The Health Foundation
Inspiring Improvement

Using CQUIN indicators to drive commissioning and implementation of shared decision making

The MAGIC team – Newcastle

January 2014

This case study describes how the team in Newcastle working on the Health Foundation's MAGIC programme to implement shared decision making worked with commissioners to develop a CQUIN for shared decision making.

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of [English] healthcare providers' income to the achievement of quality improvement goals. Payment of this reserved amount is conditional on achieving the agreed standards of quality and innovation. As well as complying with national CQUIN indicators, health care providers are encouraged to agree local schemes to test innovative methods of driving up quality of care.

To test methods of implementing shared decision making in a large NHS Foundation Trust, local indicators for CQUIN were developed for shared decision making (SDM) within Newcastle Hospitals and agreed with commissioners. The value to the Trust of successfully achieving the standards set for demonstrating implementation of shared decision making in three specialities was almost £1m.

Requirements set out in the CQUIN

The core elements of the CQUIN agreement were:

— Health care professionals will attend advanced skills training in shared decision making;

— The clinical environment encourages patient involvement in decision making about treatment and care, for example by using the 'Ask 3 Questions' patient awareness-raising materials[1];

— There is access to and use of good quality decision support material;

— The patient record or letter to GP and patient shows evidence of high quality shared decision making conversations.

[1] The Ask 3 Questions approach is increasingly being adopted by a wide range of healthcare organisations to encourage and empower people. The approach is based on research by Shepherd et al. showing that encouraging patients to ask three simple questions leads clinicians to provide higher quality information about options and their benefits and harms. A range of materials encouraging people to 'Ask 3 Questions' is available for download from the Person-Centred Care Resource Centre.

The CQUIN set out a series of 6 specific actions to embed shared decision making into routine clinical practice:

	Actions to support locally agreed shared decision making CQUIN indicator – embedding SDM into routine clinical practice
1.	Identify 3 clinical pathways where there are treatment choice/options to implement shared decision making
2.	Conduct a survey of patients regarding the experience of their involvement and their perception of the decision process
3.	Education in shared decision making skills – lead clinicians to attend shared decision making advanced skills workshops
4.	Dissemination of the 'Ask 3 questions' patient awareness-raising materials in outpatient clinics
5.	Review with the clinical teams patient information material and support tools to discuss options in the patient pathway
6.	Following the outpatient appointment, or inpatient episode, the clinical record and letters to GP and patient to include details of options discussed with patients, preferences stated and patient values

What we did

1. Identify 3 clinical pathways where there are treatment choice/options to implement shared decision making

The three clinical pathways identified for implementation of shared decision making were:

— Neurology – myasthenia gravis

— Renal services – pre-dialysis

— Critical care – high risk haematology patients with potential for elective ITU admission

2. Conduct a survey or patients regarding the experience of their involvement and their perception of the decision process

Using the shared decision making questionnaire (SDMQ)[2], we undertook an audit of patients' perceived involvement in decisions about their care and treatment for myasthenia gravis and pre-dialysis patients.

The results for both teams indicated that:

— In 96% of cases the clinician discussed the pros and cons for each treatment option

— In 96% of cases the patient was asked what was important to them in making a decision about care or treatment

— In 96% of cases the patient was involved as much as they wanted to be in decisions about their care and treatment

— In all cases (100%) following the consultation, the patient felt more able to understand their illness

It was not feasible to undertake this type of patient experience survey in the critical care group.

3. Education in shared decision making skills

The lead clinicians for these pathways attended the advanced skills in shared decision making workshop (a small component of over 200 staff who have attended training across the Trust) and are appraising their delivery of clinical care to ensure that shared decision making is apparent[3].

4. Dissemination of the 'Ask 3 questions' patient awareness-raising materials in outpatient clinics

The Newcastle team developed a variety of materials to encourage people to play an active role in decisions about their treatment and care – specifically a series of posters and flyers encouraging people to 'Ask 3 Questions'. (A short film also developed to encourage involvement – 'So Just Ask' – could not be used in these clinical specialties as there was no suitable equipment available.)

An environmental audit tool was developed for periodic checking that patient awareness–raising materials are in use and are easily visible to patients in waiting areas and consulting rooms[4].

5. Review with the clinical teams patient information material and support tools to discuss options in the patient pathway

As a result of the review with clinical teams:

— Medication related information was re-drafted for patients with myasthenia gravis and a new decision aid was also produced. All of these documents have been reviewed by 'expert patients' and are used routinely in clinic and are available on the Trust internet.[5]

— The renal team are using the patient decision material published by NHS Right Care, specifically:

- http://sdm.rightcare.nhs.uk/pda/established-kidney-failure/
- http://sdm.rightcare.nhs.uk/pda/established-kidney-failure-dialysis/
- http://sdm.rightcare.nhs.uk/pda/established-kidney-failure-transplant/

Such materials were not suitable for haematology patients due to the extremely individual circumstances of each case. The critical care team hold in-depth discussions with patients following a decision to undergo bone marrow transplant. These discussions relate to the pros and cons of admission to the intensive care unit after the procedure, including the evidence for long-term benefit. The team has also developed a framework for talking to patient's relatives where the patient lacks capacity for decision making.

[2] This questionnaire is available for download from the Health Foundation's Person Centred Care Resource Centre.

[3] Training materials developed by the Newcastle team are available for download from the Health Foundation's Person Centred Care Resource Centre.

[4] The environmental audit tool is available for download from the Health Foundation's Person Centred Care Resource Centre.

[5] A series of materials relating to myasthenia gravis developed by the team for patients is available for download from the Health Foundation's Person Centred Care Resource Centre.

6. Measuring the quality of the consultation

A case note audit tool was developed to review documented consultations and assess whether the core components of shared decision making were included:

— treatment options and their benefits and risks were discussed

— any stated preferences were discussed

— patient's values were elicited.

It was also noted, when a decision was made, whether this was shared, or made by either the patient or clinician alone.

The audit found:

Neurology

An audit of myasthenia gravis outpatient clinic letters to GP and patients was undertaken. In 85% of cases there was written evidence in the patient record that options were discussed. In 80% of cases there was written evidence that the clinician elicited patient values and preferences within the consultation.

Renal services

According to electronic outpatient records, 100% of patients were involved in discussions about the options available to patients at a stage of disease where dialysis is recommended. In 93% of cases, patient's values and preferences were elicited.

Critical care

Audit of the recorded discussion in the clinical notes of critical care, high risk, haematology patients demonstrated that in all cases (100%) there was written evidence that treatment options had been discussed and that patient preferences and values had been elicited.

Conclusion

The locally agreed Shared Decision Making CQUIN indicator has acted as a driver for the organisation to further embed shared decision making into routine clinical practice and to develop tools and measures to verify that the standards set for increased patient involvement and for high quality shared decision making consultations have been met. These standards create a simple framework on which to base implementation project plans and have been well-received by the clinical teams using them.

The case note audit tool has been of interest to the Trust clinical governance and risk department who plan to use a modified version of it routinely for case note audits.

Commissioners agreed that the stated CQUIN indicators had been met and the Trust received payment of the reserved portion of income.

We are aware that other commissioning organisations have become interested in Shared Decision Making CQUIN indicators. South Tyneside NHS Foundation Trust has implemented one for orthopaedics and County Durham and Darlington are participating in one for long term conditions.