



PRIMARY CARE SEMINAR

Presentations
SAPC 2014, Edinburgh

24 June 2014
14.30-17.00

JS07, Smeall Building

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AGENDA

Oral presentations (10 mins + 10 mins for questions)		
14:30	Luke Mounce	Do patient's characteristics predict failure to receive care for Type 2 Diabetes? (p.3)
14:52	Colin Greaves	The REACH Heart Failure Manual: Development of a complex, home-based intervention to support self care for people with heart failure (p.4)
15:14	John Campbell	Common patterns of morbidity and multi-morbidity and their impact on health related quality of life: evidence from a national survey (p.6)
Elevator pitches (3 mins + 5 mins for questions)		
15:36	Colin Greaves	Diabetes prevention in the real world: Systematic review of the effectiveness of pragmatic lifestyle interventions for the prevention of type 2 diabetes and of the impact of guideline recommendations on effectiveness (p.7)
15:46	Raff Calitri	A cross-sectional survey study of service users' experiences of out-of-hours primary medical care in England (p.8)
15:56	Chris Wright	Development of an online resource to support GP appraisers in the interpretation of multisource feedback and explore the potential for standard-setting (p.9)
16:06	Chris Wright	Feasibility and acceptability of a real-time feedback intervention to improve patient experience in general practice: preliminary results (p.10)
16:16	Fiona Warren	Prescribing and investigations behaviour among General Practitioners consulting face-to-face and by telephone following an urgent request for care: insights from the ESTEEM trial (p.11)
16:26	Jose Valderas	Patients' experiences of patient safety in primary care in England. A systematic review and meta-synthesis (p.12)

ORAL PRESENTATIONS

Do Patients' Characteristics Predict Failure to Receive Care for Type 2 Diabetes?

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The Problem

The increasing prevalence of type 2 diabetes is a global public health crisis that poses major care and economic challenges for both developed and developing countries. Diabetes complications are potentially avoidable, yet poor care is common. Understanding what factors drive variation in the receipt of core diabetes care is vital for informing the development of quality improvement strategies. Studies have identified provider factors predicting failure to receive care, but less is known about patient factors. Prior work has been limited to investigating basic patient descriptors that can be extracted from clinical records. We examined the proportions of patients offered indicated diabetes care in a large cohort of older people and modelled a broad range of sophisticated, baseline patient characteristics to predict subsequent failure to receive care two years later.

The Approach

English Longitudinal Study of Ageing participants (aged 50 years or older) in 2008/9 and 2010/11 self-reported on receipt of four components of diabetes care assessed by quality indicators (QIs) that were previously developed for the Assessing Care of Vulnerable Elders project. Annual checks for HbA1c, proteinuria and foot examination formed a care bundle. A further QI assessed diabetes plus other cardiac risk factors for ACE inhibitors/receptor blockers. Baseline (2008/9) patient predictors included: socio-demographic, lifestyle and health characteristics; diabetes self-management knowledge and health literacy; and whether care was received. Two logistic regression models were developed to predict failure to receive care in 2010/11; one for all-or-nothing achievement of the care bundle (n=902) and the other for the ACE inhibitor indicator (n=757).

Findings

A third of participants (2008/9=32.8%; 2010/11=32.2%) did not receive one or more of care bundle components and nearly half of those eligible were not offered ACE inhibitors/receptor blockers (2008/9=44.6%; 2010/11=44.5%). In logistic regressions, having not received the care at baseline was the biggest predictor of not receiving care two years later for both the care bundle (OR 3.32, 95% CI 2.28 - 4.84) and the ACE inhibitor indicator (OR 6.94, 95% CI 4.54 - 10.61). Participants lacking diabetes self-management knowledge or cognitively impaired were more likely to not receive the full bundle. Individuals who were younger, single, not obese or who had low health literacy were more likely to subsequently not be offered ACE inhibitors/receptor blockers.

Consequences

Non-receipt of indicated care is entrenched over time. Quality improvement strategies should target those who previously did not receive indicated care, who could be highlighted by routine clinical record audit. Increasing patients' knowledge of the care they should expect to receive may aid quality improvement.

The REACH Heart Failure Manual: Development of a complex, home-based intervention to support self-care for people with heart failure

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Carolyn Deighan (2)	Michelle Clark (2)	Kevin Paul (6)	
Jenny Wingham (3)	Jenny Elliott (2)	Louise Taylor (2)	
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The Problem

Heart failure (HF) affects almost a million people in the UK. Cardiac rehabilitation is effective and recommended by NICE guidelines. However, fewer than 5% of people with HF currently access rehabilitation programmes in the UK. A range of self-care activities such as improving fitness, managing medications, appropriate help seeking and managing stress can affect symptoms and well-being. A home-based rehabilitation and self-care support package therefore offers the opportunity to increase access to care and to substantially increase health-related quality of life in people with HF. Improved self-management of HF may also reduce hospital readmissions.

The approach

We used formal Intervention Mapping methods to develop a complex Exercise training and self-care support intervention for people with HF. This included 1) Needs Assessment: Interviews and a 'scaffolding questionnaire' survey with patients, service providers and caregivers; systematic reviews of quantitative and qualitative evidence; reviewing guidelines; consultation with experts in cardiology, cardiac rehabilitation, self-help manual development, cardiac nursing, health psychology, primary care and a 9-member patient participation group. Data from these disparate sources were synthesised using framework synthesis (Oliver et al., 2008). 2) Construction of 'mapping matrices': We constructed tables of intervention objectives and modifiable determinants of these. 3) Intervention techniques and strategies were selected to modify the determinants identified, based on existing intervention theory and taxonomies of behaviour change techniques as well as expert opinion and experience.

Findings

The above processes generated three main resources: A 'Heart Failure Manual' for use by patients, a Caregiver Resource and a training programme for intervention facilitators. Facilitation consists of 4-6 contacts (at least two face-to-face) with a cardiac nurse or physiotherapist. The intervention has four primary self-care objectives (maximise physical fitness, manage stress /anxiety, manage and take medications, manage fluid balance (and seek help appropriately when this changes)), as well as 19 secondary objectives (e.g. manage low mood, get vaccinated, improve sleep quality). The intervention is tailored to address both patient priorities and clinical priorities on an individual basis. It aims to increase both understanding of the condition and mastery of self-care activities through practice, self-monitoring of progress and facilitated problem-solving. It also aims to strongly support caregiver involvement in self-care. Our service user group participated strongly in developing the intervention objectives, reviewing text, providing 'Patient Voices' that were used throughout the manual and helping to deliver the facilitator training.

Consequences

We have rigorously developed a comprehensive self-care support intervention for people with heart failure and their caregivers. This is grounded in the evidence base, behaviour change theory, clinical guidelines, wide-ranging expertise and patient perspectives. The intervention has potential to improve health-related quality of life for people with HF. A NIHR-funded feasibility study is in progress and a multi-site RCT will follow.

Common patterns of morbidity and multi-morbidity and their impact on health related quality of life: evidence from a national survey

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The problem: There is limited evidence about the impact of specific patterns of multi-morbidity on health-related quality of life from large samples of data obtained from adults.

The approach

We used data from the English General Practice Patient Survey 2011-2012. We defined multi-morbidity as the presence of two or more of 12 self-reported conditions or another (unspecified) long term health problem. We investigated differences in quality of life (EQ-5D scores) associated with combinations of these conditions after adjusting for age, gender, ethnicity, socio-economic deprivation, and the presence of a recent illness or injury. Analyses were based on 831,537 responses from patients aged 18 years or older in 8,254 primary care practices in England.

Findings

23% of respondents reported two or more chronic conditions (ranging from 7.5% of those under 45 years of age to 51.1% of those 65 years or older). Multi-morbidity was more common among women, white individuals, and in respondents from socio-economically deprived areas. Neurological problems, mental health problems, arthritis and long-term back problem were associated with the lowest health related quality of life. The presence of three or more conditions was commonly associated with an impact on quality of life over and above the sum of the impact of the individual conditions on their own. Mental health problems had an adverse effect on quality of life, especially when occurring in combination with other physical conditions. Decrements in EQ5D scores associated with an additional condition in people with more than three physical conditions were greater for younger people than for older people. Multi-morbidity was associated with a substantially worse quality of life in diabetes than in other long-term conditions.

Consequences: Integrating mental and physical health approaches to care should be seen an essential component in the delivery of high quality care for people with long-term health conditions.

ELEVATOR PITCH PRESENTATIONS

Diabetes prevention in the real world: Systematic review of the effectiveness of pragmatic lifestyle interventions for the prevention of type 2 diabetes and of the impact of guideline recommendations on effectiveness.

Abstract No. 0150

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Problem

Weight loss is known to be the main driver for the development of type 2 diabetes. Community based interventions aiming to prevent type 2 diabetes through weight loss (as achieved through lifestyle change) vary dramatically in effectiveness. We aimed a) to summarise the evidence on effectiveness of 'real-world' diabetes prevention programmes in generating weight loss, and b) to examine whether adherence to international guideline recommendations is associated with increased effectiveness.

Approach

Relevant bibliographic databases were searched to July 2012. We included studies evaluating 'real world' diabetes prevention programmes targeting change in diet and/or physical activity, with outcome data on weight, body composition, glycaemic control, or progression to diabetes at 12 months or more of follow up. The interventions aimed to translate evidence from previous efficacy trials of diabetes prevention, into real world intervention programmes and aimed to change in diet and /or physical activity to achieve weight loss. Data were combined using a) random effects meta-analysis and b) meta-regression to explore the association between intervention effectiveness and adherence to NICE and IMAGE recommendations on intervention content.

Findings

The primary meta-analysis included 22 studies reporting weight loss at 12 months. The interventions delivered a mean weight loss of 2.12kg (95% CI: 2.61 to 1.63; I²=91.4%). This compared with 4.2 to 6.7Kg achieved in 'gold standard' clinical efficacy trials. Adherence to guidelines was significantly associated with greater weight loss, with an increase of 0.3Kg per point increase on an 11-point guideline adherence scale.

Consequences

Pragmatic, community based diabetes prevention programmes are effective in generating weight loss at 12 months. On average, they produce only half the amount of weight loss generated in clinical efficacy trials. However, effectiveness is higher for programmes that adhere to guideline recommendations on supporting behaviour change.

A cross-sectional survey study of service users' experiences of out-of-hours primary medical care in England

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Department of Primary Care, University of Exeter Medical School

The problem

Patient experience of out-of-hours services should be regularly audited using questionnaires. National Quality Standards do not recommend specific questionnaires to use, making performance assessment and benchmarking between service providers difficult. The national GP Patient Survey (GPPS) includes a section (6 items) relating to out-of-hours care, however these questions have not been validated. The Out-of-Hours Patient Questionnaire (OPQ), collects more detailed information on patient experience of out-of-hours care, and has undergone testing and validation. The aim of this study is to establish the validity of the GPPS out-of-hours items by undertaking quantitative analysis to compare responses from GPPS and OPQ questionnaires.

The approach

Six out-of-hours service providers were recruited to the study. Providers were sampled to create diversity in organisation type (NHS/social enterprise/private) and geographical location. A random sample of recent service users ($n=850$ per provider, $n=5,100$ in total) were invited to respond to a patient experience questionnaire comprising GPPS out-of-hours items and the OPQ. A reminder mailing took place after two weeks. Patients aged 12-17 years, those with temporary/incomplete addresses, those admitted to hospital following their contact with the out-of-hours service, and those suffering end-stage illness were excluded from the study. Simple data analyses were undertaken to describe response rates and respondent characteristics. Future analyses will document the construct and concurrent validity of GPPS items using standard psychometric techniques.

Findings

Data collection has taken place at two service providers so far ($n=1700$). Preliminary analysis of the results is reported below. Six hundred and forty seven service users responded to the questionnaire, providing a response rate of 38.1% (647/1700). Respondents had a mean age of 52.0 (± 24.7) years, were predominantly female (65.5%), had a median Index of Multiple Deprivation 2010 score of 13.07 (range 2.84-61.66), and most had either received telephone advice (44.4%) or attended a treatment centre (34.5%) as a result of contacting the out-of-hours service. The majority of respondents (92.3%) reported finding it easy to contact the out-of-hours service, and nearly half of respondents (47.1%) reported that care was received quicker than expected. Only 5.3% of respondents felt that they did not have confidence or trust in the clinician they saw or spoke to. Overall, 88.6% rated their experience as 'good' or 'very good'. Further analysis will be undertaken once all data have been collected, and will be available for presentation on the day.

Consequences

This study will provide important data on the validity of GPPS out-of-hours items, and will inform further qualitative work which is due to be undertaken with service provider staff.

Development of an online resource to support GP appraisers in the interpretation of multisource feedback and explore the potential for standard-setting

Dr Christine Wright, Professor John Campbell, Mr Luke McGowan, Dr Di Jelley, Dr Arunangsu Chatterjee.

The problem

Medical practitioners now collect a range of information about their professional practice for their appraisal and revalidation process. One component of this is multisource feedback (MSF) from patients and colleagues. Little is known about how GP appraisers interpret such feedback and use it within the doctor's appraisal meeting.

The approach

Between December 2012 and October 2013, GP appraisers from one area of England were invited to review and assess 8 MSF reports available on a purpose-built website. The anonymised reports summarised feedback collected by GPs using the GMC Patient Questionnaire (PQ) and Colleague Questionnaire (CQ), and reflected a range of doctor performance. Participating appraisers made a series of judgments based on what they saw in each report, including an overall rating of the doctor's performance, their level of concern about the doctor's practice, and actions they might suggest for the doctor's Professional Development Plan (PDP). After submitting their online assessment, appraisers could view the ratings and comments submitted by an expert panel and other appraisers who had assessed the same report.

Findings

144 appraisers registered to use the website – 101 (70%) assessed at least one MSF report; 87 appraisers (86%) assessed all 8 reports. Participants were similar to non-participants in terms of their age and length of experience as an appraiser. Non-participants were more likely to be male. The pattern of appraisers' ratings suggested they were broadly able to detect variation in the range of doctor performance based on the information available in the reports. It was less clear whether appraisers' interpretations of MSF and recommended actions were influenced most by the doctors' summary scores on the PQ and CQ items, the ranking of doctors' scores relative to those of other GPs ('benchmark' information), or the content of free text comments made by patients and colleagues. Variation in the leniency of individual appraisers' assessments was noted. Although the exercise focused on only one form of 'evidence' of doctors' performance used in appraisal, the feedback obtained from the appraisers who used the website suggested the resources had been useful for gaining experience of reviewing and interpreting MSF results.

Consequences

The approach outlined has significant potential to inform standard setting and provision of feedback to doctors for the purposes of appraisal and revalidation.

Feasibility and acceptability of a real-time feedback intervention to improve patient experience in general practice: preliminary results

Christine Wright, Antoinette Davey, Jenni Burt, Natasha Elmore, Martin Roland and John Campbell

The Problem

There is increasing focus within the NHS on improving the quality of health services, and organisations are expected to collect feedback from patients about their experience of health care. Traditionally, the two main sources of patient feedback used within the NHS have been complaints and compliments, and the National Patient Survey Programme. There is growing interest in using new technologies to collect patient feedback in as near to real-time as possible because, in theory, this enables the results to be assessed and acted on quickly by services. Collecting feedback is insufficient on its own to improve patient experience; organisations also need to reflect and act upon the feedback while it is still 'fresh'.

The approach

The aim of this two-phase project is to explore, in a small number of general practices, the acceptability and feasibility of a real-time feedback (RTF) intervention that might have potential to inform change and improve patient experience in general practice. Practices currently scoring in the lowest 25%-50% on specific items of the National General Practice Patient Survey (GPPS) are eligible to participate.

In the feasibility phase, two practices in South West England have been recruited to pilot and evaluate the core components of the intervention. From February 2014, the practices will collect anonymised RTF from patients who attend the surgery over a period of 12 weeks, using touch-screen kiosks in the waiting area. Practices will receive feedback reports every fortnight – these will present a summary of all patient feedback at the team level and at the clinician level (for individual GPs and nurses). Practices will also be offered one facilitated reflection session during the intervention period. In that session, an experienced facilitator will help the practice team to reflect on their RTF results, and to discuss, prioritise and plan any changes they could make to improve their services for patients.

We will calculate the proportion of consulting patients who use the RTF kiosks. We will also directly observe how patients and staff interact with the touch-screens, and seek the views of patients (via brief 'exit surveys') and staff (by conducting team focus groups) on the feasibility and acceptability of this method of collecting patient feedback.

Findings

Results arising from the feasibility work (including RTF response rates, observed challenges, and patient and staff views) will be presented at the conference together with a discussion of the implications of these.

Consequences

The results of the feasibility work will increase our understanding of the practical challenges and potential benefits for practice teams of using RTF kiosks as a means of collecting immediate patient feedback in surgery waiting areas. The findings will inform the design of an exploratory trial in the next phase of the project.

Prescribing and investigations behaviour among General Practitioners consulting face-to-face and by telephone following an urgent request for care: insights from the ESTEEM trial

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The Problem

Telemedicine is of increasing interest in primary care; however, if a patient requires a prescription/investigations, it may be more appropriate for the clinician to consult face-to-face. The ESTEEM randomised controlled trial investigated two methods of telephone triage (by GP or nurse) in response to a request for a same-day consultation, compared with usual care. Practices were randomised to one of three treatment arms: usual care (UC); GP triage (GPT); nurse triage (NT). Differences in GP behaviour regarding prescriptions and investigations were recorded.

The Approach

GP consultations (face-to-face or by telephone) occurring in the GP telephone triage (GPT) or usual care (UC) arms (where GPs were most likely to be the first clinician to manage the patient), occurring on the day of the consultation request, were included. Hierarchical logistic regression modelling adjusted for patient-level variables (age, gender and deprivation), and placed a random effect on individual GP (cluster).

Findings

Of 4782 face-to-face consultations, 65.2% yielded a prescription, whereas only 24.5% (N=5038) of telephone consultations yielded a prescription. Among GPs who performed at least 10 face-to-face consultations, the proportion of consultations that resulted in a prescription ranged from 36.7% to 100%. Among GPs who performed at least 10 telephone consultations, the proportion that gave a prescription ranged from 5.6% to 100%. The OR of receiving a prescription for a telephone vs. face-to-face consultation was 0.18 (95% CI 0.15; 0.21).

Of 4512 face-to-face consultations, 18.4% resulted in at least one investigation, of 4839 telephone consultations the equivalent proportion was 7.8%. Among GPs who performed at least 10 face-to-face consultations, the proportion of consultations that involved ordering an investigation ranged from 3.9% to 50%. Among GPs who performed at least 10 telephone consultations, the proportion of consultations resulting in an investigation ranged from 0% to 22.2%. The odds of a telephone consultation involving ordering an investigation vs. a face-to-face consultation.

Consequences

Prescribing behaviour and the ordering of investigations vary widely by consultation type; also, individual GPs differed in their use of prescriptions and investigations within a consultation type. Some GPs may prefer to see patients face-to-face following a telephone consultation should the patient require a prescription/investigations; however, there may be scope for GPs to safely increase their use of prescriptions and investigations within telephone consultations, thus potentially benefitting patients by reducing the need for face-to-face management following a telephone consultation was 0.36 (95% CI 0.30; 0.44).

Patients' experiences of patient safety in primary care in England. A systematic review and meta-synthesis.

Ricci-Cabello I, Gonçalves DC, Campbell SM, Slight SP, Valderas JM

Introduction

Patient safety is currently a priority for the National Health Service. Much of the previous work on patient safety has concentrated on hospital and specialist care, resulting on a considerable knowledge gap for primary care. A most remarkable feature of research on patient safety to date is the lack of attention paid to patients' experiences of patient safety events.

The aim of this study was to identify domains and themes related to patient safety important to, and as experienced by primary care patients in the United Kingdom.

Methods

We conducted a systematic review and meta-synthesis. We searched in Medline, EMBASE, and CINAHL. We included qualitative studies exploring patients' perspectives of the safety of the healthcare provided in primary care in the United Kingdom. We excluded studies not published in English or published before 1990. Studies were critically appraised with a modified version of the Critical Appraisal Skills Programme tool. The selection of articles, data extraction, and critically appraisal was independently conducted by two reviewers. A meta-synthesis (conducted by IRC and JMV) was limited to studies with an explicit focus patient safety.

Results

55 studies were included in the systematic review. Studies were based on semi-structured interview or focus groups, which were analysed using thematic analysis. Participants were purposively selected and sample size ranged from 12 to 71 patients. Most of the studies were methodologically strong (mean score= 8/10 points).

Eight articles were included in the meta-synthesis. Eleven themes were identified and grouped in three main categories: 1) factors contributing to safety events (communication problems, continuity of care, previous experiences, physician attitudes, patient-physician relationship, interpersonal care, and speaking up), 2) patients' experiences of safety events (experience of active failure and experience of harm) and, 3) patients' experiences of reactions to safety events (patient reactions and institutional reactions).

Communication problems between patient and provider emerged as the main theme, having the potential to prevent the occurrence of safety events, but also to prevent or ameliorate harm once a failure had occurred. Communication problems were often caused by poor interpersonal communication skills, assumptions and guesses on both parts, relationship factors and by patients believing that withholding information could help them achieve desired goals.

Discussion

Available evidence suggests that, according to patients, communication plays a central role in patient safety problems. Additional primary qualitative research is needed for a better understanding of patient experiences of safety problems in primary care.