Healthcare Improvement Scotland | ihub

Event Summary

GP Cluster Improvement Network Session 3

17 May 2023

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@SPSP_PC

Aims

1. **Network** and connect CQLs, PQLs and those supporting clusters across Scotland.
2. Share experiences and work from **cluster working** in NHS Tayside.
3. Provide an opportunity for all participants to **share their experience** in small discussion groups.

Agenda

Time	Item	Who	Slides/Links to resources
13:00	Welcome and introduction	Nico Grunenberg – Chair (GP/CQL, Primary Care QI Faculty, ihub)	
13:05	Conversation on Network MS Teams	Nico Grunenberg	Slide
13:15	Speed brainstorming	All	
13:30	Cluster working in NHS Tayside	Nico Grunenberg, Alison Clement (Clinical Director, Angus HSCP), David Wilson (new CQL, Dundee HSCP), Pascal Scanlan (former CQL, Dundee HSCP), Scott Jamieson (PQL, Angus HSCP Associate Clinical Director, Angus HSCP)	Slides
14:05	*Break*		
14:10	Breakout room discussion	All	See collation of comments from the breakout room discussions on the following pages. *Note – rich discussion. Key points included in this summary.*
14:50	Close and next steps	Nico Grunenberg	

Engagement

Thank you to all participants and speakers!

95 people registered for the event. This included CQLs and non-CQLs (such as HSCP/health board members and special boards).

49 CQLs from across **12 NHS boards** registered for the event: **~33%** of **CQLs** in post in Scotland.

Use of Data – breakout room discussion notes

Data people use/could use

- National resources:
  - **Scottish Therapeutics Utility (STU) is a useful resource.**
  - **In-Hours GP dashboard** is high level and will allow any practice in Scotland to access their in-house data and interrogate it. Estimated release date of 6-9 months from now.
- Extracted from practice clinical systems - **simple data from searches in EMIS/Vision.**
- **LIST created data collection tool on request** – inhalers, sick lines, mental health disorder sick lines.

Data tips shared

- **Small audits** are a helpful way to approach data collection.
- **Focus on quick wins**.
- **Pharmacists** are often experts at extracting prescribing data. PPIs/NSAIDS over 65. Triple whammy.
- The **best data is held locally**. National datasets can mean little to each individual practice and cluster.
- Need to understand that **no data is perfect.**
- **Caution** of collecting data that is not meeting your purpose. Small data numbers may not produce accurate data; be aware of outliers.

Questions raised

- **Unaware of LIST analysts –** who and what are they, what kind of support do they offer, how to request their support? *Note – LIST presented at previous session. See their slides.*
- **Unaware of data sources.**
- There is **quite a lot of data out there but not sure of what to do with it** (how to access it, how to interface with it, how to analyse it). An educational session for the whole cluster would be helpful.

Comments

- It is a **luxury** that teams do not have **to pull practice administrative staff** to assist with data and writing up of projects.
- Discussion on **perceived value of qualitative versus quantitative data**, and if it is the **role of clusters** to pursue data sources and identify variation.
- There seems to be more of a **focus on data which proves that clusters are involved with QI projects** (and associated writing up) than generating truly useful data.
- **Understanding the local context is important when interpreting national published data**. However, the context is not available with the data.
- **Benchmarking data is unavailable**, but data at national level is contextualised as target-driven.
- Sometimes it is difficult extracting data (even with LIST analyst help). **IT support working on other priorities** such as CTAC instead.
- **Data not available from the board;** reluctance to share patient data. Pressure to justify funding being spent in primary care as the board is in debt but having trouble getting the data.

Engagement tips shared

- **Small audits** help with practices' engagement.
- Trying to have protected time eg **PLT for small group discussion and peer support**.
- **Building relationships** (inviting guests, meeting individuals across the system (primary care, secondary care, social care and the community - all have each other's email addresses now).
- **As the CQL, you need to nudge things forward**. Act quickly and keep moving things forward.
- **Use an agenda to remind people what cluster objectives are** (eg we are going to discuss this; bring any audit information).
- **Easy wins** help bring the cluster together and get to know each other etc.

Support for new CQLs – breakout room discussion notes

Experiences of new CQLs

- Some new in their roles mentioned **no support** has been provided.
- **More support needs to be available** although newer CQLs said they appreciated this forum to network and to learn.
- **If no support** available, it can be an **uphill battle finding job satisfaction** within the role.
- **Handover** from former CQL has been via telephone calls only.
- **Suggestion** – having **CQL as critical friend**, going to cluster meetings and providing feedback.
- **Unsure of current role** as CQL and **what is expected**.
- **Concern - backfill** of role is difficult when dedicating time to CQL role.
- There is a lot of moaning around the contract. Very **difficult to keep meetings positive**.
- **Learning about QI:**
  - Some QI self-learning using NES and HIS websites.
  - Through supervision of GP trainees or University of Dundee undergraduate ScotGem students.
  - Overall concerns about training for all CQLs and new CQLs in particular.

Approaches to CQL appointments

- **Rotating CQL post** between GPs within the cluster every two years. A board considered whether CQLs could rotate for 6 months but it felt that it would be difficult for CQLs to gain skills and experience.
- The PQL/CQL structure of others has **not changed since the clusters were established**. Benefits – it provides security and established names, people and roles.

Resources shared so far

- PQL found the **list of resources shared by a network member on the Teams channel** very helpful.
- Previous network session #2 summary contains shared **tips/experiences on this topic.**

Question raised

- **Who is responsible to provide the induction** to CQLs?

Health board involvement/role in directing cluster work

Health board support required

- **Admin support** - '*Admin support would be amazing*'. Some asked for admin support from health board but did not get it.
- **Some CQLs meet monthly with their HSCP (eg Clinical Dir/Lead or Medical Director).** This helps to develop good and supportive relationships, discuss issues.
- **Having the board represented in meetings can be helpful**, even by providing admin, can change the tone and sometimes make it more constructive rather than a moan!
- **Board engagement is particularly important so that the 2C practices participate in cluster work.** However, board have their priorities (eg focus tends to be on the most possible consultations for fewer GPs).
- **Supporting sharing of work among clusters within the board/HSCP** as every cluster is working on different things.

Directing cluster work

- **CQLs need to drive the QI work** and approach HSCP/board for data that is fit for their purpose. HSCPs should not be pushing the agenda in clusters.
- **Challenge for the HSCP is not being "allowed" to be too directive** (eg by LMC). Role is to make suggestions, invite speakers etc but cannot tell clusters what to do.

Relationship between CQLs, clusters and boards/HSCPs

- Beyond Clinical Director, it can **get lost about who's who within the health board, what people's roles are and how it all fits together.**
- **Some clusters feel suspicious of health board**. CQLs do not want to feel like they are representatives of the board or government.
- **GP sub/LMC** as the main link to boards not always effective at representing all.
- **Tri-partite group** can be helpful in GP/board relationships as it discusses contract implementation and people identify areas of mutual clinical concern. This could provide areas of QI work for clusters based on existing interest.
- One area had **Terms of Reference for their GP partnership** which focus on parity for all professionals involved.

Sharing QI projects– breakout room discussion notes

QI projects done/being done by clusters?

Prescribing

- **Self-administered progesterone injection high user** (acute prescribed – looking at whether Practice Nurses can take over from GPs).
- **Unopposed oestrogens endometrial protection**.
- **Naloxone –** making sure spray is available everywhere, reducing the need to use vials and measure. This started as a cluster project and has been spread beyond.
- **Acute prescribing**.
- **Triple Whammy/NSAIDs.**

Prevention and LTC

- Setting up **re-call system for gestational diabetes, hypoglycaemia and pre-diabetes**
- **Processes for gestational diabetes.**
- **FENO (fractional exhaled nitric oxide) devices** implementation in clusters to **improve** asthma diagnosis and management.
- Looking at setting up a **bone density scan (DEXA scan) recall system**. Another person shared they developed a pathway to **reduce the long DEXA scan waiting list**.
- Quick Win - Protocol for **identifying patients with fatty liver disease.**
- **LTC related data gathering digital tools**, discussion around using Medlink and FootFall (Silicon Practice).
- **More joined up approach to LTC management:** single review – setting up infrastructure to allow this.

Other

- Projects working on **mental health**, particularly youth centres and children and young women's mental health.
- **Updating KIS for vulnerable patients** (search on patients over 75. Each GP has Rockwood frailty score chart laminated on their walls with visual representation of frailty and description of what the score entails. Incorporated into daily workload of GP partner. Updating KIS on a rolling basis when you have IDL. It becomes second nature and not additional work – very helpful including out-of-hours GPs.
- Looking at **inhalers** and returning to pharmacy for **recycling**.
- **Safe System for Q-FITs** (quantitative faecal immunochemical test)
- **Access and workload assessment** - Week of Work Audit- looking at appointment requests: how-who-why?

QI projects being planned

- Increasing **stroke incidence** based on local needs assessment. Discussion of this being an interface project in cooperation with public health.
- **Frailty** - unsure of actual QI project, but including new Frailty ANP in the area and social care planning within discussions.
- Letters being sent to **aged 40+ patients who may be under-diagnosed with hypertension**.
- **Nitrofurantoin support** for patients with px > 3 months. Review of these patients.
- Planning to work on **DOACs and benzodiazepines**.

Questions

- Tried to start recycling in pharmacy clinics but pharmacists said they were just binning them into general bin – **asking for help on how to persuade pharmacy.**

Comments on how they work on QI projects as a cluster

- **Testing, sharing and adopting/adapting** – eg workflow optimisation in one practice, one has taken on and hope that others will.
- Not working jointly as a cluster, **not collective joint projects**, quite disparate.
- Some QI work is very localised and **cannot be replicated easily.**
- **Some projects are only relevant to one/some practices** or better done at practice level.

Next steps

1. **Continue conversations** using MS Teams.
2. **Follow up email** with event summary.
3. Meet at **next session** on 21 September 2023, 1-3pm.