

Unit Six

Quality improvement and evaluating practice from a strategic perspective

Key messages

Once you have read this unit, you should have an understanding of:

- *how monitoring clinical governance extends to quality assurance of general practice nurses (GPNs) in general practice*
- *how to facilitate achievement of Standards for Better Health*
- *creating quality benchmark standards*
- *impact of achieving Quality and Outcomes Framework (QoF) targets.*

Primary care trusts (PCTs) have a responsibility to determine that GP practices, acting as independent contractors, are the providers of high-quality care. Clinical governance can be used by the PCT to monitor quality and also to identify the priority areas that need development. The *new General Medical Services (nGMS) contract*¹ has emphasised the importance of measuring quality care for patients with long-term conditions by introducing the *QoF*. This represents a new systematic examination of general practice services and standards of care. There are many ways that PCTs can seek assurance of quality standards within general practice settings in a non-threatening and facilitative way.

QoF 19 separate indicators 825 points

Tool – Examples of evaluation a PCT commissioner might carry out

What clinical governance can do

The National Primary Care Research and Development Centre² have described the evidence about the effectiveness of clinical governance programmes on quality improvements. Improving quality of care needs a range of approaches in order to be effective, and PCTs have clearly taken this on board. Many PCTs have placed emphasis on professional education and development as the main activities to promote clinical governance, and consciously attempted to win the trust of GPs. In parallel, they have established methods of dealing with poor performance.

GMS Requirement 21

In several areas, particularly long-term conditions management, there is evidence that systematic improvements have occurred. Although there is no evidence to link this directly to the work of GPNs, this seems highly likely, as many GPNs have taken on the routine management relating to long-term conditions.

General practice has become more transparent. GPs have become more willing to share data about their clinical activities, both with each other and with local NHS managers. GPNs have often been the key tool in enabling this to happen. As GPNs often take their professional leadership from the PCT, they have engaged more readily with the PCT and not perpetuated the 'us and them' culture.

Financial rewards for practices are now dependent on the good functioning of the team in meeting evidence-based quality indicators in key clinical and organisational areas of the *QoF*. Since the introduction of the *QoF*, general practices have achieved high clinical quality scores. Many of the improvements gained have been achieved by GPNs undertaking more systematic long-term conditions management. It is therefore important to consider how the quality of care delivered by GPNs can continue to improve. One way of ensuring consistently high standards is to consider GPN care under the seven pillars of clinical governance³ that underpin the Healthcare Commission's *Standards for Better Health*.⁴

The seven pillars of clinical governance

1. Risk management

PCT staff with clinical governance responsibility are required to undertake regular (although not necessarily frequent) visits to discuss practice performance in keeping with *nGMS*. These visits provide opportunities to link more closely with GPNs. GPNs are an invaluable resource within PCTs to improve patient experience. As PCTs have ultimate responsibility for patient safety, they therefore have a share in the responsibility for the performance of GPNs. One way in which to engage GPNs more meaningfully with PCTs could be through the facilitation of clinical supervision.

Clinical supervision is a formal process of professional support and learning that can enable GPNs to develop knowledge and competence, assume responsibility for their own practice and minimise patient risk. It should be undertaken as part of a GPN's educational and personal development. However, clinical supervision does not replace the normal managerial supervision of GPNs in the work place. Assessment of competence therefore remains the responsibility of the practice. Practice can be enhanced by encouraging an analysis of practice and promoting learning through experience.

The Nursing and Midwifery Council (NMC) believes that clinical supervision is best developed at local level in accordance with local needs. The *nGMS contract* (section 4.20) states that 'all practice-employed nurses should be supported to participate in clinical supervision and appraisal.' This is an area of support that could be developed by a PCT, either in conjunction with other community nurses – to improve integration, or as a single-disciplinary event that helps to strengthen the PCT's understanding of general practice nursing. See

Tool – Clinical supervision: how and why?

Example from Horden group practice (Durham) – clinical supervision in practice

'Monthly practice nurse meetings and clinical supervision sessions are sponsored by the PCT. Payment is made for time spent attending these meetings.'

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2. Clinical effectiveness

GPNs do not have the nursing management structures that other community nurses have. This means they are more at risk of professional isolation, which puts the 'currency' of their practice at potential risk. In order to minimise this risk, a PCT can be proactive in making the latest guidelines and protocols available to GPNs. Encouraging work according to protocols creates better consistency of care and, providing the protocols are firmly grounded in evidence, also strengthens quality of care.

Set up a meeting for GPNs to look at national and local guidelines, and protocols specific to prominent areas of clinical care. It may be appropriate to begin with guidelines surrounding chronic disease management highlighted in the QoF.⁵ Go through as many practice or PCT protocols as you can and make sure that they are linked to national guidelines or based on robust evidence. Keep all the policies together and arrange for GPNs to have central access to them – this will be easier if they are electronic versions. The PCT could create regular workshops to update protocols relating to general practice nursing.

See *Tool – Using protocols, standards, policies and guidelines to enhance confidence and career development*

See www.equip.ac.uk/practiceManagement/docs/protocols/protocols.htm for examples of over 100 protocols for use in general practice.

Facilitating GPN forums can also be a valuable way of gaining insight into GPN practice. This can help to improve clinical effectiveness through the sharing of ideas and information. GPNs are disadvantaged compared with their community nursing colleagues, who have regular staff meetings where nursing related issues are discussed. PCTs who have already set up systems for GPN meetings may find that as it becomes better established and the benefits begin to emerge, it is easier to encourage practices to give staff time off to attend. However, if you do not have such a scheme in your PCT, you could still work with the practices to encourage networking between GPNs. See *Tool – Setting up a GPN forum*.

Using comparative data across a number of practices, collected by the PCT, can be a way of establishing quality and suggesting where improvements can be made. Sharing this information in GPN forums could be an excellent way of helping to define standards, although it is important to respect the confidentiality of the practices. The results can be coded so that each practice knows what their individual results are, but all the others are given a code letter or number. This should be agreed in advance in order to encourage practices to participate.

Practices like to know whether they are above or below the average for the PCT. For example, if a practice is below average, it can be a powerful motive for change. However, if a practice is average or above, they will probably still want to improve. When giving feedback to practices, you need to highlight where a practice has scored well compared with the other practices in the audit. The practice also needs to think about any poor scores and consider why this has happened. For criteria where the average result is particularly low, obtain the GPN's perspective to see if there are underlying reasons for this.

If you identify a general problem in many practices, this may be best tackled by the PCT itself rather than individual practices. This indicates the value of benchmarking against results from other PCTs, which can be used to give an overall feel of the performance compared with others outside the area, or even nationally, as appropriate. If the problem is linked to nurse-managed care, then a training-needs analysis may be particularly useful to highlight underlying skills. See *Tool – Conducting a training-needs analysis* and

Tool – Training-needs analysis of GPNs – evaluation by the PCT

Another advantage of obtaining comparative data is that you can identify those practices that are performing particularly well.

Lessons may be learnt from the better practices by sharing their ideas. If results from nurse-led clinics show significant differences it may be worth approaching the GPN with the high-quality results to see if there is some reason for this. If it turns out that the GPN is particularly skilled or well-educated within a certain area, then consider whether they could be used as a mentor for this specialist area.

For practices, comparing their own data with that from other practices can provide a competitive element that sharpens practice and improves standards.

QoF Education 8
3 points

3. Education, training and continuing professional development

If PCTs can assist with continuing professional development (CPD) for GPNs, they will be well placed to gain assurance of the quality standards and procedures within general practice. Strengthening the links between PCTs and GPNs will help GPNs to gain a sense of where their professional leadership lies.

See [Tool – Support and development of GPNs – evaluation by the PCT](#) to consider how supportive the relationship between the PCT and GPNs is perceived to be.

Educational multidisciplinary meetings

Joint educational multidisciplinary meetings between practices are now occurring more frequently and are to be encouraged by the PCT. This sharing of information and learning represents a major cultural shift and will help to avoid professional isolation for GPNs. The PCT could invest in this by providing locum cover in order to create protected learning time for practices to engage in CPD.

GPNs have sometimes struggled to be released from the practice to attend educational events or courses. The *nGMS contract* clearly states that practices should be committed to developing their staff.¹ The PCT should therefore check that GPNs are no longer finding release problematic – they could also be proactive in facilitating release of GPNs by developing a bank of locum GPNs. One major advantage to this would be that the PCT could be assured of the competence of locums by insisting that these bank GPNs attended a basic introductory course for general practice nursing that provided evidence of their clinical competence.

See [Tool – Creating a bank of locum GPNs](#) to consider various ways of making a locum GPN service available to practices.

QoF Education 4
3 points

Induction programmes

Assistance from the PCT in setting up comprehensive induction programmes for GPNs will also be useful in providing quality assurance. A baseline set of competences could then be assured if all new GPNs had to complete a competence document linked to the induction programme. Rather than relying on the fact that there may be induction programmes in place within individual practices, PCTs should evaluate how effective these are. See [Tool – Sample induction programme](#) to determine whether or not the induction programme provided by the practice is as comprehensive as it should be.

See [Tool – Sample induction programme](#) to ensure all appropriate components are included within the induction programme. If a competence file is commenced alongside this, GPNs can continue to add to it, providing a safe record as to what a particular GPN can and cannot do.

It is also important to consider the induction needs of locum GPNs who provide cover across other practices and need familiarisation with new systems and practices to minimise patient risk. See

[Tool – Modified induction for locum GPNs](#).

PCTs are well placed to identify and train GPN mentors who could then act as assessors of competence if required.

QoF Education 8
3 points

Appraisal

Appraisal is another essential part of CPD that PCTs may be able to provide assistance with. Although this should be conducted annually, nurses may find it helpful to have additional, less formal, reviews more frequently. The PCT could keep records to signify when GPN appraisals are due and then approach the practice to see if they require assistance or advice in arranging this. As the role of appraiser involves skills in feedback and identification of objectives, practices may benefit from training in this sphere. PCTs could also check with GPNs that a personal development plan (PDP) has been developed in response to the appraisal.

Although the following tools have been designed for practices to use, they may also be useful for the PCT.

See [Tool – How to give constructive feedback: being an effective appraiser](#),

[Tool – Documentation for appraisals – using an action plan](#) and [Tool – Creating a personal development plan](#).

Peer review

PCTs may want to promote peer review of performance to inform GPNs about their skills in dealing with patients. This is a non-threatening and pragmatic way of learning more about individual style, in order to see what improvements can be made.

[Tool – Using peer review to improve practice](#)

4. Use of information

The information highway means that it is easy for practice staff to keep up-to-date. Connecting for Health promises some fantastic opportunities for the future with the advent of electronic patient records.⁶ Over the next 10 years, the national programme for information technology (IT) in the NHS will connect more than 30,000 GPs in England to almost 300 hospitals. General practices have introduced computerisation at a varied pace, but it is now viewed as an essential tool to improve efficiency of care.

Since PCTs rely on the accuracy of information from practices, they should check that all staff entering information about patients are using defined Read codes. They must also have been adequately trained in the correct categorisation for various clinical conditions. This makes auditing and categorising information much easier and is therefore essential for assessing whether the practice has met QoF targets.

Decision-making support software such as PRODIGY⁷ can be valuable in ensuring consistency of care by GPNs and GPs. Consideration should be given as to whether GPNs are enabled to use this within consultations or as a learning tool. In addition, it is important for the PCT to ascertain that GPNs can use (and have access to) IT to access evidence-based information for patient management. If using electronic patient records, GPNs should ensure that all care plans are individualised and alert systems put in place to identify particular areas or needs.

PCTs could provide training in IT systems and the implementation of the Caldicott guidelines to GPNs using their IT departments.

5. Staffing and staff management

The *nGMS contract*¹ refers to improved human resources (HR) services for staff, including entitlement to all NHS conditions and initiatives to improve working lives. See **Unit: *Employment of general practice nurses*** for further information on HR.

Even in small practices, it is still important to have clearly identifiable lines of managerial responsibility of GPNs. This will both ensure staff feel clear about their position and facilitate performance management. Senior-level GPNs may also act as line managers for junior staff or health care assistants (HCAs), if the practice feels this is appropriate and if staff are willing to take on the required training and preparation. The PCT could provide or advise on training for leadership and managerial skills, and perhaps invite GPNs to join nursing management or strategy groups.

The *nGMS contract*¹ includes directives to improve HR practice, including staff development and *Improving Working Lives* initiatives. The PCT can help practices with good employment practice⁸ by facilitating the adoption of the *Agenda for Change*, creating standardised job descriptions, person specifications and appraisal templates, as well as providing pre-employment checks and evaluating whether or not current employment practice is as good as the practice would wish for.

Use **Tool – Employment – evaluation by a practice employer** to consider whether or not the GPN job description provides an accurate reflection of the role and if terms and conditions are fair or attractive.

General practice is all about teamwork, and the practice will be unable to provide optimal quality services for patients if it does not function well as a team. Facilitating team away-days for practices may be a useful way for the PCT to engage with practices in a non-threatening manner and encourage the appropriate use of skill-mix and workforce planning.

Example from Thistlemoor medical practice (Peterborough) – emphasis on team working in practice

'We believe that role redesign and delegation cannot be successful if the whole team is not working as one. We recognise the importance of communicating with staff as a means of empowering them and engaging them in change. Therefore, for the past 4 years, we have met twice a week with staff – one of these is a clinical meeting, where we discuss clinical protocols, make practice formulary changes, discuss interesting or significant events, and discuss risk management issues, which we use for in-house training, presentations, etc. The other is a staff meeting, where we decide on practice policies, training issues, significant events, issues to do with running of the practice, and so on. Everyone is encouraged to participate and once decisions are made, they are operational with immediate effect. Attendance at these meetings is compulsory and overtime is paid to those who come in specially to attend. Contributions from staff members are recognised and good ideas are rewarded. It encourages systems thinking, teaching people to reintegrate activities to see how what they do is interconnected with what others do.'

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Although the following tools have been designed for practices to use, they may be useful for the PCT to consider and disseminate. See the following tools *Tool – Team work – how well is your team functioning?* and

Tool – Is your practice a good place to work?

Example from Horden group practice (Durham) – encouraging practice teams to highlight their strengths and weaknesses together

'The practice annually carries out a multidisciplinary SCOT (Strengths, Challenges, Opportunities, Threats) analysis, from which evolves the practice development plan. This in turn highlights PDPs, which are further explored during annual appraisal meetings. By involving the whole practice team (including staff connected to the practice) in how the practice should develop, you will attain a greater diversity of insight into the services that can and need to be developed for both patient and staff satisfaction.

The areas highlighted for the next 3 years include development of a weight-management service, which will be run jointly by a practice nurse and HCA. There will also be further skill development for HCAs to undertake spirometry and ear syringing, as well as additional training in chronic disease management for new staff members, to support the existing service. Our community nurse is currently undertaking her clinical skills training.'

For more information contact Angela Fisher (Practice Development Manager) at: angela.fisher@GP-A83044.nhs.uk.

Quality team development programmes

The PCT has a role to play in establishing quality improvement programmes, such as the Royal College of General Practitioners (RCGP) quality team development (QTD) programme.⁹ PCTs will need to demonstrate improvements against the developmental standards outlined in *Standards for Better Health*,⁴ and QTD will help to do this. In some areas, the programme has been initiated in the whole of a PCT area. QTD uses self-assessment, patient questionnaires and peer review to enable practices to reflect on the quality of service they offer to patients and on how they work together as a team. The process is cyclical, with the practice self-assessment, patient questionnaire, visit and development plan stages being repeated every 2–3 years.

Tool – Quality team development – for practice teams

Quality practice awards

Quality practice awards (QPA) can be encouraged to demonstrate high standards of quality within practices. This is an accredited quality-assurance system devised for practice teams by the RCGP⁹ and is supported by nursing and midwifery organisations.^{10,11} It uses a system of external peer review, with written standards, designed to assess the quality of an activity, service or organisation. It is considered a high-level quality assurance scheme for practice teams that also promotes the clinical and educational development of team members.

QPA has benefits for all members of the practice team who participate in the process. As a result of going through the process as a team, staff report:

- *better team working*
- *improved communication*
- *reduced duplication of effort*
- *increased understanding of each other's roles.*

In order for practices to demonstrate that they are working towards quality enhancement, one of the many quality tools used within business management may be useful. The following tools are well accepted as good standards of quality management. See **Tool – Quality tools from business: total quality management** and **Tool – Quality tools from business: investors in people** for further information.

If the practice is striving hard to achieve quality care from all angles, it is anticipated that the retention of staff will not be problematic. However, there will always be times when staff decide to leave. The reasons for staff departure should always be ascertained and this can be most accurately determined by introducing exit questionnaires (or interviews) as standard practice. This provides an excellent opportunity for staff to 'tell it how it is' and provide the PCT with information that can be fed back to the practice.

Tool – Using exit questionnaires: how and why?

QoF Cytology CS6
2 points

6. Clinical audit

Any evaluation should be approached by setting out measurable targets that are realistic for particular issues relating to GPN posts. In order to be meaningful, evaluation should be conducted with colleagues from general practices, rather than as a separate entity.

Audit is now well established within general practice as a reliable way of determining if the services delivered are effective. Audit information forms the basis of the QoF, and can therefore be considered as an integral part of the GPN role. Some GPNs may be fearful of audit so will need to be assured that it need not be either complex or time-consuming. **Tool – How to undertake an audit**

As well as undertaking audit it is beneficial to review the process. **Tool – Judge how well you have performed an audit** allows you to check whether or not your audit has been as thorough as possible.

Another way of ensuring that best practice is measured is to use the benchmarking process outlined in *Essence of Care*.¹² **Tool – Essence of Care benchmarking**

QoF PE2, PE5, PE6
75 points

7. Patient/service user and public involvement

Sharing information with the public is slowly gaining acceptance, and has been further encouraged within *Our Health, Our Care, Our Say*.³ Information sharing should now be a part of the PCT's strategies. The intention is to involve and consult patients and the general public about key issues within the NHS, such as planning health care services, identifying local needs and priorities, and evaluating the quality of services from a patient-satisfaction perspective.

QoF Education 6
3 points

The PCT can also disseminate information to GPNs regarding the things that matter to patients in general practice, as obtained from the Department of Health's *National Survey of NHS Patients: General Practice*.¹⁴ This survey covers a wide range of issues, including access, waiting times, views of GPs and GPNs, and the quality and range of services in general practice.

Instead of relying on anecdotal evidence or waiting for complaints to arrive, the PCT could be proactive in assessing patients' satisfaction with the care delivered by GPNs. This would be particularly important where practices have changed their working style to include more nurse-led services.

See **Tool – Patient experience of care provided by a GPN – evaluation by a patient** to verify how patients feel about care delivered by a GPN.

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