

# **QOF Quality Improvement domain 2020/21 – Supporting people with learning disabilities**

NHS England and NHS Improvement



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## Introduction

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 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 2020/21 are Supporting people with learning disability and early diagnosis of cancer. 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.

## Indicators

The two QOF indicators included in Supporting people with learning disability module are:

- QILD007 - The contractor can demonstrate continuous quality improvement activity focused upon learning disabilities as specified in the QOF guidance.
- QILD008 - The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on the care of patients with a learning disability as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings

## Rationale for inclusion

A learning disability is a significantly reduced ability to understand complex information or learn new skills; a reduced ability to cope independently; and a condition which started before adulthood with a lasting effect ([Valuing People, 2001](#)).

People with a learning disability experience significant health inequality:

- The gap between the age at death for people with a learning disabilities (age ≥4 years) and the general population (all ages) is 23 years for males and 27 years for females ([LeDeR, 2018](#)); the median age at death for someone with profound LD is 40 years.
- The commonest recorded causes of death in order are: pneumonia, aspiration pneumonia, sepsis, dementia, CVD, epilepsy.

A confidential inquiry concluded that 42% of deaths for people with a learning disability are premature. The most common reasons are delays or problems with diagnosis or treatment, and problems with identifying needs and providing appropriate care in response to changing needs.

People with Learning Disabilities are significantly more likely to have co-morbidities. Since 2015, [Public Health England and NHS Digital](#) have examined GP records to monitor the prevalence of co-morbidities for half the population of England. The co-morbidities occurring more frequently in the learning disability population than the general population are obesity, asthma, constipation, dysphagia, GORD, epilepsy, dementia and mental health problems.

Currently only about 25% of the estimated 1.1 million people in England with a learning disability are recorded on the current Learning Disability QOF register ([Learning Disabilities Observatory, 2016](#)). Improving the accuracy of the QOF register will help ensure people with a learning disability are offered annual health checks.

The annual health check is an evidence-based tool recommend by NICE ([QS101, QS187](#)). Health checks can identify undetected health conditions early, ensure the appropriateness of ongoing treatments and establish trust and support continuity of care. The [RCGP provides support](#) that practices can use. Health check action-planning provides the opportunity to positively promote health by encouraging cancer screening uptake, immunisations and healthy lifestyle. People with a learning disability are more likely to be obese, less likely to take up all national cancer screening offers and only 44.7% received a flu vaccination in 2018.

General practice has a key role in optimising prescribing to reduce harm (NICE [NG5, QS120](#)). For people with a learning disability, this includes reviewing the over-prescribing of psychotropic medication in the absence of a mental health diagnosis (STOMP initiative [PHE, 2015](#)) .

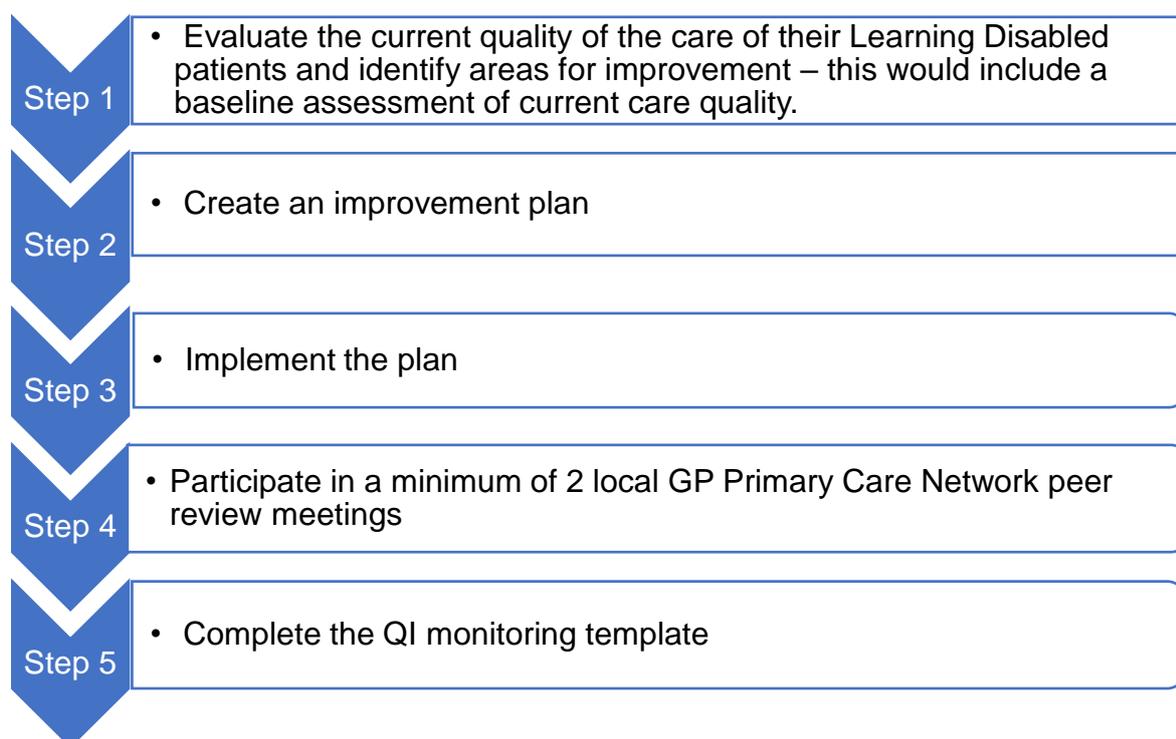
General practice can play a vital role in improving holistic person-centred care for people with a learning disability to enable them to live their ambition of fulfilled lives in the community. Providing holistic care can improve outcomes and ensure people live safely by raising awareness of the risk of abuse of vulnerable individuals. By treating people and their families with this dignity general practice will gain the respect of people with a learning disability.

## Overview of the QI module

The overarching aim of this QI module is to improve care for people of all ages with a learning disability (with or without autism), including:

- 1) Improve the **accuracy of the GP register** by increasing the identification and coding of people of all ages with a learning disability including those with a dual diagnosis of learning disability and autism so that those on the register can be proactively invited for health checks, vaccinations etc.
- 2) **Increased uptake of annual health checks** in people aged 14 and over, acting as an iterative process of personalised care planning to manage co-morbidities, reduce unnecessary hospitalisations, promote health positively and reduce premature mortality. The health check should always produce a personalised action plan to facilitate this.
- 3) **Optimisation of medications** in line with the STOMP initiative (stopping over prescribing of medication for people with learning disability) with a focus on identifying those on antipsychotic medication to review the clinical appropriateness (in partnership with local MDT including psychiatry and social care) and to monitor side effects such as metabolic effects.
- 4) Recording of the need for, and type of, **reasonable adjustments** required and evidence that these are being implemented in practice as set out in the Equality Act and record preferred means of communication as required by the Accessible Information Standard.
- 5) Consideration of the use of wider community support through **engagement with local community learning disability services and network social prescribers, in collaboration with people with a learning disability and their families and carers.**

Practices will need to undertake the following steps:



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

### 1.1 Identifying areas for improvement

All practices should start with an assessment of the current quality of care they provide to patients of all ages on the Learning Disability QOF register. This should include:

1. Improving the accuracy and increase prevalence of the Learning Disability QOF register by running searches of the NHS England provided codes to case-find people on the practice list who 'may' have a learning disability, using the [inclusion tool](#) provided to determine whether the individual would benefit from being on the register and then adding the code 'on learning disability register' for those for whom this is appropriate. (Those currently on the practice list but not on the QOF register who 'will' have a learning disability will be automatically case-found and placed on the register from 1/1/2020)
2. Completing a whole practice training needs analysis in learning disability awareness, awareness of the requirements of the Equality Act and awareness of implementation of the Mental Capacity Act.
3. Reflecting on the practice's overall approach to how it cares for people with learning disability including looking at practice data on the rate of annual health check completion, use of an approved health check electronic template, health

promotion activity including, cancer screening and vaccination rates, long term condition management and healthy living indicators (e.g. obesity, smoking, drugs, alcohol, sexual health).

4. Evaluating by practice self-assessment, how reasonable adjustments are identified, highlighted and implemented including the accessible information standard.

For practices already completing high quality annual health checks, achieving the national 75% uptake target, with application of well-received and 'consistent for the individual' reasonable adjustments, where quality of care provided by the health check is already monitored, then extended evaluation could include:

- Evaluation of the acute care of people with a learning disability by reviewing acute hospital admissions, repeat admissions, preventable admissions, failure to attend hospital appointments and investigations and by detailed mortality review if a death of a Learning Disabled person has occurred in the practice.
- Audit of adults on the QOF learning disability register but not on the QOF MH register who are currently prescribed an antidepressant, an antipsychotic or a benzodiazepine and those adults on the Learning Disability QOF register without a diagnosis of epilepsy who are currently taking an antidepressant.
- Audit of the numbers of adult patients on the Learning Disability QOF register who have a Summary Care Record with Additional Information.
- Audit of the numbers of patients on the Learning Disability QOF register who have a NHS Digital 'reasonable adjustment' flag (if available in the practice area) or alternative flag on their record.

Practices may also find it useful to undertake a reflective group meeting and/ or complete a SWOT analysis (strengths, weaknesses, opportunities, threats) of the practice's approach to identifying, managing the care of and supporting people with learning disabilities. Guidance on basic QI concepts and tools can be found in the NHS England [An Introduction to Quality Improvement in General Practice](#) and the [RCGP QI Ready tool](#). NHS England and the RCGP have also produced free support resources, in particular, the comprehensive [Health Checks for People with Learning Disability Toolkit](#).

Practices may want to involve the local community learning disability services, where this is possible, to provide additional support and advice on identifying areas for improvement including case-finding, and to access local training opportunities. Local multi-disciplinary learning disability services can also support the provision of additional community-based support and personal health budgets.

## **1.2 Creating an improvement plan**

Following the diagnostic phase above, practices should focus their QI activities on the following outcomes:

1. Increase the number of people on the Learning Disability QOF register in order to enable these people to be proactively called for health checks and flu

immunisations and have their needs for reasonable adjustments recorded and flagged.

2. Increase the uptake of high quality annual health checks, including health check action plans, to 75% of all those on the QOF Learning Disability Register aged 14 and over to enable excellent planned care to be provided to improve health outcomes.
3. Increase the numbers of people of all ages on the Learning Disability QOF register who have received an annual flu immunisation – the rationale being that respiratory infection is the commonest cause of death in people with a learning disability.
4. Improve the provision and understanding of Reasonable Adjustments by the practice including recording these using the Reasonable Adjustment Flag (if available in the practice area), using the Summary Care Record with Additional Information, ensuring adjustments needed are included in all communications from the practice and adhering to the Accessible Information Standard.

The outcomes listed will be used at a national level to assess the impact of the module and practices should consider how they measure improvement when choosing aims for their projects.

In parallel with this, the quality of the annual health check, robustness of care planning and impact on health care such as improvements in long term condition management and reduction of unnecessary hospital admission would be addressed. Quality improvement activity should focus on measurable impact.

Once practices have identified their area/s for improvement they should be clear about:

- **The aims** of the project – what will be achieved and by when. These aims should be SMART (specific, measurable, achievable, relevant, and time-bound).
- **The measures** – what data will be collected to know if the aims have been met. Measurements to assess the effectiveness of changes made should be straightforward for teams to collect regularly.
  - Process, e.g. numbers of people with a learning disability invited for health check / offered flu vaccination / with documented communication preference.
  - Outcomes, e.g. proportion of people with a learning disability having personalised health action plan in place / receiving flu vacc / showing improved management of a long-term condition e.g. improved HbA1c or BP reading / taking up appropriate cancer screening / supported to stop smoking / reduce excessive alcohol intake)
  - Balancing, e.g. checking the proportion of people with severe mental illness having a physical health check does not reduce (due to focus on learning disability)
- **The changes** – what different ways of doing things will be tested.

Practices should choose their own quality improvement activities and set their own targets for improvement based upon their baseline audit or search 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. Multiple small tests of change are recommended.

Practices should aim to find a way to ensure improvement is continuous and that quality improvement becomes routine. See Box 1 for examples of SMART aims.

Practices should consider which QI tools and techniques are most suitable to support their improvement project. Examples include:

- Case finding exercise: a series of coding searches to find and re-code any missing cases (see resources section).
- [Process mapping](#) and reviewing how health check recalls and reminders are carried out and how the process is made as streamlined as possible (e.g. with blood tests carried out in time for results to be available to reduce unnecessary extra visits, methods of invitation of the individual to the appointment by their preferred method to reduce the rate of failure to attend, guidance to paid carers about importance of the check).
- Structured review with a focus group including patients, family members and their carers using a framework such as TEACH (time, environment, attitude, communication, and help) to map how the practice identifies, records and implements reasonable adjustments.
- Creating [run charts](#) to document the monthly measurement of achievement of aims such as numbers of completed health checks, medications reviews done, flu vaccinations completed, reasonable adjustment flags added, Summary Care Record with Additional Information added or screening invitations taken up.

## **Box 1. Examples of SMART aims practices could consider:**

### **Area for improvement 1:**

The practice learning disability register has not been checked for accuracy for many years. The practice follows the new guidance from NHS England on searches for codes showing patients on the list who 'may' have a learning disability.

**SMART aim:** To review the records and/or make contact with all identified individuals to determine whether they would benefit from being placed on the register. This will be done for x% of the list of those who 'may' have a learning disability each quarter with incremental progress through the year to y% by the end of 12 months.

### **Area for improvement 2:**

The practice last year completed annual health checks on x% of people on its QOF learning disability register aged 14 and over.

**SMART aim:** To increase progressively the proportion of people on its QOF learning disability register aged 14 and over having a completed annual health check to (the national DES target of) 75% within y months.

### **Area for improvement 3:**

The practice had no system for identifying and recording reasonable adjustments needed for people with learning disability.

**SMART aim:** To introduce a system that leads to x% of all patients with learning disability having an agreed digital flag (NHS Digital Reasonable Adjustment Flag or local alternative) within 12 months.

### **Area for improvement 4:**

The practice had not recorded the preferred means of communication for invitation for the Health Check in the majority of patients and failed to invite for the health check by the preferred means.

**SMART aim:** To ensure that in incremental steps during the year x% of those aged 14 and over have preferred means of communication recorded in their notes and that this method is used to invite that x% to their health check in the coming year.

### **Area for improvement 5:**

The practice identified that 45% of people on the learning disability QOF register had a recorded flu vaccination last year.

**SMART aim:** To increase the proportion of people on the learning disability QOF register receiving the flu vaccine - or declining through a valid, documented, informed consent process to x% within 12 months.

### **Area for improvement 6:**

The practice found that 30% of female patients in the appropriate age group and on the learning disability register had attended for cervical cancer screening within recommended timescales. A staff survey identified the lack of confidence of practice nurses in assessing capacity and gaining consent and discussing sensitive sexual behaviour with women with a learning disability including the risk of sexual abuse.

**SMART aim:** All clinical staff offering cervical screening to undergo training in learning disability awareness, Mental Capacity Act and Adult Safeguarding in order to support women with a learning disability to engage with cervical screening and sexual health promotion with all staff reporting increased confidence in this area within 6 months.

**SMART aim:** The practice will increase the proportion of women attending for cervical screening (or declining through a valid, documented informed consent process) to X% in the second 6 months of the year.

### **Area for improvement 7:**

A patient registered with the practice and on the learning disability register died during the last 12 months. No documented review or significant / learning event analysis was held after the death.

**SMART aim:** Every death of a person on the LD register is considered as a significant event with a documented reflective analysis of what lessons the practice could learn including identification of good practice and areas for improvement.

### **1.3 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 outside the practice, where practicable, for example local community learning disability services, social prescribers, network pharmacist, patient support groups, family carer groups and specialist third sector organisations.

Where possible, patients and their family members and carers should be involved in quality improvement activity around the health inequalities experienced by and the impact of the person's learning disability on their life. Local learning disability services may be able to assist using support of experts by experience, local advocacy services, and local learning disability carer groups.

### **1.4 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 quality improvement activities referencing the need to improve outcomes from learning from the LeDeR (Learning Disability Mortality Review) process. It is 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 2.

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 at the stage of deciding on what quality improvement activities to undertake and the second towards the end to share outcomes and learning from these activities.

## Box 2. 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 baseline work to understand the issues for each practice concerning the quality of overall care provided to their Learning-Disabled patients
- Practices should be able to share data at the first peer review meeting. In order to monitor progress practices should share their previous year's health check uptake as a percentage of those aged 14 and over on the LD QOF register, their flu vaccination uptake as a percentage of all those of all ages on the LD QOF register and their LD prevalence data (numbers on register as a percentage of total practice population)
- 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 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?

## 1.5 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.

## Appendix - Resources available to support practices

- Lists of codes that populate the learning disability register. List of conditions where the individual will have a learning disability. List of conditions/codes where the individual may have a learning disability. NHSE Learning Disability register identification tool
- [DES requirements](#)
- Inclusion tool: <https://www.getcheckedoutleeds.nhs.uk/wp-content/uploads/2019/08/Inclusion-tool-Jan-2019-3.pdf>
- [How to do a learning needs analysis](#)
- [NHSE and PHE guidance re flu immunisation for people with a Learning Disability](#)
- Other LD immunisation guidance - [pneumococcal vaccine in respiratory disease, Hepatitis B](#)
- Links to the [AAA screening](#) and national cancer screening programmes - [cervical screening](#), [breast screening](#), [bowel scope screening](#) and [diabetic eye screening](#)
- [Links to the LeDeR programme including action from learning guidance](#)
- [Information about Summary Care Record with Additional Information](#)
- [Information about the Accessible Information Standard](#)
- [Information about NHS Digital Reasonable Adjustment Flag](#)
- [Provision of local advocacy services](#)
- [Reasonable adjustment self-assessment tool](#)
- [Making a complaint guidance 'Ask Listen Do'](#)