2019/20 QOF: Quality Improvement Case Studies

April 2019

Contents

Purpose of this document

The 2019/20 changes to the Quality and Outcomes Framework included the introduction of a quality improvement (QI) domain. This booklet contains three case studies developed by the Royal College of General Practitioners, National Institute for Health and Care Excellence and the Health Foundation which provide examples of how practices could approach their quality improvement activity.

Case Study 1: Prescribing Safety

Practice details: 5200 patients, urban practice.

Members of the practice team have undertaken small QI projects in the past, mainly based on significant event analysis and registrar-led clinical audits. A project team was formed consisting of a GP, a GP registrar, the practice pharmacist (project lead), and a medical secretary.

The team decided to focus on NSAID prescribing as its first priority. They used the RCGP QI wheel for general practice available in *RCGP How to get started in QI* guide for advice.

Culture and context – the project team asked the next whole practice team meeting attendees to jointly do a quick *SWOT analysis (strengths, weakness, opportunities and threats)* on prescribing safety in the practice. The clinical staff members present identified they had weak systems for checking safe prescribing, alerts were often ignored, and many patents were overdue a medication review. Some of the team felt there is a fear of being blamed if something goes wrong and they think it's only the GPs' job to ensure prescribing is safe. The practice team expressed a wish to move the culture to one of no-blame and learning from patient safety incidents. It was agreed to dedicate the next Protected Learning Time (PLT) to prescribing safety. In preparation for this, every staff member would be asked to complete a *short anonymous survey* giving them the opportunity to describe one potential patient safety incident they had been aware of in the last 12 months. This started to allow the practice to review its systems and processes for protecting services. The clinical pharmacist agreed to review the *PISA Patient Safety Incident Reporting Form Template* to adopt into the practice and to refresh the practice's significant event audit (SEA) template as the way of recording the QI activity. This would then be tested with the team at the next PLT event.

Project 1. Safer NSAIDS project

Diagnose – the GP registrar supported by the GP created clinical record searches to identify patients at risk of harm due to NSAIDS prescribing focussing on those with a past history of peptic ulcer disease.

Plan and test – the project team then used this data to inform their next actions and set a clear plan:

a) **Aim** – Within one month of the project, no patients on the registered list with a past history of peptic ulcer disease would be prescribed an NSAID without co-prescribing a proton-pump inhibitor.

b) **Measure** – A list of patients identified as at risk will be reviewed every week by the practice pharmacist to ensure that by the end of the four weeks, all patients have been reviewed. A three-monthly prescribing search would be carried out to demonstrate maintenance of this target.

c) **The change** – the practice pharmacist attended **the 1st peer review with fellow project leads from the local Primary Care Network** and discussed the findings of the diagnosis step and shared ideas with local practices about suggested actions to test.

   I. A receptionist was tasked with contacting the identified patients and booking an urgent medication review with the practice pharmacist, an advanced nurse practitioner or a GP.

   II. The practice's clinical coder undertook a search of all patients with a past code for peptic ulcer disease to ensure the code was amended to be clearly visible to all prescribers in future and was easily searchable.

   III. The practice manager ensured that all prescribing electronic alerts were switched on in the clinical system and all prescribers reminded of the importance of checking these alerts.

Implement and embed. All staff underwent a short training exercise with the project lead at the next PLT event so everyone was aware of what the practice was trying to achieve. The practice recalled all patients identified as at risk within four weeks and took appropriate clinical action for each patient to reduce the risk. Some patients were able to stop the NSAID altogether and some had a proton pump inhibitor added.

Sustain and spread. By reviewing the search at the end of the first month, the project team were encouraged that the QI activity had initially achieved the aim. They shared this with the whole practice team with a "What we've all achieved" poster on the staff noticeboard.

The practice manager set up a three-monthly search to ensure no new at risk patients emerged, and the clinical pharmacist reviewed this every three months.

It was agreed that any new patients identified after this intervention should be reported through the new PISA Patient Incident Form and be subject to a practice-based Significant Event Analysis to help identify ongoing issues that may need to be addressed through new improvement cycles.

The GP registrar presented the summary of the QI activity at the **2nd Primary Care Network peer review meeting** and was able to use the work as evidence in her training portfolio.

What the practice did next?

It was agreed to extend the search criteria for all patients over 65 years old prescribed any NSAID medication without co-prescription of a PPI in the last 12 months and all patients taking repeat prescriptions for NSAIDS. To undertake a virtual or telephone clinical review (led by the clinical pharmacist) of all patients over the next 6 months. The improvement cycle begins again.

Project 2. The valproate pregnancy prevention project

Diagnose – the practice pharmacist ran a search for any prescriptions for valproate issued within the last 3 months in girls and women of childbearing potential.

Plan and test – the team, made up of the pharmacist, lead practice nurse, and a medical secretary, were reassured that no patients were identified. However they wanted to ensure a practice-based system was developed to ensure compliance with the MHRA pregnancy prevention guidelines.

a) **Aim** – To ensure that valproate is not prescribed to girls of any age or woman of childbearing potential without a pregnancy prevention plan in place.

b) **Measure** – Repeated monthly prescribing searches of registered patients show no at-risk patients.

c) **The change** - the practice pharmacist attended **the 1st peer review** and discussed the findings of the diagnosis step and shared ideas about suggested actions to test.

   i. All prescribing staff to be reminded of the Valproate Pregnancy Prevention packs sent to all practices by MHRA, which include professional and patient information, at the next clinical team meeting. The practice administrator ensured packs are available in all consulting rooms, including in locum information and registrar induction packs.

   ii. Pharmacist set up monthly search and is tasked with checking the results and reporting back to the lead practice nurse (with a regular slot marked on her daily calendar as a reminder).

Implement and embed. The two changes were implemented. The pharmacist ran a search (created by NHS Digital) and the lead practice nurse used her dedicated QI slot to check the results each month. Any identified patients would have been called in by the medical secretary to discuss their medication but so far, no patients were identified.

Sustain and spread. The medical secretary realised that hard copies of the MHRA guidance could run out, so she kept an electronic file of the Valproate Pregnancy Prevention packs available. It was agreed that the practice nurse would continue to run the monthly search. The project lead also attended the **2nd peer review meeting** with colleagues from the local primary care network and shared the team's work.

What the practice did next?

The practice manager and lead GP were confident that the practice now had a safe system in place to identify new patients who may be affected by valproate prescribing and risk of pregnancy. They agreed to add this to the lead nurse's mid-year and annual appraisal as an objective to ensure the system remained in place.

Project 3. The lithium safer monitoring project

Diagnose – a project team was set up and led by a senior healthcare support worker, supported by a GP and the reception team leader. An initial search (set up by the practice pharmacist who taught the healthcare support worker how to run it) was undertaken which identified five patients currently being issued lithium prescriptions.

Plan and test – the team were joined at the planning meeting by a patient volunteer who was being prescribed lithium. The patient helped the team to map how prescriptions were ordered and issued and how monitoring was undertaken. This group set the project's aim, measures and changes which were also discussed with colleagues at the **1st primary care network peer review meeting**.

a) **Aim** – All patients prescribed lithium have appropriate lithium blood test monitoring on initiation and at recommended intervals as part of the holistic care they are offered for their mental health condition.

b) **Measure** – A three-monthly search of all patients prescribed lithium would be carried out, identifying those with and without recorded blood concentration results within the last 3 months.

c) **The change**:
   i. Two electronic searches to be set up. One monthly search would be carried out to look at all patients with lithium on their repeat prescription with and without issues in the last 3 months (to identify early any underuse which could suggest low compliance with treatment leading to clinical deterioration). One three-monthly search would monitor all those prescribed lithium having regular blood monitoring performed.
   ii. All patients showing possible medication underuse, failure to attend for monitoring, or blood monitoring levels outside acceptable range would have a robust follow up plan to be used by the practice staff and co-designed by the practice, and a focus group of patients who are (or have been) prescribed lithium.

Implement and embed. The searches were set up and the results monitored by a healthcare support worker who had a supervising GP to whom he could take concerns about specific patients.

The healthcare support worker and the reception team leader invited a group of patients who were or who had been prescribed lithium to join a one-off focus group to discuss their perspectives and suggestions for the proposed management plans. It was agreed that a new follow up protocol and management plan would be tested for six months, and then measured to see if concordance with monitoring improved. A further measure was added, at a patient's suggestion, of whether any patients had become unwell from not taking lithium appropriately during those six months. A significant event analysis or root cause analysis could then be used to understand the factors that led to this event. This information could be used as part of the diagnosis step, in identifying new areas of the practice's work that could be improved in a new cycle of improvement.

Sustain and spread. The project was written up as a small poster presentation and shared with the patient focus group and at the **2nd local primary care network peer review meeting**/ learning event to share the learning and approach.

What the practice did next?

The patient champion and the project lead also presented the poster at a local voluntary sector conference which led to ideas about more patient involvement (and several new patient volunteers) to support other QI projects the practice could undertake. One of these ideas, related to supporting young carers of people with mental health problems, was chosen to be a QI project for next year.

What evidence did the practice provide for QOF payments?

The contractor completed the annual QOF QI domain self-declaration. They kept a copy of their QI monitoring template and clinical audits for future payment verification if needed, as well as evidence for future CQC inspections.

Case Study 2: End of Life Care

Practice details: 8000 patients, urban practice.
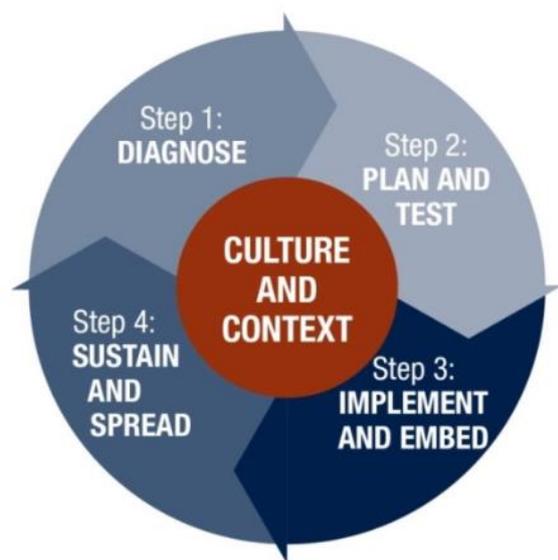
The team decided to focus on identifying people for the end of life care register and subsequent care planning as its first priority. They used the RCGP QI wheel for general practice (available in RCGP *How to get started in QI* guide for advice.

Culture and Context: 3 members of the team (one GP, a Healthcare Assistant, and a senior medical secretary) volunteered to do some basic online QI training so they could lead the first project and share their learning. The GP and senior medical secretary agreed to be the clinical and non-clinical leads.

Diagnose: the first part of the continuous improvement cycle. Next EoLC MDT spent 30 minutes doing a *SWOT analysis* (Strengths, Weaknesses, Opportunities and Threats) of the practice's approach to identifying people with EOL care and support needs. They identified that the practice's EoLC 'supportive care register' had too few people on it for the practice's population compared with how many of their patients had died in the last year. They next undertook a *Retrospective Deaths Audit*, looking at a sample of the last 20 of the 80 deaths that occurred in the last 12 months. This confirmed a baseline of 20% of people affected by advanced serious illness and end of life care had been identified on the practice supportive care register, and only 20% of those identified had a care plan with preferences for their goals of care including treatment escalation, preferred place of care and death. 50% of those identified had their family member(s) or care-giver identified. 20% of these family member(s) or care-giver identified had been contacted and sign-posted with information following the death of the person on the supportive care register.

Plan and test: the team agreed actions to try to increase the **proportion of people who died, affected by serious illness and end of life care, who had been identified** in a timely manner on a practice 'supportive care register', in order to enable improved care, reliably and early enough for all those who may benefit from support. numbers of patients identified.

This meant they had to agree a SMART outcome aim (what the project wants to achieve and by when), a measure (how they will know if anything is changing), and the change itself (what will people do differently).

a. *Aim* – the practice team decided to aim to increase from 20% to 50% of people who die, **affected by serious illness and end of life care, to be identified** on a practice 'supportive care register', over

the next 12 months. The aim is to increase identification of people having end of life care needs to allow for better planning and coordinated care.

b. *Measure* – the practice manager set up a search each month to show what percentage of the total number of people who died were on the EOLC supportive care register. This number was then plotted on a simple graph each month, which was reviewed monthly by the MDT.

c. *The Change* –**1st practice meeting** (aligns with advice in Appendix 1) held to review the project so far. Practice team agreed it seemed appropriate and feasible to increase identification of people with advanced serious illness and end of life care needs. It was agreed to undertake some patient and family members/ care-giver interviews, and practice staff and MDT surveys to gain ideas and learn from their experience of care delivered by the practice.

The clinical lead also took their QI plan for this **specific measure** to the GP network peer meetings. Local practices all agreed that achieving 50% of people who died were identified on the supportive care register for this practice seemed appropriate given its population (i.e. with 3-4 deaths per month, 1-2 would have been identified on the EOLC supportive care register). However, they recommended trying to focus on learning gained getting from 20 to 50% in the first 6 months as 12 months may miss opportunities to improve the practice model for improving identification. One local practice had already met its target for the EoLC supportive care register and shared their ideas about how they had achieved it, which the project leads agreed would work for them. These included:

i. All staff including clinical and non-clinical to undertake a short training session on everyone's role in identifying people with end of life needs (e.g. admin staff coding letters, reception staff talking with carers, clinical staff seeing patients routinely e.g. on home visits or care homes to consider if appropriate).

ii. Using both clinical judgement and a recognised risk stratification tool (e.g. SPICT or the Gold Standards Framework Patient Identification Guidance) all staff in the practice to proactively find cases which the MDT could formally assess and agree as people who should be on the end of life care register. They also decided to review the Frailty register, patients resident in care homes and patients on the dementia register as potential people to screen with the question "would I be surprised if they died in the next 12 months?".

Implement and embed: All staff underwent the short training exercise with the project lead at the next Protected Learning Time event and staff actively searched for appropriate patients. Within 3 months had identified a further 30 patients for the EoLC supportive care register. The project leads then started to plan how personalised care planning could be carried out for these new patients over the next few months, which became the next cycle of improvement.

Sustain and spread: The project team shared the success of the first improvement cycle with the whole practice team with a "Thank You" poster on the staff noticeboard. The HCA who had taken the main leadership role on the project attended **2nd peer review meeting** to share the QI work undertaken by the practice.

What the practice did next? The practice agreed to continue to monitor the monthly Supportive Care Register numbers on a run chart to ensure that the success of the first few months didn't drop

off. They had already diagnosed the next issue for them was improving the personalised care planning process for patients and carers, so the continuous improvement cycle moved on to this focus.

They decided to create a new aim of improving the personalised care planning of people on the register including the offer of a carer's assessment so that 75% of patients on the newly improved register would have a completed plan by the end of the year; the measure was the number of people on the register having a completed a personalised care plan and carers' assessment. The team then began to plan new changes to test and implement focussing on how a range of staff could support care planning, such as two receptionists who had undergone care navigation training wanted to participate in the identification and assessment of carers – and the cycle begins again for the second half of the year.

What evidence did the practice provide for QOF payments?

The contractor completed the annual QOF QI domain self-declaration. They kept a copy of their QI monitoring template for future payment verification if needed, as well as evidence for future CQC inspections and it was also used by the GP in the project team for appraisal evidence.

Case Study 3: End of Life Care

Practice details: 10,000 patients, rural practice.
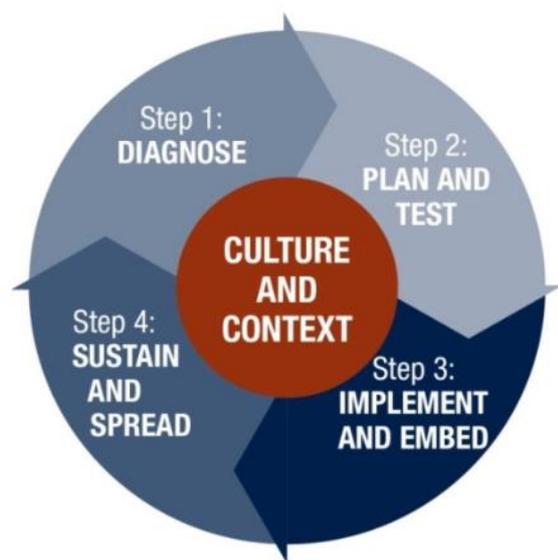
The practice set up a project team which decided to focus on people identified on the end of life care register involving those important to them, are sensitively offered care and support planning discussions, with subsequent recording and sharing of these wishes as a priority. They used the RCGP QI wheel for general practice.

Culture and Context: 2 members of the team (MDT lead GP and the practice manager) agreed to lead on the project as they had already done some basic online QI training. The GP and practice manager agreed to be the clinical and non-clinical leads.

At an EOLC MDT meeting, they discussed and agreed their plans and a hospice Clinical Nurse Specialist (CNS), a community matron and care home manager agreed to actively participate in the improvement project. The lead acute geriatrician was also interested in contributing.

Diagnose: Following the practice's *Retrospective Deaths Audit* (undertaken six months ago), the project team looked at a further sample of the last 20 deaths that had occurred in the past 6 months. This confirmed that the practice had improved their month on month identification of people who had been added to the EoLC supportive care register prior to their death.

Each month the practice manager continued to print a list of all deaths for review and reflection by their EOLC MDT. Although identification had increased, the MDT confirmed a baseline of only 15% (for this practice population a total of 15 deceased) of people affected by advanced serious illness and end of life care who died, had a record of having been offered discussions about their EOLC wishes (Treatment Escalation and Advance Care Plan). Only 10 of these 15 deceased patients (67%) had their plan in a format (e.g. electronically) which could be shared with key teams in order to enable the person's wishes to be upheld in and out of hours. The hospice CNS cited a paper (Mullick et al, 2013) which evidenced that people who have been offered Advance Care Planning discussions were more likely to achieve a better experience of care and death.

Plan and test: the MDT agreed actions to try to increase the **proportion** of people **affected by serious illness and end of life care who died**, who had been offered timely personalised care and support plan discussions. These would be **documented and shared electronically**, in order to enable improved care, reliably and early enough for all those who may benefit from support.

This meant the project team had to agree a SMART outcome aim (what the project wants to achieve and by when), a measure (how they will know if anything is changing), and the change itself (what will people do differently).

a. *Aim* – the practice team decided to aim to increase from 15% to 60% of people identified on the 'supportive care register' who will be **offered timely and relevant personalised care and support planning discussions** which will be **documented and shared electronically**. The aim was to increase personalised care and support planning for people with advanced serious illness and end of life care needs allowing better planned and coordinated care to improve their experience.

b. *Measure* – the practice manager set up a search each month to show the percentage of the total number of people who died who had **sensitively offered timely and relevant personalised care and support plan discussions** with subsequent **documentation and sharing electronically**. This number was then plotted on a simple graph each month, which was reviewed monthly by the MDT. For each patient who discussed their care plan, the project team also reviewed the quality of the plan to help the MDT consider what most helped the patient and those important to them.

c. *The change* – At their first practice EOLC meeting the project team agreed the aim of the QI project.

It was agreed to undertake some patient and family members/ care-giver interviews, and practice staff and MDT surveys to gain ideas and learn from their experience of care delivered by the practice.

The clinical lead also took their QI plan for this **specific measure** to the primary care network peer meetings. Local practices all agreed that achieving a minimum of 60% of people on the supportive care register having an Advanced Care and Support Plan was appropriate. The practice representatives at the network meeting also recommended inviting the hospice medical director, Community Nursing EOLC Lead and acute trust EOLC to the GP network meetings to look at trying to focus on learning gained across the system for Advance Care Planning. One local practice had already met its target for **offering timely and relevant personalised care and support plan discussions** with subsequent **documentation and sharing electronically**. They shared their ideas and these included:

i. All staff, clinical and non-clinical undertaking a training session on Advance Care Planning and Communication Skills

ii. All staff, clinical and non-clinical, agreeing and having an update on the key dataset items with correct coding to document elements of Treatment Escalation and Advance Care Plans.

iii. The MDT reviewing the quality of a random sample of care plans each month and also to identify areas of improvement with any learning from deaths every quarter. The Practice team and MDT agreeing how each professional group would work to support creating, reviewing and updating records. This was triangulated with results of patient/ carer interviews / feedback.

Implement and embed: All staff underwent the training exercise with the project leads at the next Protected Learning Time event and staff actively searched for appropriate patients with Advance Care and Support Plans. Within 3 months, the practice had developed a further 12 plans for people

on the EoLC supportive care register. The project leads then started to plan how personalised care planning quality content and documentation (creation, updating, reviews, coding) could be assessed for these patients over the next few months, which became the next cycle of improvement.

Sustain and spread: The project team shared the success of the first improvement cycle with the whole practice team with a "Thank You" poster on the staff noticeboard. The Practice Manager who had taken the main leadership role on the project attended **2nd peer review meeting** to share the QI work undertaken by the practice.

What the practice did next? The practice agreed to continue to monitor the monthly Supportive Care Register numbers and those who had also achieved sensitive and timely discussions to form a personalised care and support plan, that were recorded and shared. The activity was represented on a run chart and shared at the monthly EOLC MDT and practice meetings, to ensure success was communicated and areas for improvement spotted early for review. The MDT agreed to monitor the quality of Care and Support Plans and deaths, considering if the person's wishes had been upheld in their care plans, agreeing to share learning via practice and GP peer network meetings. The continuous improvement cycle was built with this focus.

They decided to create a new aim of improving the experience of care of those on the Supportive Care Register and those important to them. This included considering how to sensitively seek feedback from patients, families and carers. They used this feedback to look at key themes where they could improve their practice. They involved their PPG in this process. The team then began to plan new changes to test and implement focussing on how a range of staff could support an improved patient and carer experience. For example, having a flag for people identified on the EOLC 'supportive care register' enabling receptionists to help prioritise access and support for patients and their carers – and the cycle begins again for the second half of the year.

What evidence did the practice provide for QOF payments?

The contractor completed the annual QOF QI domain self-declaration. They kept a copy of their QI monitoring template for future payment verification if needed, as well as evidence for future CQC inspections and it was also used by the GP in the project team for appraisal evidence.