Section 5: Quality improvement domain

Prescribing safety

Indicator	Points	Achievement thresholds
QI001. The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance.	27	NA
QI002. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.	10	NA

End of life care

Indicator	Points	Achievement thresholds
QI003: The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance	27	NA
QI004: The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings.	10	NA

Rationale for inclusion of a QI domain

This is a new domain which seeks to fulfil the recommendation in the Report of the Review of QOF[128] to introduce a quality improvement domain. The aim of this domain is to provide support for contractors and their staff to recognise areas of care which require improvement, and take steps to address this through the development and implementation of a quality improvement plan and sharing of learning across their network. Being skilled in quality improvement has been recognised as a key role for healthcare professionals in the Shared View of Quality[129].

NHS England and GPC England have worked with the Royal College of General Practitioners, NICE and the Health Foundation to develop the topic specific guidance included here. This guidance sets specific objectives for each topic which contractors are expected to work towards and provides advice on potential quality improvement

[128] https://www.england.nhs.uk/wp-content/uploads/2018/07/quality-outcome-framework-report-of-the-review.pdf
[129] https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf

actions. Within the parameters set out in this guidance, contractors are encouraged to understand where they have the potential to make quality improvements and then to design and implement bespoke quality improvement plans, including improvement targets to address these. There are no deadlines given for the completion of the diagnostic activities, the subsequent plan or the network meetings. However, contractors are advised that they are expected to be working on these improvement activities throughout the QOF year.

The two topic areas identified for 2019/20 are prescribing safety and end of life care. These topics will change on an annual basis. Through practice engagement with these and future modules we expect to see measurable improvement in the quality of care and patient experience at a national level against the areas of focus described in the individual modules.

The focus of the indicators and associated points is on contractor engagement and participation in the quality improvement activity both in the practice and through sharing of learning across their network. This is to recognise that not all quality improvement activity will be successful in terms of its immediate impact upon patient care. If a contractor does not achieve the targets which they have set themselves this would not in itself be a reason to withhold QOF points and associated payments, unless they have also failed to participate in the activities described in the guidance.

All the supporting information and resources referred to in this guidance will be made available on NHS England's website by end of March 2019**.** Further information as to how to undertake quality improvement activities is available from a number of sources including:

- **NHS England Sustainable Improvement Team**[130] - this is a national resource to support quality improvement activity in primary care and includes training, practical advice and support from quality improvement specialists.
- **NHS Improvement**[131] - resources including improvement tools and case studies.
- **RCGP QI resources**[132] - resources including the RCGP QI Guide for General Practice and other quick guides to the use of quality improvement tools and techniques. These are available to both members and non-members.
- **Health Foundation**[133] - an easy to read and practical guide to undertaking QI
- **NICE Practical Steps**[134] – online guide to putting NICE guidance into practice and tools to support this.
- **Institute for Health Improvement**[135] – a US site with a range of resources to support QI activity.

[130] NHS England. https://www.england.nhs.uk/sustainableimprovement/
[131] NHS Improvement. https://improvement.nhs.uk/improvement-hub/)
[132] RCGP. www.rcgp.org.uk/qi
[133] The health foundation. https://www.health.org.uk/publications/quality-improvement-made-simple
[134] NICE. https://intopractice.nice.org.uk/practical-steps-improving-quality-of-care-services-using-nice-guidance/index.html
[135] Institute for health improvement. http://www.ihi.org/

Prescribing safety

Indicator	Points	Achievement thresholds
QI001. The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance.	27	NA
QI002. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.	10	NA

Rationale

Medicines prevent, treat or manage many illnesses or conditions and are the most common intervention in healthcare (NICE, 2015). The number of prescribed medicines supplied in primary care in England has been increasing year on year. The Health Survey for England 2016 (NHS Digital, 2017) reported that 1,104 million prescription items were dispensed in 2016, an increase of 1.9% (20.5 million additional items) on the number dispensed in 2015. The average number of prescription items per head of the population in 2016 was 20.0, compared with 19.8 items in the previous year.

As primary care staff will be aware, the number of people with multiple conditions is increasing; 25% of all people in England live with 2+ conditions and 8% live with 4+ conditions (Health Foundation, 2018). Over a 2-year period, people with 4+ conditions visited their GP almost 25 times for face to face consultations and were prescribed over 20 different medications.

In May 2012, the GMC published its report *Investigating the prevalence and causes of prescribing errors in general practice* which found that 1 in 20 prescriptions contained an error in terms of medication or monitoring. Most were graded as mild or moderate severity but 1 in 550 was a severe error. Many such errors relate not just to a prescriber's clinical knowledge but also to communication between primary and secondary care, communication with patients and carers, and safety monitoring systems in practices.

Through these QOF indicators practices are being encouraged to help meet the WHO challenge to reduce medication-related harm by 50% by December 2022 (*Medication Without Harm*, Third Global Patient Safety Challenge, WHO, 2017) and recently announced five-year action plan to reduce antimicrobial resistance (Tackling antimicrobial resistance 2019-2024, HM Government 2019).

Overview of the QI module

The overarching aim of these QI indicators is to lead to improvements in the

following aspects of prescribing safety:

- Reduce the rate of potentially hazardous prescribing, with a focus upon the safer use of non-steroidal anti-inflammatory drugs (NSAIDs) in patients at significant risk of complications such as gastro-intestinal bleeding.
- Better monitoring of potentially toxic medications and the creation of safe systems to support drug monitoring through a focus upon lithium prescribing (or another agreed medication if no patients on the registered list are currently being prescribed lithium).
- Better engagement of patients with their medication through a focus upon valproate and pregnancy prevention.
- Improve collaboration between practices, networks and community pharmacists to share learning and improve systems to reduce harm and improve safety.

Practices will need to:

i. Evaluate the current quality of their prescribing safety and identify areas for improvement – this would usually include a baseline assessment of current prescribing (QI001)
ii. Identify quality improvement activities and set improvement goals to improve performance in the three identified areas – see below (QI001)
iii. Implement the improvement plan (QI001)
iv. Participate in a minimum of 2 network peer review meetings (QI002)
v. Complete the QI monitoring template in relation to this module (QI001 + QI002)

The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

Detailed contractor guidance

1. Identifying areas for improvement

All practices should undertake an audit of the current quality of their prescribing in relation to the following measures:

- Patients at significant risk of gastrointestinal adverse effects who have been prescribed a nonselective nonsteroidal anti-inflammatory drug (NSAID) without co-prescription of a proton-pump inhibitor (PPI) in the preceding 6 months.
- Patients receiving lithium and being monitored in primary care who have not had a recorded check of their lithium concentrations, estimated glomerular filtration rate, urea and electrolytes, serum calcium and thyroid function in the previous 6 months.
- Girls and women of childbearing potential currently being prescribed valproate have had an annual specialist medication review and are taking this in compliance with the pregnancy prevention programme as documented by a specialist in the annual risk acknowledgement form. This standard applies equally

to unlicensed use for pain, migraine and other conditions.

Where practices do not have any patients being prescribed lithium they may select an alternative medication to focus on based on their prescribing data and professional judgement. It is recommended that the medication chosen reflects similar issues to lithium prescribing e.g. a requirement for systematic toxicity monitoring. Suggested alternatives include the appropriate monitoring of amiodarone, phenobarbital or methotrexate. As this is a quality improvement exercise, this should not lead to the removal of locally agreed shared care protocols, including any associated funding to deliver the activity. Any alternative to lithium should be agreed between the contractor and the commissioner.

Even if a practice does not have any girls of any age or women of childbearing potential who are currently prescribed valproate, they should ensure their practice has a robust system in place to identify and refer for annual specialist review any new at-risk patients being prescribed valproate and should ensure continuous measurement of this measure. The inclusion of valproate prescribing and monitoring seeks to further promote health care professional awareness of the appropriate monitoring actions whilst awaiting the report of the Independent Medicines and Medical Devices Safety Review, chaired by Baroness Cumberlege.

These medications have been selected as they are linked to significant potential harm if prescribed and managed inappropriately. At a national level, progress against these measures will be monitored and used to inform any evaluation of this QI module.

Box 1. How to do a prescribing audit

A prescribing audit is considered to have five steps:

1. Choose a relevant topic (such as NSAID prescribing)
2. Derive some standards from good quality guidelines (e.g. NICE)
3. Measure your prescribing practice (through searches in the clinical system) and compare how you do against your chosen standards
4. Plan any actions needed to make improvements or sustain good practice and implement them, setting clear goals to achieve
5. Repeat the measurement of your prescribing practice against the standards to assess the impact of the changes you have made. Continue repeated cycles of these steps as you judge necessary.

An audit function is available on all GP software systems to identify and recall all women and girls being prescribed valproate who may be of child bearing potential. Contractors should use this tool in preference to developing their own bespoke searches.

Practices may also find it useful to undertake a reflective group meeting and complete a SWOT (strengths, weaknesses, opportunities, threats) analysis. Guidance as to how to do this can be found in the RCGP guide *How to get started in*

QI[136] . Understanding and sharing individual learning experiences and promoting reflective practice as individuals and in groups helps in the creation of a culture of learning and continuous improvement and the ultimate success of any quality improvement activity.

2. Identifying quality improvement activities and setting improvement goals

Following the initial baseline assessment, practices should develop a quality improvement plan which describes the actions they are going to take to address the prescribing safety improvements they are going to make. Evidence based improvement quality activities include:

- Audit of current prescribing against validated measures
- Review of patients identified as potentially at risk through the audit
- Review of practice systems to address organisational factors which contribute to medication related harm
- Ongoing measurement to demonstrate the impact of any changes[137] [138]

Objectives to support these plans should be SMART (Specific, Measurable, Achievable, Relevant and Time-bound). See Box 2 for examples. Practices should set their own targets for improvement based upon their baseline audit results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting.

Factors to consider when setting these targets include:

- The severity level of identified clinical risk to patients
- The urgency of the timescale to review patients and reduce the risk
- The availability and training of appropriate practice staff to review patients

Quality improvement activities can involve the whole practice team and specialist advice as necessary. In relation to prescribing safety, practices are encouraged to work with clinical and community pharmacists to consider potential improvements and how these may be realised.

There are many aspects of prescribing safety which would be suitable for quality improvement work, but practices should as a minimum address the aspects listed above. A number of external resources are available to support practices with improving prescribing safety such as the RCGP Patient Safety toolkit. In addition, the Academic Health Sciences Network (AHSNs) are implementing the PINCER intervention between now and 2020. Practices are encouraged to engage with their AHSN to access this support.

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[136] RCGP. https://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/quality-improvement-guide-for-general-practice.aspx

[137] Avery et al. A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis. The Lancet 2012;379(9823):1310-1319. https://doi.org/10.1016/S0140-6736(11)61817-5

[138] Dreischulte et al. Safer prescribing – a trial of education, informatics and financial incentives. N Eng J Med 2016;374:1053-1064. https://doi.org/10.1056/NEJMsa1508955

Box 2: Examples of SMART objectives

Objective 1:

Baseline practice prescribing analysis identifies patients on regular NSAID prescriptions with a recorded contraindication.

SMART outcome: Repeat analysis after 3 months (and repeated at 3monthly interval thereafter) shows NO PATIENTS with a recorded contraindication have been prescribed NSAIDS.

Objective 2:

Baseline practice prescribing analysis shows only 5% of patients obtaining a regular (repeat) NSAID have had a clinical safety risk assessment clearly documented within the last 12months.

SMART outcome: Increase from 5% to X% over the next 6 months (practice to decide) and X-Y% over the 6-12 months (practice to decide) of people prescribed NSAIDs regularly have a documented clinical safety risk assessment (as part of their medication review) as per NICE advice within the preceding 12months.

Objective 3:

Baseline practice prescribing analysis shows 50% of patients prescribed lithium for more than one year and suitable (as per NICE guidance) for 6 monthly checks had had a recorded serum lithium level checked within the last 6 months.

SMART outcome: At a repeat analysis 6 months after the baseline analysis there is an increase from 50% to X% (practice to decide) of patients prescribed lithium for greater than a year who are suitable for 6 monthly checks who have a recorded serum lithium level within the last 6 months.

Objective 4

Baseline practice prescribing analysis shows no girls or women of childbearing potential are currently prescribed valproate without a highly effective pregnancy prevention plan in place as per MHRA guidelines. However no practice system is in place to routinely identify new potential at risk patients.

SMART outcome: Within one month the practice can demonstrate an appropriate repeated monthly search of the clinical system to identify all girls or women of childbearing potential who have been recommended to start valproate medication have had a clinical review to ensure compliance with the pregnancy prevention programme as recommended by the MHRA.

Guidance on specific elements of the quality improvement activity

NSAID prescribing

NICE Clinical Knowledge Summary (CKS) on NSAID prescribing (revised August 2018) provides advice on this topic including how to reduce harm from gastrointestinal side effects such as ulcer, perforation, obstruction or bleeding. Nonsteroidal anti-inflammatory drugs (NSAIDs) must not be prescribed to people with:

- active gastrointestinal (GI) bleeding, or active GI ulcer
- history of GI bleeding related to previous NSAID therapy, or history of GI perforation related to previous NSAID therapy
- history of recurrent GI haemorrhage (two or more distinct episodes), or history of recurrent GI ulceration (two or more distinct episodes).

The CKS advice also sets out how to assess risk of harm from NSAIDS in patients and then what appropriate prescribing decisions to take. This advice can be used as evidence-based standards against which to assess a practice's current prescribing.

Examples of the audit standards which practices could adopt are:

- No patients with a current clinical contraindication are currently being prescribed an NSAID medication.
- 100% of patients with an NSAID medication on regularly receiving a repeat prescription have had a documented clinical safety risk review in the last 12 months.
- 100% of patients identified as high risk and requiring ongoing treatment have been prescribed a selective NSAID.
- 100% of patients identified as moderate risk and requiring ongoing treatment have been prescribed an appropriate NSAID with proton pump inhibitor unless contraindicated.

Practices should then demonstrate the action they have taken to reduce risk to these patients, and the system or process they will continue to use to maintain safe NSAID prescribing.

Monitoring or potentially toxic medications – Lithium

NICE guidance Bipolar disorder: assessment and management, NICE (2014) clearly sets out the requirements for monitoring lithium once a patient has been returned from secondary to primary care.

Analysis of the practice's prescribing data and searches within the practice's electronic clinical system will be able to identify individual patients prescribed lithium who are not being managed in line with NICE guidance. Practices are encouraged to review their process for following up a person who has not responded to invitations for monitoring or fails to order or collect prescriptions to ensure concordance with treatment plans and avoid clinical deterioration and crisis.

Practices can use the QI approach to ensure their processes for lithium monitoring are robust and comply with NICE guidance and take action to identify and reduce any risks to individual patients.

Valproate and pregnancy prevention programme – MRHA alert April 2018, updated October 2018 (see also *Drug Safety Update* volume 11 issue 10; May 2018)

During 2018, all practices and individual GPs will have been sent a pack of information advising them of the need to identify any girl or woman of childbearing potential (this is defined as a pre-menopausal woman who is capable of becoming pregnant) currently being prescribed valproate and setting out a series of actions for health professionals including GPs. Valproate use in pregnancy is associated with an increased risk of children with congenital abnormalities and developmental delay. Valproate is contraindicated in women of childbearing potential unless the conditions of the valproate pregnancy prevention programme are fulfilled. Whilst the rates of prescribing of valproate continue to decline slowly there are wide geographical variations in prescribing.

Clear actions have been set for general practices to identify and recall existing patients, provide them with a copy of the Patient Guide, to check they have had a specialist review in the last year and to have systems in place to identify and appropriately manage new patients who are prescribed valproate and are of child bearing potential.

The pregnancy prevention programme requires GPs to:

- Ensure continuous use of highly effective contraception* in all women of childbearing potential (consider the need for pregnancy testing if not a highly effective method).
- Check that all patients have an up to date, signed, Annual Risk Acknowledgment Form each time a repeat prescription is issued.
- Ensure the patient is referred back to the specialist for review, annually.
- Refer back to the specialist urgently (within days) in case of unplanned pregnancy; or
- where a patient wants to plan a pregnancy.

* The Summary of Product Characteristics for valproate states that 'Women of childbearing potential who are prescribed valproate must use effective contraception without interruption during the entire duration of treatment with valproate. These patients must be provided with comprehensive information on pregnancy prevention and should be referred for contraceptive advice if they are not using effective contraception. At least one effective method of contraception (preferably a user independent form such as an intra-uterine device or implant) or two complementary forms of contraception including a barrier method should be used. Individual circumstances should be evaluated in each case when choosing the contraception method, involving the patient in the discussion to guarantee her engagement and compliance with the chosen measures. Even if she has amenorrhea she must follow all the advice on effective contraception.'

For children or for patients without the capacity to make an informed decision, provide the information and advice on highly effective methods of contraception and

on the use of valproate during pregnancy to their parents/ caregiver/ responsible person and make sure they clearly understand the content.

The practice should regularly use the audit function on their clinical system to identify at risk patients and ensure timely recall for clinical review in line with the MHRA alert. Such continuous measurement can be used to demonstrate compliance with the MHRA alert.

This improvement programme offers general practice a further opportunity to ensure these actions have been completed and that ongoing systems to protect patients from harm have been put in place.

3. Implementing the plan

Practices should implement the improvement plan developed to support their objectives. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues in community pharmacy where practicable.

Practices should undertake continuous improvement cycles to achieve the outcomes they have set themselves. These should focus upon necessary changes to practice systems and processes, staff roles, methods of recording and sharing information as well as reviewing care for individual patients.

Continuous measurement is recommended to demonstrate the impact of the changes being tested. The audit cycle should be closed by repeating the audit and clarifying the outcomes achieved.

Example case studies can be downloaded from https://www.england.nhs.uk/wp-content/uploads/2019/03/1920-qof-quality-improvement-case-studies.pdf

4. Network peer review meetings

A key objective of the network peer review meetings is the establishment of a system to enable shared learning across Primary Care Networks. The aim of this is to share best practice in prescribing safety.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings.

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner. Suggested discussion points for these meetings are made in Box 3.

The network clinical lead or their nominated deputy should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings but we would recommend that the first meeting takes place early in the QI activity and the second towards the end.

Box 3. Suggested peer review meeting discussion points

The first peer review meeting should take place early in the QI process and focus upon:

- Sharing of the outputs of diagnostic work to understand the issues associated with prescribing safety
- Validation of practice improvement targets

Discussion points could include:

1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?

The second peer review meeting should take place towards the end of the QI process and should focus upon:

- Celebrating successes and sharing of key changes made in practice.
- How these changes can be embedded into practice.

Discussion points could include:

1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity prescribing safety is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?

5. Reporting and verification

The contractor will complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and unforeseen circumstances which impact a contractor's ability to participate. In these circumstances contractors are expected to make efforts to ensure alternative participation in peer review.

Verification – Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exception and unforeseen circumstances then they will need to demonstrate other active engagement in peer learning as review.

The reporting template is available from https://www.england.nhs.uk/publication/quality-improvement-reporting-template-safe-prescribing/ . Patient identifiable information should not be included in this template or appended to it.

End of life care

Indicator	Points	Achievement thresholds
QI003: The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance	27	NA
QI004: The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings.	10	NA

Rationale

In 2015 the National Palliative and End of Life Care Partnership published *Ambitions for palliative and end of life care: a national framework for local action 2015-2020*. This quality improvement activity is designed to support practices to respond to those ambitions and to build the foundations needed to provide excellent, holistic and individualised care for all.

Identifying patients in need of end of life care, assessing their needs and preferences, and proactively planning their care with them are key steps in the provision of high quality care at the end of life in general practice. There is evidence to suggest that there is the potential for the quality of this care to be improved[139]. Increased use of healthcare services during this time also occurs often with limited clinical effectiveness and poor experiences for people. Better identification of people in the last year of their life followed by appropriate care planning and support for them are recognised as key elements of good medical practice as set out by the General Medical Council (*Treatment and care towards the end of life: good practice in decision making*, 2010).

Involving, supporting and caring for all those important to the dying person is also recognised as a key foundation of good end of life care. As well as being individuals facing impending loss and grief, they often provide a key caring role for the dying person.

[139] National Audit Office. End of Life Care: Report by the Comptroller and Auditor General. 2008; available from https://www.nao.org.uk/wp-content/uploads/2008/11/07081043.pdf

Overview of the QI module

The overarching aim of these QI indicators is to lead to improvements in relation to the following aspects of care:

1. **Early identification and support for people** with advanced progressive illness who might die within the next twelve months.
2. **Well-planned and coordinated care** that is responsive to the patient's changing needs with the aim of improving the experience of care.
3. **Identification and support for family / informal care-givers**, both as part of the core care team around the patient and as individuals facing impending bereavement.

Practices will need to:

i. Evaluate the current quality of their end of life care and identify areas for improvement – this would usually include a retrospective death audit (QI003)
ii. Identify quality improvement activities and set improvement goals to improve performance (QI003)
iii. Implement the improvement plan (QI003)
iv. Participate in a minimum of 2 GP network peer review meetings (QI004)
v. Complete the QI monitoring template in relation to this module (QI003 + QI004)

The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

Detailed contractor guidance

1. Identifying areas for improvement

All practices should start with an assessment of the current quality of care they provide for patients and their families at the end of life. This would usually include the completion of a retrospective baseline audit analysis of deaths unless this has been completed in the previous 3 months. Box 4 provides further information about how to do this. The purpose of this is to understand firstly, the numbers of people who had been identified on the palliative care register and therefore deaths which had been anticipated and secondly, how many patients had care plans in place. If the practice already has well-established end of life care process then this baseline audit analysis could focus upon other aspects of care such as:

- Priority care goals achieved e.g. is preferred place of death recorded and achieved?
- Quality of care plans including treatment escalation and advance care plans e.g. legal status of Power of Attorney and advance Directives, and emergency treatment preferences such as recording of decision on cardiopulmonary resuscitation (note evidence suggests that this should be part of the care planning process and not done in isolation).

- Main carer is identified with offer of assessment and support
- Anticipatory medicines are available in the place of care

We encourage practices, particularly those with well-established end of life care processes to seek the views of family members / informal carers which for example could be done through a ***survey of carers*** or a ***structured interview with one carer or patient every six months*** to evaluate how well the practice meets their needs and what improvements could be made.

Box 4: How to do a retrospective death baseline analysis (audit)

Practices should review a sample of X deaths over the previous 12 months to establish baseline performance on the areas of care listed above and to calculate their expected palliative care register size. A suggested template to support data collection for the audit can be downloaded from https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/.

The number of deaths each year will vary between individual practices due to differences in the demographics of the practice population. Practices could use the number of deaths reported in their practice populations in the previous year to assess how well they are identifying patients who would benefit from end of life care. An audit standard against which to assess current practice would be that the practice was successfully anticipating approximately 60% of deaths.

Practices may also find it useful to undertake a reflective group meeting and complete a SWOT analysis. Guidance as to how to do this can be found in the accompanying RCGP guide How to get started in QI[140]. Understanding and sharing individual learning experiences and promoting reflective practice as individuals and in groups helps in the creation of a culture of learning and continuous improvement and the ultimate success of any quality improvement activity.

2. Identifying quality improvement activities and setting improvement goals

The identification of quality improvement activities should be informed by the results of the retrospective death baseline audit and analysis. Practices should focus their QI activities on delivering improvement across the following four **measures**:

1. An increase in the proportion of people who die from advanced serious illness who had been **identified** in a timely manner on a practice 'supportive care register', in order to enable improved end of life care, reliably and early enough for all those who may benefit from support.
2. An increase in the proportion of people who died from advanced serious illness who were sensitively **offered timely and relevant personalised care and support plan discussions**; **documented and shared electronically** (with

[140] RCGP. https://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/quality-improvement-guide-for-general-practice.aspx

appropriate data sharing agreements in place) to support the delivery of coordinated, responsive care in and out of hours with key cross-sector stakeholders.

3. An increase in the proportion of people who died from advanced serious illness where a family member / informal care-giver/ next-of-kin had been **identified**; with an increase in those who were **offered holistic support before and after death,** reliably and early enough for all those who may benefit from support.
4. A reliable system in place to monitor and enable improvement based on timely feedback of the **experience of care** from staff, patients and carer perspectives.

These measures will be used at a national level to assess the impact of the module.

Identification and care planning should be addressed in parallel. Improvement activity should focus on impact. and may include a dedicated focus on specific areas or patient groups e.g. the practice may perform well in relation to supporting patients with cancer at the end of life, but could improve in relation to other patient groups e.g. those with respiratory disease, children with life limiting illnesses or people with learning disabilities.

Practices may also wish to review the RCGP and Marie-Curie Daffodil standards: core Standards for advanced serious illness and end of life care in general practice[141] and the NICE QS for End of Life Care in Adults (QS13) and Care of dying adults in the last days of life (QS144) for further suggestions of appropriate quality improvement activities.

For each of the measures, practices should identify and agree their own objectives which are *SMART* See Box 5 for examples of SMART outcomes. Practices should set their own targets for improvement based upon their baseline audit results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting.

[141] https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/daffodil-standards.aspx

Box 5: Examples of SMART outcomes for each measure

Measure 1:

Baseline analysis from retrospective audit – 20% of people affected by serious illness and end of life care who died, had already been identified on a practice 'supportive care register'.

SMART outcome: Increase from 20% to X% of people **affected by serious illness and end of life care who died, to be identified** on a practice 'supportive care register', over the next 6 months.

Measure 2:

Baseline analysis from retrospective audit – 10% of people **affected by serious illness and end of life care who died**, had been sensitively offered timely and relevant personalised care and support plan discussions and these were **documented and shared electronically.**

SMART outcome: Increase from 10% to X% over the next 6 months (practice to decide) and X-Y% over the 6-12 months (practice to decide) of people **affected by serious illness and end of life care who died, to be** sensitively offered timely and relevant personalised care and support plan discussions and have these **documented and shared electronically.**

Measure 3:

Baseline analysis from retrospective audit – 10% **of family members / informal care-givers/ next-of-kin** identified on a practice 'supportive care register' were contacted and offered information on dealing with grief and bereavement within 1 month of the person on the register dying.

SMART outcome: Increase from 10% to X% (practice to decide) of **family members / informal care-givers/ next-of-kin** identified on the practice 'supportive care register' to be contacted and offered information on dealing with grief and bereavement within X weeks /months (practice to decide) of the person on the register dying – within a 12-month period.

Measure 4:
SMART outcomes:
To support and reflect on retrospective death audit and practice-relevant QI planning within the 12-month period, achieving a minimum of:

a) 2-5 family/care-giver or patient interviews (See Appendix 1) e.g. semi-structured discussion, using an agreed template or annual carer survey relevant to EOLC needs.

Optional and additional SMART OUTCOMES could include:

- Staff feedback to support the QI planning (See Appendix 1) e.g. survey
- MDT feedback to support the QI planning (See Appendix 1) e.g. survey, discussion at MDT

3. Implementing the plan

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues in community and related services (such as district nurses, hospice services, and community pharmacy) where practicable. Where possible, patients and their family members and informal care givers should be involved in continuous quality improvement around people affected by advanced serious illness and end of life care. This is especially the case in relation to measures 3 and 4.

Practices should undertake continuous improvement cycles to achieve the outcomes they have set for themselves in relation to the measures they are focusing on.

Example case studies can be viewed at https://www.england.nhs.uk/wp-content/uploads/2019/03/1920-qof-quality-improvement-case-studies.pdf

4. GP Network peer review meetings

A key objective of the network peer review meetings is to enable shared learning across the network. The aim of this is to improve learning from deaths and the provision of best practice end of life care. It is also intended to provide a forum for practices to identify wider system issues impacting upon care quality which may require a collective response.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings.

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner. Suggested discussion points for these meetings are made in Box 6.

The network clinical lead or their nominated deputy should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings but it is recommended that the first meeting takes place early in the QI activity and the second towards the end.

Box 6: Suggested peer review meeting discussion points

The first peer review meeting should take place early in the QI activity and focus on:

- Sharing the outputs of the diagnostic work to understand the issues for each practice about end of life care.
- Validation of practice improvement targets.

Discussion points could include:

1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring that the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?

The second peer review meeting should take place towards the end of the QI activity and focus on:

- Celebrating success and sharing of key changes made in practice.
- Encouraging a compassionate, no-blame and active learning culture.
- How these changes have been embedded and will be sustained.

Discussion points could include:

1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity in end of life care is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?

5. Reporting and verification

The contractor will need to complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. In these circumstances contractors are expected to make efforts to ensure alternative participation in peer review.

Verification - Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exceptional circumstances then they will need to demonstrate other active engagement in network peer learning and review.

The reporting template is available from https://www.england.nhs.uk/publication/quality-improvement-module-documentation-end-of-life-care/ . Patient identifiable information should not be included in this template or appended to it.