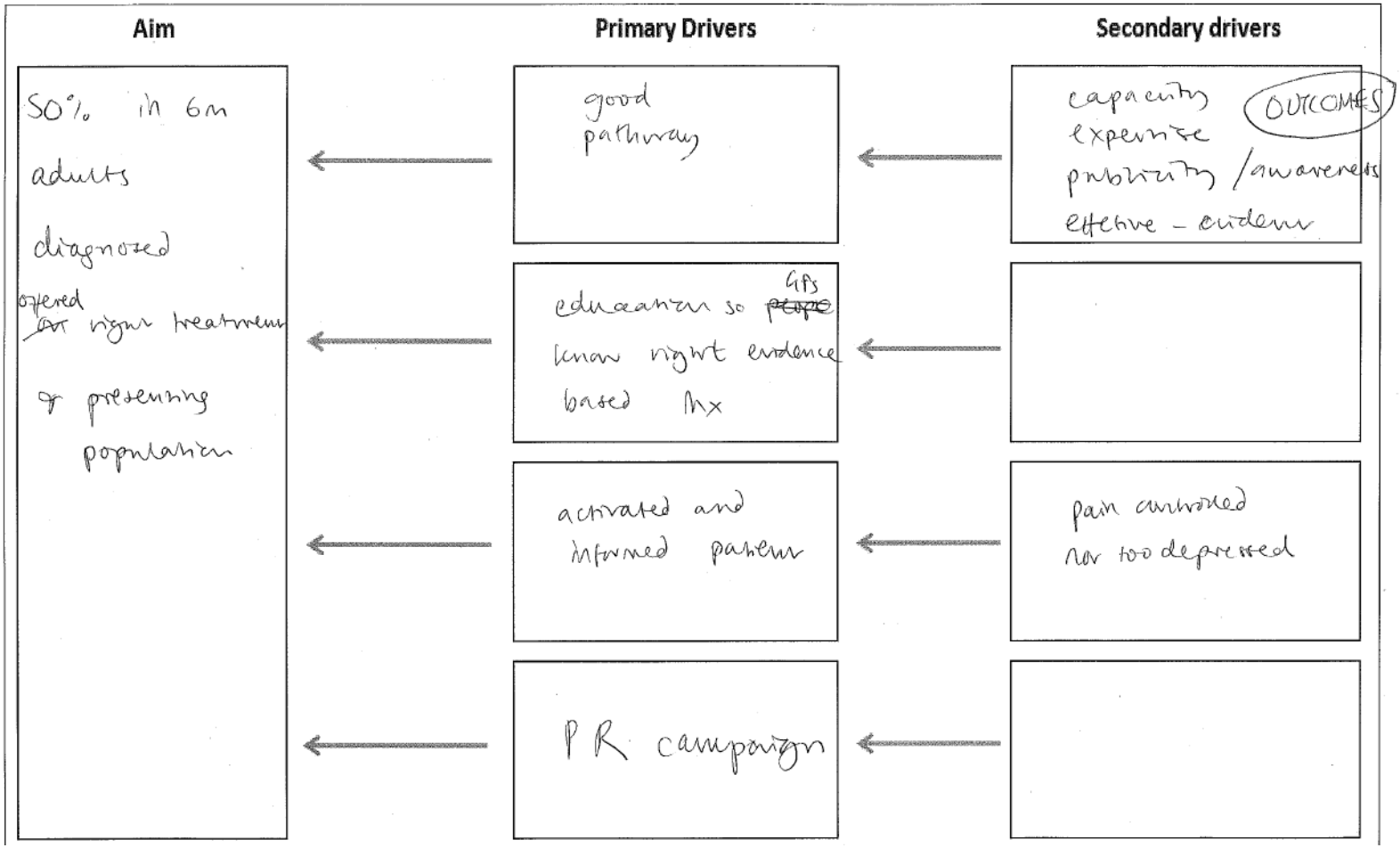

Patient recognises there is an issue urgent!
Access eg goes to A + E
see a clinician
clinician aware
referral making process eg not sure where forms etc are or admin staff so may be delayed whilst staff to find out
clinician not aware of issue eg locum

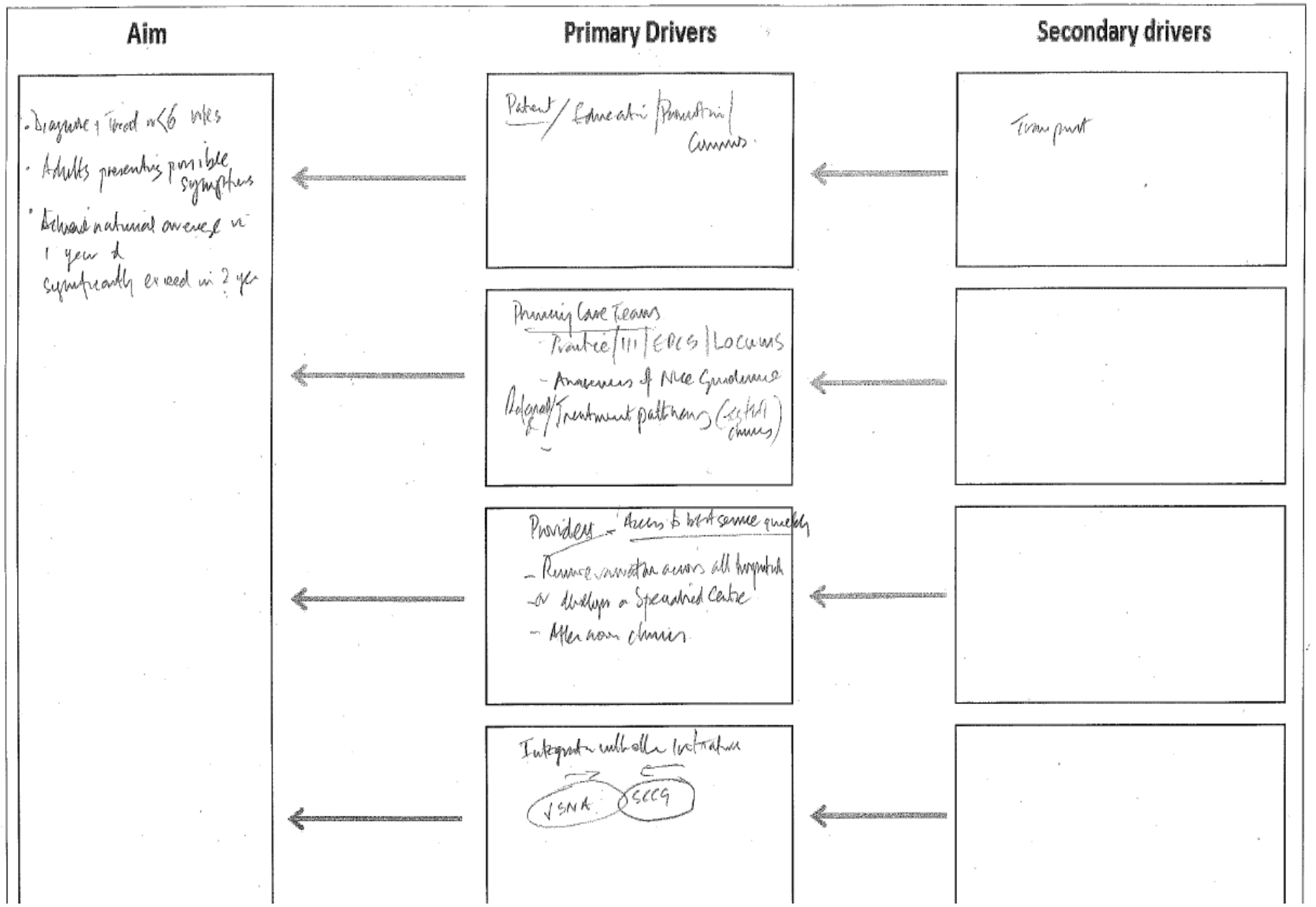
Diagnostic phase

- **Driver Diagrams**
  - 3 teams explored what the aim was and what factors could drive that improvement – primary and secondary


Aim
Primary Drivers
Secondary drivers
GP EDUCATION
80% OF SOUTHWARK ADULT ASTHMA RECEIVE THE CORRECT TREATMENT WITH IN 6 WEEKS.
HOT CLINIC INTEGRATED W/ PRIMARY CARE
→ CONVERSATION VS RECEIVED?
CONSULTANT CONNECT.


Aim
Primary Drivers
Secondary drivers
By March 2019 ~~90%~~ regist ~~All~~ ptsn who have RA receive their diagnosis and treatment within Six weeks.
By March 2019 90% of Southwark registered patients with RA receive their diagnosis and treatment within six weeks.
Raising Awareness
~~Process~~ (
Improving Systems
Alerts on EMIS.
Electronic access to referral form
Directory Service ~~for~~ ERS being Clearer


Aim
Primary Drivers
Secondary drivers
50% in 6m
adults
diagnosed
offered
right treatment
& presenting
population
good
pathway
capacity
expertise
publicity / awareness
effective - evidence
OUTCOMES
education so GPs
know right evidence
based Rx
activated and
informed patient
pain controlled
not too depressed
PR campaign

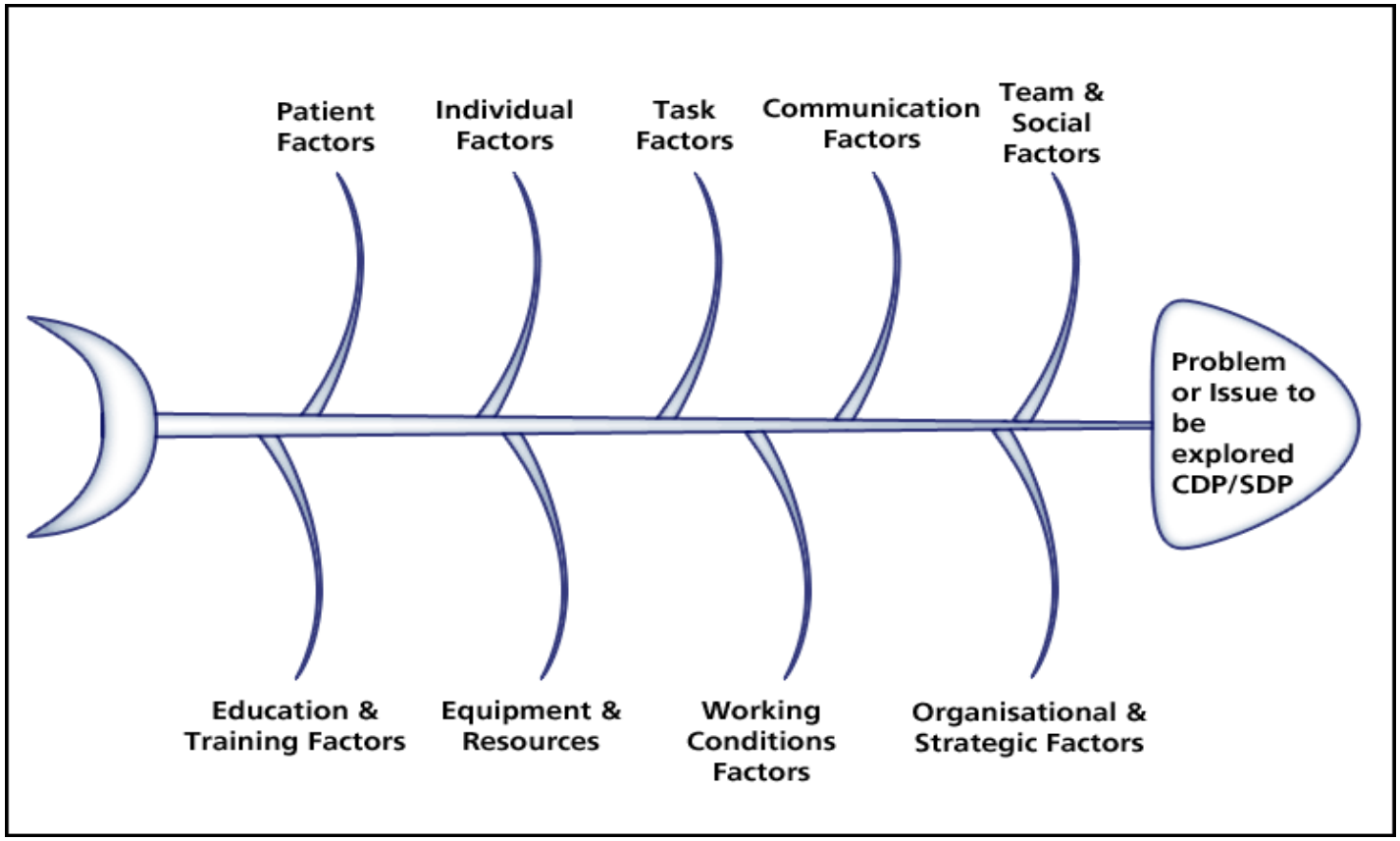

Aim
Primary Drivers
Secondary drivers
Transport
Providers
Integrate with other initiatives
VSNA
SCCG

Agreed a Smart Aim

50% of all adults presenting with **symptoms** of inflammatory arthritis within Southwark **general practices** and **recorded** in EMIS notes will receive **DMARDs** within **6 weeks** if the diagnosis is confirmed by the **final quarter** of 2018/19

Fishbone tool: Not just QI

- Used in root cause analysis for serious incidents
  - Focuses questions of enquiry
  - Comprehensive approach
  - Challenges fixed thinking
  - Communicates why you have highlighted an issue
  - Emotionally neutral



(CDP = Care delivery problems; SDP = Service delivery problems)

Patient Factors

- Multiple attender and very reliant on GP1 and then GP3 as a result of borderline personality disease.
- Had pre-existing ideas about her symptoms, probably linked to anxiety, possibly a chest infection. Was used to thinking about and explaining the way she felt through years of therapy.
- The cerebral metastases probably lead to some personality change so that patient started to behave out of character for her, leading to her becoming more withdrawn rather than more dependant in the 3 months before her hospital admission

Individual Factors

- GP3 knew patient well and was used to discussing and supporting her through her mental health issues and was aware of presenting patterns. Allowing time to be taken up in consultations discussing coping mechanisms may have left GP3 with less time to think more deeply about physical presentations.
- GP5 was consulting with patient as an acute presentation and perhaps didn't take previous consults into context as much as someone who had been seeing her regularly might have.

Task factors

- CXR was ordered as per NICE guidance, but beyond this, there is no further guidance as to what to do when CXR normal but ongoing symptoms (that don't satisfy TWW criteria outright). Haemoptysis was a one off occurrence and not mentioned again by patient after the normal CXR, which is another reason why TWW referral not triggered.

Team and Social factors

- Practice had held a previous SEA after lung mets were missed in a woman with a chronic cough earlier in the year. At that time we identified that there is no clear NICE pathway after a normal CXR but that a CT chest/TWW referral should be initiated if clinical suspicion high enough. GPs were aware of this, but suspicion wasn't high enough to trigger further investigations despite this.