APPENDIX 3

Project Illustrations

Example 1 – Patient Outcomes (COPD/Respiratory conditions)

- Practice A has been identified having a higher than expected number of admissions to hospital with respiratory conditions. This data has been provided by business intelligence and reviewed by the practice with the help of the CCG QI Clinical lead and their neighbourhood CBM.

- Over the preceding 12 months they have had 88 unplanned admissions to hospital for patients with respiratory conditions. This is a significantly higher admission rate per 1000 patients then their peer practices.

- This is chosen to be the focus of once of their PCQS QI Projects, and they use the model for improvement (IHI) to plan and test out their changes.

- Their overall aim is to reduce the number of admissions to hospital for respiratory conditions by 30% by the end of the scheme (April 2019).

- They will measure their monthly admission rate and plot it on a run chart.

- The practice will put together a project team to test out ideas for change, by referring to published evidence on what has worked well elsewhere, by drawing on the experience of their peer practices (neighbourhood working) and by asking the patients who have been admitted recently about what factors influenced the admission and how it might have been prevented.

- Change ideas for testing are likely to include: an increase in the number of patients with a winter action plan, and increase in the number who have had a practice nurse review with an FEV1 measure, improve information for patients on managing exacerbations at home, a pharmacists review of medication concordance. As each idea is implemented, the admission rate will be monitored monthly for improvement.

- If the project succeeds there will be a saving of approximately £70k in the use of non-elective services.

- The project is also in line with the CCG priority to use RightCare data to improve pathways for Respiratory Care and will support the achievement of our local Quality Premium payment for COPD generating, if achieved across the CCG, an additional £184k, subject to achievement of the NHS Constitution Requirements.

Example 2 – Prescribing (mandated component)

- Practice B has been identified by openprescribing.net data as prescribing significantly more trimethoprim per 1000 patients than their peers (6.41 items/1000 patients per month, compared to an average of 2.59 items/1000 patients per month)

- Due to high resistance rates of infections to trimethoprim prescribing in our CCG, patients may not be receiving optimum care

- Successful reduction in trimethoprim prescribing will generate a Quality Premium payment for the CCG

- The practice, with the support of the CCG QI lead and the medicines management team decide to use the model for improvement to plan and test out their changes.

- There overall aim is to reduce their prescribing to below 2.59 items/per 1000 patients per month by the end of March 2018. The practice has a list size of 6110 and so is aiming for a median number of trimethoprim prescriptions per month of less than 16.

- They will measure their number of prescriptions of trimethoprim monthly and plot this on a run chart.

- With support from the medicines management technicians they will test out ideas for change, based on best practice. These may include a review of patients who are using trimethoprim as a preventative therapy, a change in practice protocols for treatment, an increase in the use of the local antibiotic smartphone app and individual feedback to the prescribers.

- This project will support the achievement of the overall QP Premium indicator for use of antibiotics in UTIs which could generate £94k income for the CCG, again subject to achievement of NHS Constitution Indicators.

<u>Example 3 – Patient Experience</u>

- Practice C has been identified by the Primary Care webtool and the National GP Patient Survey as being a significant outlier in patients overall experience of making an appointment. 38% of patients score them as ‘Good’ or ‘Fairly good’ compared to a national average of 78%

- Their aim is to increase their score in the 2019 GP Survey to 50% or above (overall measure). However they need a ‘real time measure’ to monitor the success of their changes and so decide to increase their use of the Friends and Family test administered by text message and adding the additional option question ‘Score your overall experience of making an appointment’. They will gather this data monthly and plot it on a run chart to monitor their change.

- They put together a practice project group and with support from the Primary care team and the QI Clinical lead they come up with ideas for testing out. These ideas may include changing the number of reception staff answering the phone at busy times, offering a wider range of appointment options including telephone consultations, increasing their use of the Extended hours hub for working patients and increasing the number of patients able to book their appointments online. As

they implement their changes they will monitor for improvement using PDSA methodology.

- A positive outcome to the project will support the achievement of the CCG Quality Premium related to patient experience and generate a potential income of £208k if the target is achieved, again noting the potential reduction impact relating to the NHS Constitution indicators.

Example 4 – Patient Outcomes (early diagnosis of cancer)

- Practice D has been identified by the CCG MacMillan GP as having a significantly lower fast-track referral rate for suspected cancer than peer practices and a corresponding high level of cancers diagnosed as an 'emergency' during an unplanned admission

- As practice-level data does not exist for stage of diagnosis, they start their project by gathering their baseline data. This involves retrospectively looking at the last 20 cancer diagnosis the see how many were diagnosed at stage 1 or 2 and comparing this with national averages.

- They use the model for improvement and their aim is to bring their stage 1 and 2 diagnoses into line with national averages by the end of the project in March 2019. As cancer diagnoses are infrequent they will use a 12-month rolling graph, starting with their base line data to monitor for improvements, with the support of the QI Clinical lead. Every month the proportion diagnosed at stage 1 or 2 will be added to the graph.

- Their change ideas may include: easier access to the NICE guidance on when to refer, regular monitoring of their use of fast-track referrals, practice promotion of screening for bowel, breast and cervical cancer, improvements in their rate of screening. As this is a complex project, they will use a Driver Diagram to organise their change ideas.

- A positive outcome to the project will support the achievement of the QP Premium related to early diagnosis of cancer and generate a potential income of £208k if the target is achieved, again noting the potential reduction impact relating to the NHS Constitution indicators.