

Unit Eight

Quality improvement from a PCT's perspective

Key messages

Reading this unit will:

- explain how PCTs can use clinical governance to build a quality improvement culture in general practice
- describe quality improvement methods that PCTs can introduce to their practices.

Clinical governance can be used by the PCT to identify the priority areas for development. Clinical governance can be used not only to monitor issues of quality, but also to help with improvements (see Box: *Clinical governance – the strategic context*). **Unit 8: Quality improvement** gives a general overview about clinical governance.

Until recently, general practices had not systematically examined the quality of their services and the standards of care that they provide – however, many practices had been performing audit and improvement programmes.

Example: Clinical governance – the strategic context

Southwark PCT has established a clinical governance department to support teams and individuals to constantly improve the quality of their services, and to reduce any risks to patients and staff. During 2003–2004, the team was expanded as part of the reorganisation of the clinical leadership and quality directorate. Strategically, the clinical governance team has been involved in two major exercises: the clinical governance survey for community teams and general practices, and a self-assessment of clinical governance systems and processes. This work has informed the clinical governance programme for 2004–2005 and the surveys will form the basis of local clinical governance development plans.

What clinical governance can do

The National Primary Care Research and Development Centre have described the evidence about the effectiveness of clinical governance programmes on quality improvements.¹ They reported that PCTs had introduced a wide range of new local approaches to quality improvement. These included guidelines, incentives, educational events, benchmarking, feedback to practices and patient surveys.

Past research had shown that improving quality of care needed a range of approaches in order to be effective so the PCTs had clearly taken this on board. PCTs emphasised professional education and development as the main activities to promote clinical governance, and consciously attempted to win GPs' trust. In parallel, they established methods for dealing with poor performance. Other areas reported on included those detailed overleaf.

- **PCTs set up organisational structures to support clinical governance.** Lay influence was very limited in these structures and PCTs have not solved the problem of how to involve users in promoting quality improvement.
- **PCTs set up their own local medical networks and leadership was provided by the GP or nurse responsible for clinical governance.** Leaders were also generally appointed with responsibilities for particular areas (eg coronary heart disease, mental health). Clinical leads had more influence on practices than PCT managers.
- **Local clinical governance leads relied heavily on persuasion and expertise or 'soft' leadership.** There were three types:
 1. the first was the argument that patients would benefit because the National Service Frameworks and other recent quality standards were soundly evidence based
 2. GPs perceived the new quality standards as being promoted by fellow doctors who were making the best of a difficult situation
 3. the third form of persuasion was an appeal to professional autonomy. The willingness of PCT managers to intervene to implement national standards was important background to this approach, and the Bristol and Shipman cases enabled local medical leaders to argue that unless GPs adopted evidence-based practice, voluntarily, government or NHS management would intervene more directly.
- **Developments in quality improvement in most PCTs were led by small groups of practices and the majority followed these 'early innovators'.** In most PCTs, a minority of practices either found the PCT's approach too limited or preferred to implement clinical governance in their own way. In some of the topics addressed, eg giving priority to coronary heart disease, there was remarkable unanimity among GPs considering how independently minded they normally are. This shows the importance of aligning management priorities with aspects of care that clinicians regard as important. The failure of health promotion clinics in the early 1990s is an example of this going wrong.
- **In a number of areas, especially the management of long-term conditions, there is evidence that systematic improvements have occurred.** PCTs have also developed mechanisms for identifying poor performance, though it is less clear whether effective mechanisms to address identified problems have been developed yet.
- **General practice has become more transparent.** GPs have become more willing to share data about their clinical activities with both each other and local NHS managers. Joint educational meetings between practices have also become commonplace. These are major cultural shifts. Sharing information with the public is also slowly gaining acceptance and becoming a part of PCTs' strategies. For practices, comparing their own data with that from other practices ('benchmarking') has become a surrogate for competition and a means of promoting change within their own practices.
- **PCT staff with clinical governance responsibility undertake regular (though not necessarily frequent) visits to discuss practice performance.** These visits were not always welcome. Furthermore, there was a tension between approaches designed to help practices improve quality and the need of the NHS to achieve greater managerial control. This tension will not be reduced by the annual inspection visits that are needed to ensure that payments have been appropriately claimed under the quality and outcomes framework (QOF). There is an argument for separating the 'supporting' from the 'inspecting' functions that PCTs now undertake.
- **PCTs used Personal Medical Services (PMS) contracts as a means of improving quality of care.** These examples were most successful where the sites had clear objectives and where resources were clearly targeted to meet those objectives. Improvement was also more likely to occur where there was clear leadership (in both practices and PCTs), and where there were changes in the roles and responsibilities of staff within practices. Using comparative data

Using comparative data

Comparative data collected by the PCT across a number of practices can be a way of establishing quality and suggesting where improvements might be made. It is important to respect the confidentiality of the practices. This can be achieved by coding the results so that each practice knows which are their individual results, but all the others are given a code letter or number. This should be agreed in advance or some practices may not wish to be included.

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 motivator for change. However, if a practice is average or above, they will probably still want to improve. When giving feedback to practices, it is important to highlight where a practice has scored well compared with the other practices in the audit. However, the practice also needs to consider any poor scores and understand why this has happened.

It is also important to reflect on any criteria where the average result is particularly low. This might show that there is a general problem in many practices. Even an above-average practice score may still indicate sub-optimal performance. This type of problem may need to be tackled by the PCT itself, rather than by 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 of the area, or even nationally, as appropriate.

Another advantage with comparative data is that good practices can be identified. Lessons may be learnt from the better practices by sharing their ideas. If the audit was piloted with one or two practices, these practices may have already dealt with some of the problems being faced by the PCT as a whole.

Quality Team Development Programme

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*.² PCTs will need to demonstrate improvements against the developmental standards outlined in *Standards for Better Health*³ and QTD will help with this process. 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. This enables practice teams to identify areas of good practice, as well as areas for improvement. It also allows development priorities to be identified. The process is cyclical, with the practice self assessment, patient questionnaire, visit and development plan stages being repeated every 2–3 years. Further information and a registration form for PCTs can be found on the RCGP website (see [Tool – Quality Team Development – for practice teams](#)).

Assessors (GPs, nurses and managers) are trained by the RCGP, and give verbal feedback and a structured written assessment within 6 weeks of the visit. A major advantage of this programme is that it is developmental and linked to the criteria in the QOF so is not seen as judgmental, but formative. In an evaluation of the programme,⁴ several practices had introduced formal and systematic planning procedures for the first time as part of their QTD activity. The programme helped PCTs to prioritise the use of scarce resources. PCTs also commented that QTD has been beneficial in implementing national policies on clinical quality and modernisation. Ideas for improving practices evolved through contact with the practice and interchange of information.

Quality Practice Award

PCTs could also support and encourage the Quality Practice Award (QPA) programme in which general practices take approximately 2 years to meet certain criteria of excellence set by the RCGP (see [Tool – Quality Practice Award](#)). The QPA is a quality assurance process undertaken by GP practices, which recognises a high standard of quality patient care delivered by every member of the practice team. The team is assessed on a number of criteria, including clinical care, health promotion and continuity of care.

Assessors visit the practice to interview the team and make recommendations for continuing improvement. Not all practices will be willing, or able, to invest their time and effort into demonstrating their excellence against externally set criteria. However, Greater Glasgow NHS Board⁵ reported that 92% of practices had either achieved, or were working towards, the award as part of their initiative on

access. A developmental programme such as the QTD programme is likely to be generally applicable, even to those practices who see themselves as late adopters of change.

Promoting quality through collaboration

Collaborative teams that tackle specific tasks that require improvement have been shown to be effective. They need organisation from a body such as the PCT, and funding for facilitation and expert advice. Research has shown that suggested collaborative teams⁶:

- *require the participation of a number of multiprofessional teams with a commitment to improving services within a specific subject area and to sharing with others how they made their improvements*
- *focus on a clinical or administrative subject, eg waiting times and delays or improving asthma care*
- *evidence of large variations in care, or of gaps between best and current practice*
- *enable participants to learn from experts about the evidence for improvement, about change concepts and practical changes that have worked at other sites, and about quality improvement methods*
- *use a change testing method to plan, implement and evaluate many small changes in quick succession*
- *set measurable targets and collect data to track their performance*
- *result from participants meeting at least twice, usually more, for 1–3 days to learn the methods, report their changes and results, share experiences, and consider how to spread their innovations to other services*
- *exchange ideas between participants and use collaborative organisers to provide extra support, sometimes through visiting facilitators, email, and conference calls.*

In order to minimise much of the investigative work involved in a traditional quality project, it is important that the team in a collaborative are given all the evidence of a previously identified problem and the ideas about what change is required. They should also be given expert support. The benefit of this approach is that the team will have peer stimulus that might not otherwise have been available.

Other quality initiatives derived from business practice include Total Quality Management

see [Tool – Quality Tools from Business – Total Quality Management](#) and Investors in people see

[Tool – Quality Tools from Business – Investors in People](#). Most of the evaluation exercises and tools in [Unit 9: Completing the cycle – evaluation](#) can also be used to promote quality.

Summary

- *PCTs can use clinical governance to build a wider approach to quality improvement in general practice.*
- *PCTs have a role to play in helping practices to compare their performance with that of their peers.*
- *There are a number of quality improvement methods that can be employed and some of them are specifically tailored to general practice.*

References

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