Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

QUALITY IMPROVEMENT ACTIVITY: Guidance from the Faculty of Public Health 2013

Background

A compulsory element of annual appraisal for revalidation is the requirement for evidence on 'review of practice'. It is accepted that traditional clinical audit is not a common occurrence for many public health specialists, and nationally led audits in public health are a rarity. However, public health specialists will be expected to present evidence from an audit at least once per five-year revalidation cycle. FPH understands audit as a loop: the audit must be completed to find out what improvement (if any) was made as a result of the action plan.

In the other years, if no audit has been completed, the appraisee must present evidence of quality improvement from two 'case reviews'. The intention behind this requirement is to bring two examples showing that you review your daily work – examples which are significant and from which you have learned something important and outlining the impact it has on your practice. Case reviews must include reflection.

The phrase 'case' comes from clinical work, because the daily work of clinicians is seeing patients. In public health work that concept – the daily work – may translate into a wide variety of activities – meetings, outbreaks, events, projects and so on. Case reviews must show reflection against national standards or guidelines and include evidence of discussion with peers or presentation at department meetings.

Introduction

Below are examples of case review and audit for the main areas of public health. **Although based in reality, the examples as given are fictionalised to a greater or lesser extent.** These examples have been submitted by members of the FPH Professional Standards and Knowledge Committee and are designed to act as guidance to the specialty when preparing supporting information for revalidation. Theexamples are supported by the FPH Specialty Specific Guidance.

Public health is a team activity, and many of the examples will relate to teamwork. Appraisal is individual, so the appraisee must highlight their personal contribution to the audit or case review.

HEALTH SERVICES AUDIT (1)

Audit title:
Variation in identification and care of COPD patients – improving patient outcomes

What we decided to audit and why we thought this was important
Tackling health inequalities was a key local priority. A core component of this work was focused on the management of long term conditions. COPD was a major cause of both mortality and morbidity in our borough which has one of the highest levels of smoking in London. COPD mortality was significantly higher locally when compared to both national and regional figures. A third of the deaths in the borough occurred in the population aged under 75 years, thus a condition having a substantial impact on the life expectancy gap between the borough and England.

The audit involved reviewing local prevalence, use of services and outcomes of individuals with COPD to develop a local baseline profile.

What we found and how we thought we could do better
The baseline profile found:

- 2.3% gap in the expected and observed prevalence of COPD - 4240 people were living in the borough with undiagnosed COPD
- Emergency admissions for COPD were three times higher than expected based on the admission rates for England
- COPD was the second biggest cause of emergency admissions locally
- The disease accounted for 9.3% of the life expectancy gap for men when compared to England and 13.5% of the gap in life expectancy for women

This was discussed at our team meeting.

Several improvement areas were identified:

- Improve the gap between expected and recorded prevalence
- Increase referrals into pulmonary rehabilitation
- Reduce the number of non-elective admissions and readmissions for COPD

Our improvement plan and results of re-audit
The approach taken to improving outcomes for COPD patients was to work in collaboration with primary care, secondary care and commissioning to develop a local enhanced service (LES). This incentivised practices to perform targeted case finding spirometry in smokers/ex-smokers aged 35 years and over who presented with relevant symptoms and for provision of appropriate interventions such as referral to pulmonary rehabilitation and self-management.

A re-audit was performed 12 months after the LES was implemented; it found there was a good level of participation among practices. There had been a statistically significant increase in the recorded prevalence of COPD, with 1423 case finding spirometries performed in the target population, resulting in 453 new diagnoses of COPD - equivalent to one diagnosis for every three spirometries performed. There had also been an increase of 54% in the referrals to pulmonary rehabilitation

The action plan set a target of 80% of COPD patients being given a self-management booklet. This target was only achieved by 6 practices and a recommendation was made to reduce the target to 70% as this was felt to be more realistic.

Following the audit, an action plan was developed to take forward the findings and an annual cycle of re-audit and quarterly monitoring of LES performance agreed.

My personal contribution to this work
As a consultant in public health I was responsible for developing the data profile; identifying areas for improvement; coordinating and developing a LES as a tool to address the gaps identified and evaluating the impact of the LES.

HEALTH SERVICES AUDIT (2)

Audit title:
Outcome focussed commissioning

What we decided to audit and why we thought this was important
The public health contribution to our commissioning team is to provide a clear focus on clinical outcomes. In the national services, it is possible to obtain outcome data on almost all patients treated (a 100% consecutive case series) in almost services. Patient experience and serious untoward incidents are monitored through separate systems.

We believed that we discuss outcomes in all commissioning review meetings with providers, but wanted to check whether in fact we did.

What we found and how we thought we could do better
We looked at the minutes of all review meetings with providers for a 6 month period ended December 2010. 'Diagnosis only' services were excluded since aim of the commissioned service is to establish a definitive diagnosis, not to provide treatment. The minutes were reviewed and coded independently by a specialist registrar.

In 15 out of 23 (65%) meetings, there was evidence in the minutes that outcomes were discussed. For five meetings no minutes could be found on the team filing system.

This was discussed at our team meeting.

Our improvement plan and results of re-audit
The improvement plan was to ensure that clinical outcomes are a standing item on all agendas with provider units. Re-audit for the six months ended Dec 2011 showed that discussion of outcomes was recorded in the minutes for 18 out of 25 eligible meetings (72%).

My personal contribution to this work
I attend all review meetings for the services in my portfolio and am responsible for ensuring an agenda item on outcomes.

HEALTH SERVICES & HEALTH IMPROVEMENT AUDIT

Audit title:
National Health Promotion in Hospitals Audit

What we decided to audit and why we thought this was important
The public health contribution from NHS providers has been an underutilised opportunity for contributing to health improvement. Following a simple audit of hospital records in Stockport for lifestyle screening and the offer of health promotion to in-patients who smoke, consume excess alcohol or are overweight we rolled out the audit model to Greater Manchester in 2007 and then Nationally in 2009 with the support of the Department of Health.

What we found and how we thought we could do better
In 2009, 53 Acute and Mental Health Trusts participated and we found the following:

- 81% of patients were assessed for smoking; 25% were found to be smokers and on average 20% of smokers received health promotion – but only 1 trust met our standard that 100% of patients were assessed for smoking, although 21 trusts met the standard that 35% of smokers received health promotion.
- 69% of patients overall were assessed for alcohol use and on average only 11% of those assessed for alcohol were found to be hazardous/harmful/dependent drinkers. This level of hazardous drinking was lower than 20% expected although 21 trusts did report this level. On average 45% of patients misusing received health promotion.
- 40% of patients were assessed for obesity and 21% of those assessed were identified as obese, a level of obesity similar to the general population. Overall 45% of obese patients were delivered health promotion.
- The audit demonstrated huge variation between trusts in terms of identifying and tackling these lifestyle issues and we felt that Trusts could be encouraged to take up the approach through publicity of results and re-audit. The impetus for this has been reinforced by the recent pronouncement by the Future Forum to make every health contact count to which we and another Trust contributed.

Our improvement plan and results of re-audit
The improvement plan was to ensure that we obtained funding to repeat the audit in 2011 and feedback results at a national conference in 2012. We have repeated the national audit in 2011 having obtained listing of this audit on Quality Accounts along with all other National Audits.

My personal contribution to this work
I created the idea for this project and supported members of my team in winning a DH grant and in setting up the original audit. I was responsible for organising feedback at the International Health Promoting Hospital Conference held in Manchester in 2010 (which I was also responsible for co-ordinating and hosting) and for securing continuing funding for the next audit round which has been completed and will be presented on March 19 2012.

Note – to satisfy FPH guidance this example would need to include the results of re-audit, for example (these data are fictional):

"At re-audit we found:

- 87% of patients were assessed for smoking; 23% were found to be smokers and on average 21% of smokers received health promotion – but 12 trusts met our standard that 100% of patients were assessed for smoking, although 35 trusts met the standard that 35% of smokers received health promotion.

- 72% of patients overall were assessed for alcohol use and on average only 9% of those assessed for alcohol were found to be hazardous/harmful/dependent drinkers. On average 48% of patients misusing received health promotion.
- 48% of patients were assessed for obesity and 22% of those assessed were identified as obese, a level of obesity similar to the general population. Overall 45% of obese patients were delivered health promotion."

HEALTH IMPROVEMENT AUDIT

Audit title
Ethnic variation in programme uptake

What we decided to audit and why we thought this was important
We decided to audit uptake of our obesity programmes by ethnicity. This is important because obesity is a particular issue for people of South Asian origin, and there is evidence that people from minority communities may feel uncomfortable in standard weight loss programmes.

Participants are referred for weight loss schemes by their GP, or make direct contact with the PCT. The PCT offers free places on three different commercial weight loss programmes. The contracts with these organisations require the collection of monitoring information, including self-reported ethnicity, for all participants.

What we found and how we thought we could do better
Monitoring data for the six months ended March 2010 showed that 15% of participants in our programmes self-identified as being of South Asian ethnicity. Locally 25% of the population is of South Asian origin (2001 census data).

We discussed this data at our team meeting.

The results indicate ethnic barriers to access. We tackled this by appointing a link worker in August 2010 whose remit was to work on the development of recipes suitable for ethnic minorities. The link worker developed suitable recipes in collaboration with the three providers of weight loss programmes and also promoted the programmes among local community leaders.

Our improvement plan and results of re-audit
At re-audit the proportion of attenders of South Asian origin had increased to 21%. This increase is statistically significant but still leaves us with room for further improvement.

My personal contribution to this work
As a consultant in public health I was responsible for setting up the audit, and devising and implementing the action plan. I worked closely with the link worker to develop suitable recipes and to work with the local community.

HEALTH PROTECTION AUDIT (1)

Audit Title:
Documentation and follow-up of VTEC

What we decided to audit and why we thought this was important
Following the Griffin Enquiry into an outbreak of VTEC associated with a petting farm in Godstone, the Health Protection Agency developed standards for the public health management of cases of VTEC. At around this time a new case management system (HPZone) was introduced into Health Protection Units. VTEC can cause serious illness and we wanted to audit whether the HPU met the standards and whether public health actions were adequately documented.

What we found and how we thought we could do better
Audit of a random sample of 25 cases reported between 1/4/2010 and 31/3/2011 found that 22 cases had complete questionnaires on HPZone. For 2 of the remaining 2, there was documentation to show questionnaires had been forwarded to HPA Centre for Infections. In only 10 cases was there sufficient information to show whether questionnaires had been returned by Environmental Health Officers within 24 hours. Of the 9 cases in risk groups, only 1 had documented evidence of date of microbiological clearance.

We discussed this data at our team meeting.

The results indicated that although cases are vigorously followed-up, documentation on HPZone was poor. This may partly be because this was a new system which staff were unfamiliar with.

Our improvement plan and results of re-audit
The improvement plan addressed consistency of data on HPZone through training and a new protocol was agreed with Local Authorities to improve documentation of microbiological clearance in risk groups. At re-audit 100% cases had questionnaires on HPZone and information on timeliness of their return. Of 12 cases in risk groups, information on microbiological clearance was documented for 7. Work is to be undertaken with Local Authorities to improve this still further.

My personal contribution to this work
As lead for gastrointestinal infections for the HPU I contributed to the audit proforma and methodology, and I developed and led the implementation of the improvement plan.

HEALTH PROTECTION AUDIT (2)

Audit title:
Monitoring outcomes in tuberculosis

What we decided to audit and why we thought this was important
The Annual Report from Enhanced Surveillance for Tuberculosis showed that the rate of completion for tuberculosis treatment was only 40% for x District for all cases notified in 2007. This was way below the recommended standards recommended by WHO and in the CMO's TB action plan. Hence we decided to audit the outcome of Tuberculosis for all the cases notified in 2007, in order to find the possible causes and take measures to improve the completion rates.

What we found and how we thought we could do better
The first requirement for monitoring outcome is the timely submission of outcome reporting forms by TB nurse. We reviewed all the TB notification forms jointly with the TB nurse, using the paper reports, and the electronic database reports obtained from the National Enhanced Surveillance for Tuberculosis (ETS).

Outcome reports were submitted for 16 out of 30 notified cases. Of these, 12 had completed treatment, one had died due to other causes, one had moved out of area, and two were still on treatment due to interruptions caused by side effects of drugs. There was no record of outcome forms for the other 14 cases, when the report was compiled at the Regional Office using the ETS database, at 24 months after the initiation of treatment. The results of our audit showed that twelve of these cases had completed treatment in time, and two were still on treatment at that time. It also became apparent that the TB nurse was not supported adequately by the treating clinicians to submit outcome forms to the HPU in a timely manner.

We discussed this data at our team meeting.

The HPU systems for monitoring receipt of these forms required minor improvements.

Our improvement plan and results of re-audit
We set up systems within the HPU to monitor submission of outcome reports, and worked to improve engagement from treating clinicians in outcome surveillance, as a part of the Hospital Trust's Clinical Governance Programme. In a re audit of cases notified in the following calendar year, 26 of the 28 cases had timely submission of outcome reports with 24 cases completing treatment.

None of the patients were lost to follow up, and information on the patients who had moved out was given in a timely manner to the receiving HPUs.

My personal contribution to this work
As a specialist with the communicable disease unit my role was to work with the local TB nurse to provide expert input to their practices, emphasise the public health importance of monitoring outcomes, and to build up on existing relationships by celebrating good practice.As a CCDC and team leader, this audit enabled me to train a newly appointed practitioner and to integrate quality improvement into our routine practice.

HEALTH INTELLIGENCE AUDIT

Audit title:
'Death certificate only' (DCO) registration

What we decided to audit and why we thought this was important
We participate in the UK association of cancer registries (UKACR) system for quality and performance indicators. The national target for DCO is 2%. If a cancer is not recorded till the patient has died, it implies a missed opportunity to register the cancer at presentation. Hence the information is variably out of date; and our ability to obtain supplementary information is hampered.

What we found and how we thought we could do better
Our Cancer Registry and Information Centre already meets the national target for 2% DCO but we thought we could do even better. We process electronic death cards within the week they are received from ONS and where further information is necessary the GP is contacted immediately to ask for additional information.

Our improvement plan and results of re-audit
The %age of DCO has fallen from 1.8% in 2009/10 to 1.3% in 2010/11.

My personal contribution to this work
This is a large and ongoing national audit. I am a specialist in public health and a member of the Observatory management team. So I contribute to systems and processes for improving registration.

ACADEMIC PUBLIC HEALTHAUDIT (1)

Audit title:
Learner ratings of course content and delivery

What we decided to audit and why we thought this was important
As an academic department we run a variety of short and long courses. We decided to focus on our MSc course which is the most significant course for our department in resources required and potential for income.

After each course we run, learners are invited to complete a questionnaire on course content and delivery.

What we found and how we thought we could do better
For the cohort of MSc students in the year 2009/10 evaluation questionnaires were completed by 31 of the 32 students on the course. Each session is scored from 1 (low) to 5 (high).

We found that sessions on social sciences scored lower (mean score 3.8) than sessions on epidemiology and the quantitative sciences (mean score 4.6). Free text comments suggested that the main problem was lack of perceived relevance to public health practice in the UK.

We discussed this data at our team meeting.

Our improvement plan and results of re-audit
We changed the content of the social science sessions to include a more structured approach with better teaching materials, particularly examples relevant to public health practice. We also introduced guest sessions from the local PCT public health department.

For the 2010/11 cohort, mean scores for social science sessions improved slightly (from 3.8 to 4.0 P = 0.6) but remain lower than for quantitative sessions (mean score 4.5). Questionnaires were completed by 26 of the 28 students on the course.

My personal contribution to this work
I establish and teach this course.

ACADEMIC PUBLIC HEALTH AUDIT (2)

Audit title:
Success rates with major research funding bodies

What we decided to audit and why we thought this was important
Gaining research funding from competitive national and international is central to the success of departments of public health in research intensive universities. The proportion of grant applications that are funded should be maintained as high as possible partly because a low success rate represents wasted effort (both academic and administrative), partly because several funders publish league tables of grant funding success rates by institution and partly because continued failure diminishes a key performance measure (i.e. total grant income secured).

We therefore decided to audit our success rates with three major funders – MRC, NIHR and major charities

What we found and how we thought we could do better
We examined data over the preceding three calendar years and found that 9/61 (15%) submitted grant applications had been funded (not always to the extent initially requested). This compared unfavourably with competitor institutions whose success rate seemed more typically to be 25-30%. We felt that this proportion could be improved with consequent improvements in motivation (repeated grant failure is wasteful of time and also dispiriting)

Our improvement plan and results of re-audit
We decided to set up a review committee to which all grant applications to the relevant funders would have to be submitted. The review committee received the written application and then met with the PI to discuss particular points and queries and to make suggestions verbally. The committee did not have the power of veto over submission but grants were not submitted by the Research Office unless a proposal had at least been considered. The committee was composed of senior academics who had experience of sitting on grant funding committees. The committee met monthly but could conduct business electronically if necessary in order that funding opportunities were not missed.

The re-audit covered an 18 month period after establishment of the review committee. We found that only 3 proposals had been submitted without consideration by the committee.
The number of applications had increased sharply (given the shorter period of time surveyed) as a result of the appointment of new staff. The proportion funded had increased to 22/71 (31%) ($p = 0.04$)

Although there are potential confounding factors, it was concluded that the review committee had been valuable and should be continued. The idea has subsequently been adopted by other departments.

My personal contribution to this work
I act as research director for the Department and convene and Chair the Review Committee

ACADEMIC PUBLIC HEALTH AUDIT (3)

Case study:
Review of belimumab – single technology appraisal (STA) for NICE

What we decided to study as a case and why we thought this was important
We wanted to assess how comprehensive we had been in our review of the literature and the manufacturer's submission for this important new technology for systemic lupus erythematous (SLE). It was one of the first appraisals we had undertaken for NICE as a team at Warwick Evidence.

What we found and how we thought we could do better
We examined the manufacturer's submission and realised that it was excessively long and complicated. There were over 20 appendices and over 600 pages of information and data. One of the criticisms of our submission by NICE was that we had not been 'fair' in identifying strengths in the manufacturer's submission. The NICE group gave us three stars overall out of four and we partly wanted to know why we had not scored four!

Our improvement plan
We reviewed our own analysis and prepared a presentation to discuss belimumab at one of our team meetings. We agreed that we had worked well together as a team on belimumab and that we considered that the criticism by NICE was probably unjustified. We ensured that our response to the manufacturer included all the relevant methodological detail and also that everyone in the team understood the methodological issues. We prepared a paper for publication on the basis of our work on this submission and have submitted it to the BMJ.

We agreed that we need to be vigilant with our assessments by NICE and that we need to ensure that for each of our STA s we have a feedback and debriefing session where we consider the issues raised. Although on this occasion we rejected the criticism from NICE, it was concluded that our review process had been valuable and should be continued. We will include a report of the meeting in the quality assurance (QA) section of our annual report to the HTA programme and to our advisory group.

My personal contribution to this work
I am director of Warwick Evidence and convene our team meetings. I have to sign off our QA and other reports and ensure reporting to our advisory group.

PUBLIC HEALTH CONSULTANCY AUDIT

Audit title:
Excellent consulting

What we decided to audit and why we thought this was important
I run an independent consultancy offering public health services to local NHS organisations, including PCTs, health Boards, acute and community Trusts.

We decided to examine our practice against the standards suggested by Peter Block in his book 'Flawless Consulting'.

1. Define the initial problem
2. Decide whether to proceed with the project
3. Select the dimensions to be studied
4. Decide who will be involved in the project
5. Select the method
6. Do discovery

7-9. Funnelling the data and making sense of it
10. Provide the results
11. Make recommendations
12. Decide on actions

We decided to audit our most recent project, which concerned the development of a care pathway in a local health economy for patients with heart failure. We asked the client to rate each phase of the project using a score of 'excellent' 'good' 'fair' 'poor'.

What we found and how we thought we could do better
We found that we scored well on the early phases less so on the later phases. Phases 1-5 were rated as 'excellent' or 'good' and phases 7 – 9 were rated 'good', but Phases 10 – 12 were only rated 'fair'.

Our improvement plan and results of re-audit
We focussed on the design element labelled by Block as 'design more participation than presentation'. We agreed to create our feedback meeting as a learning event rather than a passive presentation. We sought advice from an adult educationalist on how to achieve this.

My personal contribution to this work
I am the chief executive of the consultancy and responsible for our systems and processes.

CASE REVIEW

Case review title:
Improving uptake of healthy start vitamin

Description
I chaired a meeting to review our approach to the local implementation of the Healthy Start vitamin programme. A recent CMO communication had emphasised the importance of increasing uptake of the Healthy Start vitamins to both mothers and children to tackle vitamin D deficiency in these potentially at risk groups. Locally there were concerns about the impact of vitamin D deficiency and the increasing publicity of this had resulted in increased prescribing of vitamin D and this had been identified as a cost pressure. There also appeared to be a lack of consistent messages among frontline staff about vitamin D and the Healthy Start vitamin programme in general. A number of health professionals were keen to implement universal free Healthy Start vitamins across the borough.

What went well
The meeting was well attended, with representatives from general practice, paediatrics, health visitors, midwives, medicine management and children's centres. All individuals could see the value of working together and were enthusiastic about finding solutions to the logistical issues which were impacting on the delivery of the programme locally.

As part of the meeting public health gave a presentation that provided an overview of the programme. This was useful and a number of people commented on how this had improved their understanding of the programme and that prior the meeting, although they knew the vitamins provided those eligible with recommended doses of vitamin D, they had limited knowledge of the processes and eligibility for the programme.

Prior to the meeting several individuals had expressed frustration about the PCTs performance in terms of the proportion of eligible children receiving the Healthy Start vitamins. The meeting provided an opportunity to discuss the constraints of the programme and particularly how the national process for distribution and purchase of the vitamins impacted on what we could do locally. The improved understanding of those attending enabled a more feasible discussion with increased understanding of what was achievable locally.

The discussion enabled several actions to be agreed. This included a review of the current pathways to identify barriers and options for future provision. It was also agreed that the group would identify 10 key and consistent messages which would be used to promote Healthy Start vitamins by all partners across the borough.

What could have gone better
Division of tasks – as Chair I was keen to make sure tangible actions were identified from the meeting. Although I delegated some of the work to others, the main pieces of work that came out of the meeting fell primarily to public health to undertake. It would have perhaps have been better to have split the tasks so that the different departments attending the meeting each contributed to the work plan of the group.

Only one of the providers of maternity services was involved in the meeting. However women locally receive maternity care at a number of Trusts. Providers of maternity care play an important role in ensuring women know about Healthy Start Vitamins and where they can get these. In future it will be important to ensure the other acute trusts are involved in this work

Making sure all those who attended the meeting were involved in the discussion was challenging as there were some people attending who were quite dominant and who also already had quite strong feelings about how we should be taking the work forward.

Implications for PDP/Practice?

Technical

Keeping up to date with evidence – it is important to keep up to date both with the evidence base around vitamin d deficiency and approaches to managing this aswell as the national policy around Healthy Start Vitamins, where updated guidance is due out imminently

Skill

Developing effective negotiation skills and being more assertive when tasks need to be delegated – when chairing a working group I need to ensure all members are involved in the actual 'work' falling out of the group, delegating work amongst all members rather than just a few

Influencing skills

The cost implications of universal coverage need to be considered and a business case developed to support any propose changes to implementation of the programme. Although several attending the meeting were very keen on free universal provision it was important to ensure the impact of a number of options available were considered and costed before decisions were made. Strong influencing skills are important in such situations and I feel this is an area I could strengthen.

CASE REVIEW

Case review title
Review ofa specific drug commissioning policy.

Description
I chaired a meeting to review our policy on an expensive drug in the light of a recent publication. Our commissioning policy is to fund the drug for all patients who meet agreed clinical eligibility criteria. There has been a global shortage of the drug because of production difficulties in the main manufacturing plant. This created a natural experiment with some patients receiving no drug for an extended period. A group of clinicians from the Netherlands wrote up their national experience. It showed no difference in the event rate for clinically significant acute events before and after the shortage, but steady worsening of a biomarker during the period of shortage.

What went well
The meeting was well attended by clinicians and the relevant patient groups. The discussion was measured and focussed on the evidence presented in the paper, which all present seemed to have read and thought about. Dissenting views were express and debated.

The consensus view was that there was a small number problem in the Dutch experience for this very rare disease and that a review of the much larger UK experience would be worthwhile. The accumulation of the biomarker was regarded as important evidence of on-going disease process in the absence of drug therapy.

What could have gone better
Discussion of the paper did not result in any specific decisions beyond the need for further research.

Implications for PDP/Practice?
Technical
Keep up to date with the literature on this drug.

Skills
Continue to practice influencing skills. Explore the potential of the newly formed Faculty of Medical Leadership and Management.

CASE REVIEW

Description
I took a call from the TB Specialist Nurse about the possible exposure of a number of babies in Special care Baby unit to mother with “confirmed TB”, diagnosed by a locum consultant physician. The hospital was organising an incident meeting for the following morning, but requested my advice on immediate public health action.

What went well?
Based on the clinical information and risk assessment, my advice was that it was essential to confirm the diagnosis before embarking on public health action. I reviewed the NICE guidance on the public health management of TB, particularly in very young babies. I also discussed the topic with my consultant colleagues, and took their advice.

The incident meeting was well attended by Hospital clinicians, including the infection control nurses. The senior consultant’s opinion was that there was no evidence of tuberculosis. Public health advice was received well, and it was agreed that we should wait for the results of microbiological investigation. These proved negative so no further public health action was required.

What could have gone better?
The TB nurse was initially reluctant to accept my advice and wanted to arrange for immediate action before a diagnosis was confirmed.

Notification from clinician was delayed by several days.

Implications for PDP?
Technical
Keep up to date with the literature on transmission of TB in healthcare settings and public health action following exposure.

Skills
Improve influencing skills to ensure timely notification of TB and that there is early reporting of incidents where there may be transmission outside a household setting.

CASE REVIEW

Description
An irate patient (also a GP) called the office to find out who has advised her GP to give her rifampicin. The context was that this GP was a contact of a case of meningococcal disease and had been given rifampicin for prophylaxis. This had caused significant nausea, had dyed her soft contact lenses orange and she had discovered that the alternative, ciprofloxacin, would not have interfered with her oral contraception. I looked at the web based entry for this patient, and told her that my consultant colleague had advised a single dose of ciprofloxacin, and I was not able to figure out where the confusion arose, so he could call the consultant when she was next in. I also emphasised that we leave the choice with patients and their treating clinicians as to whether they should have ciprofloxacin or rifampicin since both are licensed for this purpose.

What went well?
I was able to elicit that the correct procedure had been followed in the office, in terms of advice on antibiotics, and able to share all the information transparently with the patient.

The GP called the consultant, and was satisfied with the clarification.

We discussed this issue at the clinical meeting, and emphasised that it is important to provide information for prescribers.

What could have gone better?
The information faxed to the clinician had advice on rifampicin and ciprofloxacin. Owing to a problem with his fax machine he only received information about rifampicin.
The entry in the web based system was wrongly attributed to the consultant as the nurse entering had not entered their name/initials.

Implications for PDP?
Technical
Be aware that ciprofloxacin is the preferred drug in all ages and that it has a lower side-effect profile that rifampicin. Ensure that clinicians are clear about which antibiotic to use and that they receive relevant information.

Procedural
Need to be aware of this problem with the web based system, and look for the history of different entries.

Skills
Ensure Standard Operating Procedures address this issue.

CASE REVIEW

Case review title:
Review of a Doctor Foster Alert

Description
I routinely check Dr Foster mortality alerts for the Trust. Towards the end of last year (2011) I noticed a new alert related to in-hospital deaths from convulsions and epilepsy. I further drilled down to identify an excess of 15 deaths related to status epilepticus over a 10 year period. I also received a request from a 4th year medical student to undertake a 3 week study project as a public health attachment with me. I asked her to help me undertake a review of these cases as her study to introduce her to use of routine data, audit, case review against guidelines and quality and safety issues.

What went well
The audit went well with the medical student reviewing 15 cases within the time frame and producing her report for our and her purposes. We obtained the latest guidelines from Greater Manchester Neurologists from which we identified specific criteria and standards against which we audited. We involved the associate Medical Director an Intensive Care specialist and our visiting consultant neurologist. Although we could not criticise immediate care and management of the status epilepticus we did identify some weakness in assessment for ICU, as well post ictal care and therapeutic management. None of the deaths were deemed avoidable as all were among elderly with significant comorbidities. The findings have been discussed at a clinical effectiveness committee and revised guidelines adapted for the Trust. Issues around order of discharge diagnostic coding were recognised.

What could have gone better
With hindsight the audit should have included some survivors to determine whether or not the poor post ictal management was more widespread. A trust presentation to a wider clinical audience has yet to take place.

Implications for PDP/Practice?
Technical
Keep up to date with clinical guidelines and repeat audit of the management of types of epilepsy.

Skills
Continue to practice influencing skills. Explore the potential for developing more formal teaching of use of clinical information to medical students.