In Chapter 4, we established that there is room for improvement in the quality of care currently provided by general practice in England. While most general practice professionals are committed to providing a high-quality service to their patients, quality improvement is not embedded in every practice.

There has been an increasing focus on quality improvement in recent years, greater availability and sharing of data and information, and various forms of peer review of practice as a result of organisational changes, such as practice-based commissioning and new federated models of working. General practices are also making greater use of evidence-based clinical guidelines and decision-support aids (such as the Map of Medicine). The QOF has demonstrated that general practice is prepared to change the nature of the care it provides in order to meet quality targets – for example, by making good use of practice nurses, investing in information technology, and employing ‘QOF leads’ to ensure targets are met (Dixon et al 2010).

However, the inquiry believes that if general practice is to improve the safety, experience and outcomes for all those whom it cares for – including those who directly access services in general practice and those who access services beyond general practice but for whom the practice is ultimately responsible (Batalden and Davidoff 2007), then general practice must make quality improvement intrinsic to its everyday activities.

In this chapter, we discuss what can be done to foster a culture within general practice that supports quality improvement. In particular, we examine how general practice can be more proactive in the use of data and information to support improvements in quality. The chapter draws on work commissioned by the GP inquiry (Dawda et al 2010) and discussions at an expert seminar hosted by The King’s Fund in July 2010 on quality improvement in general practice. The chapter includes examples of local initiatives to improve quality.

Developing an environment for quality improvement requires action at many different levels. Policy-makers, regulators and commissioners all have roles to play in facilitating quality improvement. The chapter begins by focusing on what can be done within a general practice. It then discusses how external actors (such as regulators, commissioners and professional bodies) can create an environment that predisposes, enables and, ultimately, reinforces the adoption of quality improvement in general practice.

Supporting quality improvement from within general practice

General practice can provide an environment that supports quality improvement by addressing a range of factors, including:

- culture
- leadership
- collaboration and teamwork
- data and information tools
improvement skills
- incentives
- time.

This section looks at each of these in turn.

Culture

Attitudes

The introduction of medical audit and a shift to evidence-based medicine, coupled with contractual changes over the past 20 years, have raised awareness of the need to improve quality in general practice. However, some GPs remain ambivalent about further advances in assessing and improving quality – and particularly about the idea that they should continually and proactively seek new opportunities to improve. This attitude is expressed to those delivering training in improvement in general practice, and features in the medical press (Gillam 2010).

Lack of a systems mindset

Quality from a clinical perspective has traditionally been influenced by the ‘craft-based’ model that regards health care as an enterprise shaped chiefly by well-trained and highly autonomous clinicians, with individual performance and decision-making being the main determinant of quality and patient outcomes. The structure of general practice means that many GPs work in a degree of isolation from their peers, so perpetuating the view of doctors as ‘autonomous artisans’ (Bohmer 2010).

Indeed, much of general practice in England might be characterised as being a ‘cottage industry’ in need of modernisation (Swensen et al 2010), since the individualistic mentality is at odds with most improvement methods that employ systems-based approaches to learning, delivering and shaping care.

Resistance to management theory

There are a range of approaches and tools to support quality improvement and the management of change. They include Lean Manufacturing, Six Sigma and the Model for Improvement. Each of these frameworks has a unique focus, and addresses slightly different problems, but they all seek to help staff with the challenge of translating evidence and/or innovation into practice in a reliable and efficient manner. Organisations often adopt aspects of more than one framework in their quality improvement endeavours.

For many GPs, quality improvement is seen as belonging to the domain of the professional manager, and is pejoratively referred to as ‘management speak’. This view is reflected by Richard Smith (1990), who states that descriptions of the principles and processes employed in improvement ‘may sound annoyingly theoretical’. Those working in general practice need to be engaged with quality improvement and identify with it as something they relate to. This requires a shift in the mindset and culture of general practice to one that views quality as a high priority, and in which every member of staff sees delivering and improving quality as a core part of their job. GPs and other staff are more likely to be persuaded by their trusted colleagues.

Vision

Quality improvement approaches provide tools for sustainable improvement in structures and processes of care, but they do not determine what the goals of improvement should
be. Practices, federations and consortia will therefore need to agree a clear vision and strategy to guide their improvement efforts. This would be the basis for determining priorities for improvement and then aligning structures, capacity and skills with those (Dawda et al 2010).

There is a need to nurture and support a culture of professionalism within general practice that is open and self-reflective – a culture in which self-audit and critical examination of practice among peers is the norm. There needs to be a culture of continuous quality improvement, with a commitment to seek information to understand practice performance and learn from high-performing practices. The development of GP commissioning consortia and larger provider organisations (such as federations) may create an environment that is conducive to quality improvement, including a local culture of peer review, accountability and support. Giving GPs more responsibility for evaluating and shaping health services may also predispose them to consider new approaches to quality improvement.

Leadership

If team members are to embrace change, their practice leaders must have a demonstrable commitment to quality improvement. These leaders will need to:

- deliberately and explicitly embrace an ethos of putting patients first and seeking to provide excellent care
- involve every member of staff in the mission of continually improving care
- value and incorporate patients in measuring and improving their care.

The Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement/Academy of Medical Royal Colleges 2010) clearly articulates the general leadership qualities that GP leaders need.

There is also a need to develop leadership skills that enable GP leaders to balance their role in supporting colleagues with the need to challenge them. The inquiry recognises that quality improvement in general practice requires knowledge that can be derived only from detailed understanding of the work of practices and the populations they serve. As such, peer challenge within and between practices is an important means of improving the quality of care. Yet it is often argued that doctors who choose a career in general practice frequently do so because of the autonomy of family doctors and their relative freedom from oversight and scrutiny.

Much hinges on the willingness of GP leaders to build effective relationships, to engage in difficult conversations with their peers, and to challenge, for example, unwarranted variations in practice or outcomes. The hope is that pressure from respected and credible peers will be a more effective means of improving performance than previous approaches. Evidence from previous approaches to GP-led commissioning (including the most recent practice-based commissioning schemes) underscores the need for credible and respected leaders who the local GP community is willing to follow.

The evidence would suggest that GP commissioning might lead to improved communication between general practices where relationships are good, but that it might equally inflame existing tensions where such relationships have not been developed (Curry et al 2008). Overall, history tells us that empowering general practice to take an active and innovative role in commissioning has tended not to stretch beyond a minority of enthusiasts.

Leaders of commissioning consortia will need a set of skills and capabilities that may differ from those required in leading provider organisations. There are likely to be a set of
specific commissioning skills that GPs working in consortia will either need themselves or will have to buy in. Moreover, the GP consortia themselves will need support to develop a wide range of new skills – in leadership, commissioning, management and finance – if general practice is to grasp the opportunity ‘to work with community leaders and their local authorities to take the reins and steer their local services to improve quality standards and outcomes’ (Department of Health 2010c).

Collaboration and teamwork

Building relationships within a practice is critical to quality improvement. As we saw in Chapter 2, general practice is increasingly a team-based activity, but GPs are commonly the owner–managers of the business. As such, they tend to shape and/or approve decisions about how a general practice is run. The lack of other professionals in leadership roles in general practice can create barriers to involving the whole team in quality improvement. Doctor-dependent cultures can stifle improvement (Lawrence and Packwood 1996; Baker et al 1995). Meanwhile, non-GP members of the practice team who are unused to being involved in planning or assessing improvement can be anxious about assuming greater responsibilities (Baker et al 1995). However, the evidence from experience suggests that collaboration and teamwork is critical in taking quality improvement forward in general practice (Dawda et al 2010).

Quality improvement flourishes best in a culture that promotes the engagement and empowerment of all staff in:

- measuring, understanding and improving quality
- accountability for improving, employing openness about performance and variability and incorporating rewards and penalties
- continual rather than periodic improvement, where improvement contributes to the ‘fabric of the practice’ and is a part of every person’s working day.

An example of team involvement in quality improvement is presented in the box below.

**Case study: Team involvement**

A six-partner practice felt that it needed to improve the contribution of its office staff to quality improvement. The practice felt that these staff would be a rich resource of ideas and contributory actions for the improvement efforts, but found them hard to engage. As a small-scale test of change, they put a staff suggestion box in the office. Several cards appeared in the box, but most were simply venting frustrations. Nothing much more happened.

As a second test, they added a section to the suggestion form asking for ideas for changes that would reduce the frustrations. There were more responses and several useful ideas for improvements. However, none of the office staff then acted on these ideas, as they felt they did not have the authority to do so.

The practice then provided staff with some training in the Plan/Do/Study/Act (PDSA) methodology. They were encouraged to operate the suggestion box within the office environment and were empowered to make small-scale changes and test them as they felt appropriate. This soon led to several ideas that were made mainstream, and led to improvements in quality.

Following the initiative, in appraisals staff said they felt more motivated, proud of the changes they had made, and more included in the way the practice was run.

Source: Adapted from Dawda et al (2010)
Improving the quality of care in general practice

Using data to support high-quality care

In Chapter 3 we looked in detail at what the inquiry has learned about measuring quality in general practice, and our analysis in Chapter 4 shows the potential to use routine data to benchmark practices, highlight variations in performance and suggest areas for quality improvement. Here, we look at how this data can be used within practices to support quality improvement.

Quality measures are an important element in driving improvements in general practice, and can be used in a number of ways – for example:

- to enable patients to choose their general practice on the basis of comparative performance measures, thereby incentivising GPs to improve quality in order to attract patients (and income)
- to motivate the intrinsic professionalism of GPs and general practice professionals to aspire and reach improved standards of care
- to challenge the reputation of general practices through benchmarking their performance against their peers, driving a desire to protect or improve their reputations relative to others (Berwick et al 2003).

Most approaches to quality improvement require information and data to evaluate needs and opportunities to refine solutions and monitor outcomes. While there has been an increase in the amount of performance data collected about general practice, general practice still does not routinely and proactively use this data to support quality improvement (Dawda et al 2010).

We now consider four tools for quality improvement:

- point-of-care prompts
- predictive risk modelling
- benchmarking and peer review
- patient surveys and feedback.

Point-of-care prompts

Data tools are now available that enable care to be more proactive and anticipatory. Many of the IT systems in use in general practice incorporate point-of-care prompts and decision-support software. QOF has driven the development of point-of-care alerts that notify clinicians, during clinical consultations, where an activity rewarded in QOF has not been delivered. The possibility exists to use similar prompts for locally identified priorities and to identify gaps in care – for example, where a patient with a particular diagnosis is not receiving all of the recommended care in line with clinical standards.

Existing GP medical record systems could be adapted, through the use of templates, to embed evidence-based clinical standards into clinical practice. For example, Map of Medicine guidelines could be incorporated into EMIS templates. These could also be used to improve the quality of referral information. For example, GPs could be required to complete all fields of the template before referral, incorporating the template into the referral letter and providing an agreed minimum set of information to the receiving specialist.

By linking the data with Hospital Episode Statistics, it is possible to identify gaps in care where a presentation in one part of the system indicates an underlying health condition that may not be being proactively managed in general practices. For example, it might identify a patient who attended A&E with an asthma attack but who is not currently being prescribed a preventive inhaler.
Practices need to make full use of clinical decision-support tools in order to reduce variation that is caused by not practising in line with evidence-based guidelines. However, clinicians must be able to use decision support appropriately so that it does not reduce the consultation with the patient to a series of mechanistic prompts and responses.

**Predictive risk modelling**

Predictive risk modelling uses statistical techniques to identify individuals at risk of ill health in the future, based on their past medical history and use of health services. Data from general practice and from hospital outpatient, inpatient and A&E departments, as well as potentially also pharmacy and social care data, can be combined to predict the risk of an emergency hospital admission during the following year (Wennberg et al 2006). There are simple tools that use only hospital data to predict the risk of readmission, such as the Patients at Risk of Readmission tool. These have most commonly been used to identify patients who could benefit from more intensive case management to prevent a further deterioration in their condition.

Tools that use more comprehensive data enable profiling of the whole population, allowing segmentation and more targeted approaches to case management, disease management and supported self-management. These tools are most often used to design community-based interventions that enable people with long-term conditions to be cared for at home, preventing clinical deterioration and the need for a hospital admission. The report to the GP inquiry on managing long-term conditions concluded that this approach had great promise. However, it noted that few general practices were proactively using risk prediction and risk stratification tools, and reported that the evidence base for the effectiveness of interventions was variable (Goodwin et al 2010a).

In future, general practice will increasingly need to take on population management, and to proactively identify individuals within the community who are at risk of developing disease. General practices need to make full use of data and access to information about the health and needs of their registered population, and to use tools to identify high-risk patients who might benefit from preventive advice or support.

**Benchmarking and peer review**

Peer review involves sharing clinical performance data among members of a professional peer group. This common approach to quality improvement uses data that can be collected and distributed within and between practices. *Measuring for Quality Improvement* (Information Centre for Health and Social Care 2011) sets out the Department of Health’s aspiration to encourage local care teams to use quality indicators to benchmark their performance on a day-to-day basis, on the assumption that this will galvanise the professions to improve care.

The approach can be highly effective. For example, evidence from a review of evaluations of physician profiling found small but statistically significant improvements in clinical practice associated with doctors sharing comparative data on clinical practice (Balas et al 1996).

Benchmarked data can be the basis for feedback and challenge of existing behaviours and practices. However, particularly in areas such as referral and prescribing, the justification for a practitioner deviating from the norm should be used primarily for learning rather than judgement.

If data is to be used effectively for peer review, it must be presented in a way that helps staff to engage with it. Quality improvement methods make much of how to present data visually. There are a number of standardised methods that can:
show linkages between multiple improvement projects
■ measure wasted staff time
■ illustrate variation over time and between items
■ highlight ‘high-impact’ aspects of care.

Experience in other health care settings, and in early adopter GP practices, indicates that these are highly effective means of engaging and enthusing staff in service improvement. Two practical examples of approaches include the ‘bundle’ approach and ‘statistical process control’ (see the box below).

**Two practical approaches to benchmarking data**

**The bundle approach**

Triangulating data sources can be a powerful means of establishing a more rounded view of a practice’s performance. Using multiple single measures often provides an impression of good performance. However, when these measures are viewed using bundles it often become clear that patients are not receiving care reliably (see pp 64–5). Bundles therefore highlight the opportunities for improving the reliability of care.

**Statistical process control**

Applying statistical methods to the monitoring and control of quality can help ensure that general practice operates at its full potential. For example, monitoring time-series data might enable the user to identify performance that falls outside of expected limits (control limits), an increasing or decreasing trend or an unusual trend or pattern, and to assess whether the process is unstable and unpredictable or whether variation is inherent in the process. This method leads to a more evidence-based approach to handling normal variation in data.

For more information on using and interpreting statistical process control, see NHS Institute (2010).

**Patient surveys and feedback**

Achieving quality – as perceived by the patient – is a central aim of quality improvement strategies, and requires the involvement of patients in evaluating care performance. However, a historic shortcoming of the NHS as a whole is that too little attention is paid to data on patients’ experience, and too little time devoted to involving patients in decision-making (Parsons *et al* 2010).

Some general practices have been at the leading edge in developing and supporting the use of patient experience data, but the historically low profile of the public and patients in accountability and governance structures for general practice has meant that the patient voice has been relatively weak in the quality improvement environment.

We recommend that practices routinely collect and act on patient feedback on their experiences of care, using simple technologies that are available in the practice. Practices should also use standard instruments, such as the GP’s Experiences Questionnaire (GPEQ) and Improving Practice Questionnaire (IPQ), to systematically gather patients’ views of their care. Groups of practices can then use this data for benchmarking and improvement and, where appropriate, to identify and challenge poor performance. This data could form part of the multi-source feedback (from staff and patients) used regularly in appraisal, revalidation and practice accreditation.
The key point is that this data must not only be collected – they must be acted on. There is increasing use being made of patient-reported outcome measures, but their routine collection is currently limited to surgical procedures. Further work is needed to develop valid patient-reported outcome measures (PROMs) for use in general practice.

Pressure from patients to drive higher-quality services is important, and needs to be encouraged. This might be facilitated, for example, through providing patients with access to their own medical records and/or supporting them to make informed choices about the care they receive.

Improvement skills

In order to embed quality improvement within general practice, many staff will need to acquire new skills in measurement, service redesign and improvement methods. This may require considerable investment by practices. Historically in PCTs and SHAs, there has been a shortage of staff who have been able to facilitate improvement in general practice, and there is only limited provision for practices to access appropriate training (Dawda et al 2010). For example, the research literature suggests that staff in general practice receive a limited number of days’ training, practical project support and ongoing coaching (Wilcock et al 2002; Geboers et al 1999; Hearnshaw et al 1998; Baker et al 1995). Practices need to schedule protected learning time each month for practice training, and incentives should be provided to support that.

However, training alone is unlikely to be sufficient to ensure that new ways of working are rapidly adopted. Facilitative, practical support may be needed to help practices implement the quality improvement techniques that they will learn about in training programmes (Dawda et al 2010). This approach to supporting quality improvement activity is similar to the Medical Audit Advisory Group (MAAG) model used in the 1990s, which was a key factor in the successful spread of audit in general practice. The experience with MAAGs suggests that external support such as that provided by Quality Improvement Support Teams (QISTs) can be developed locally, through multi-disciplinary groups of general practice-employed staff, patient representatives and other partners in care. Teams such as this offer the opportunity for quality to be integrated across all aspects of general practice, with an emphasis on meeting patient needs.

There is no ‘magic bullet’ for quality improvement (Oxman et al 1995). There is no definitive evidence that any single approach is superior, and the effects are highly context-specific (Boaden et al 2008; Walshe et al 2002). Walshe (2009) argues that little further knowledge is to be gained by researching which approach is most effective, and that further research should be directed at identifying the determinants of effectiveness. He suggests that implementation is the key success factor, regardless of the quality improvement initiative (Walshe and Freeman 2002). It has been shown that quality improvement strategies in primary care can make a difference, but that no single method is always effective (Lester and Roland 2009). Nevertheless, passive education appears to be the least effective approach, and multi-faceted interventions the most effective – especially when sustained over time (Bero et al 1998).

Incentives

Most of the incentives faced by practices and staff working in general practice are currently determined by external organisations. More attention needs to be paid to creating incentives for individual staff working within general practice. An increasing proportion of doctors are salaried while other practice staff, such as practice nurses, have generally not shared in performance-related bonuses – despite their significant
contribution to the attainment of levels of QOF achievement, for example. Practices may need to develop micro-incentive schemes to reward the behaviour that is desired. Some US medical groups with budgets have created locally determined financial incentives linked to quality metrics (Thorlby et al 2011). However, there is likely to be less scope for offering financial incentives in the future, due to tighter funding and a desire to control public-sector pay deals.

The focus on financial incentives has meant other non-financial incentives have largely been ignored. Indeed, to some extent they have crowded out more altruistic or professionally motivated behaviours (Le Grand 2003). A wide range of influences shape clinicians’ behaviour – the desire to deliver quality care and to be seen in high standing by colleagues are particularly powerful forces, since these are core to most clinicians’ professional identity (Mountford and Webb 2009). High-performing medical groups in the United States recruit and select clinicians not merely on technical competence but on values and behaviour. Groups make a point of celebrating and publicly acknowledging success, ensuring that professional pride is a motivating force. As larger, federated models of general practice develop, they need to be clear about the culture and values in which they are asking clinicians to work.

The proposals to give GP consortia responsibility for the commissioning budget will also change the incentives faced by practices. Making practices accountable for the financial consequences of their clinical decisions should create a greater incentive to drive improvement and challenge poor practice. While practices will be required to join consortia, consortia will largely be free to determine how they relate to member practices.

GP commissioning consortia will need to establish a system of rewards and penalties that are genuinely influential and can focus on local priorities. They need not be entirely, or even wholly, financial – and should be designed in collaboration with member practices. However, these need to be mindful of the potential conflicts, and of interests and public perceptions of these. There should be clearly differentiated consequences for high-performing and poor-performing practices. General practice will be more predisposed towards quality improvement if the consequences of poor performance are clear.

**Time**

All staff in general practice need time to train and to update their skills. Continuing professional development is currently an inadequate mechanism through which to do this, and protected time is not always given to all staff within general practice. Concerns about a lack of time for undertaking any new activity are prominent in the minds of many GPs when presented with ideas about quality improvement. Although proponents of improvement assert that, once embedded into an organisation, these approaches are both more effective and more efficient, these benefits rarely seem evident to GPs when they first hear about quality improvement.

Effective quality improvement requires an investment of time by practice staff to perform the tasks of reviewing and interpreting data, agreeing priorities for improvement, and planning change projects. It is essential that practices carry out these activities on a regular basis. It is suggested that most practices will need to devote half a day per month to such meetings (Dawda et al 2010). There is also a need to develop different modes of learning, such as short ‘just in time’ reminders, e-learning modules and team-based learning.

There is a real need for general practice to create space for reflection and learning – both individually and in teams. The current organisation of many general practices, including approaches to triage, skill-mix, appointment scheduling and demands for longer opening
times, mitigate against freeing up time to step back and think differently, and to trial approaches to measurement and system improvement. The contractual arrangements for staff need to build this in – perhaps adopting an initiative such as contractual programmed activities that are set out within the consultant contract and are agreed as part of job plans.

Bringing it all together

So far, this chapter has set out a number of enablers, drawn from our review of quality improvement in general practice, that we believe are needed to create an environment in general practice that supports quality improvement. It has also identified some of the challenges to embedding quality improvement in general practice. We now go on to consider two case studies of quality improvement in general practice that illustrate how a range of approaches and practical initiatives can be put together to support quality improvement locally.

Case study: NHS Tower Hamlets

NHS Tower Hamlets is a PCT that has adopted a multi-tiered approach to quality improvement, based on investing in the capacity to deliver services in primary care while developing GP leadership and robust frameworks for assessing and rewarding quality.

In 2005, the trust devised a comprehensive strategy for developing local health services called Improving Health and Well-being in Tower Hamlets. This was undertaken in partnership with local health care professionals (including GPs), the local authority, and representatives of the local community. Refreshed in 2009, this strategy forms the basis for the development of quality improvements of local primary and community care services.

Key elements of the strategy have included investment in more GP and nurse posts, to increase capacity to enable practices to register more patients and offer extended hours. Individual practices developed into clusters, and have sought to work more closely with other providers, including community health care teams, the local authority, the voluntary sector and with specialist care.

These integrated primary care networks have focused on key local priorities, including the management of people with diabetes and childhood immunisations. In each case, a hybrid Local Enhanced Service arrangement was developed, with clear performance criteria in terms of achieving better health outcomes. In diabetes, for example, some 70 per cent of the funding is provided upfront and 30 per cent held back to be allocated based on performance. The aims of the innovations have been:

- to tackle variations in care
- to ensure greater consistency
- to use the workforce more appropriately
- to focus on outcomes including patient satisfaction, better control of diabetes and a higher uptake of immunisations.

Supporting quality improvement

The health and well-being strategy has included a range of measures to improve the quality of general practice in Tower Hamlets, combined with remedial action to tackle instances of unacceptably poor performance.
The trust created a salaried post for a lead GP to take on responsibility for GP appraisal, alongside a team of GP appraisers competitively selected from local practices. The appraisal function has a written framework, with clear standards of performance.

A specific budget supports continuing professional development for GPs and their staff. Activities supported include:

- protected learning time of half a day a month for all practice staff (clinical and non-clinical) on topics related to newly commissioned services, local enhanced services, QOF domains, and learning needs identified from appraisal and personal development plans
- monthly forums for individual professional groups, including GPs, practice nurses and practice managers
- group-based consultation skills training led by RCGP College examiners and local GP trainers
- one-to-one coaching by GP trainers on consultation and clinical record-keeping skills
- one-to-one peer support, coaching and clinical supervision by GP educationalists, drawn from a panel (many of whom are GP appraisers), reporting back to the PCT
- mentoring by GPs trained in mentoring skills, undertaken in complete confidence, with no information being shared with the PCT
- encouragement and subsidy for practices to engage with the RCGP’s Quality Practice Award
- external consultancies commissioned to work with practices to address dysfunctional teams and to support high-achieving practices to develop further.

**Tackling poor performance**

A key issue in NHS Tower Hamlets’ case has been to support and address failing general practices. To tackle this, commissioners of GP services have made full use of their powers to ensure that general practice fulfils the terms of the quality of care as stipulated in their contracts. This has given the trust the levers to seek quality improvement and, ultimately, where all efforts have failed, to terminate contracts. NHS Tower Hamlets has also used the NHS Performers List Regulations as a tool for managing quality and through this has taken action at various times to refuse entry, suspend, contingently remove or ultimately remove doctors from the Performers List. The trust has used these mechanisms, as well as referral to the national regulator, to remove poorly performing GPs.

**Case study: NHS County Durham and Darlington**

NHS County Durham and Darlington are two PCTs that work together to form part of a regional quality improvement collaborative known as the North East Transformation System (NETS) coalition. The NETS coalition links NHS organisations in north-east England with the Virginia Mason Medical Centre (VMMC) in Seattle, United States, where ‘lean thinking’ principles have been used to improve the quality and safety of health care. Lean thinking is an approach to continuous quality improvement that seeks to satisfy customer needs by eliminating non-value-adding activities, or ‘waste’. It originated in the Japanese automotive industry, but is being used increasingly in other sectors, including health care.
Supporting quality improvement

NHS County Durham has established an innovative initiative called the Primary Care Pathfinder Programme to implement NETS and lean thinking in general practice, to help improve quality and productivity. The programme is designed to deliver safer care and better patient experience by increasing the effectiveness of processes within general practice. It also focuses on freeing up time for staff to do their jobs more effectively, by removing unnecessary process steps.

To demonstrate how NETS and lean thinking can be applied, the trust has run a series of rapid process improvement workshops with general practices. For each workshop, practices identified a specific issue for improvement, chose metrics relevant to the process and provided baseline data in the run-up to the event. They were tracked for three months afterwards at 30, 60 and 90-day checkpoints.

Outcomes

The programme has resulted in a range of improvements in safety, patient experience, effectiveness of care processes, staff morale and productivity, including:

- safer care processes, such as reduced risk of error by simplifying process steps and improving work procedures
- more effective processes, such as improved flow of work and reduced waiting times
- improved patient experience – for example, with better room layouts and reduced interruptions
- better staff morale, and less stressful environments in which to practice.

To date, more than 300 primary care staff have been involved in the programme through improvement activities, training and other awareness-raising events. The trust has now produced a resource called NETS for General Practice Toolkit to aid implementation within general practice and provide examples of application. The toolkit provides simple, easy-to-use guides on tools and techniques of lean thinking within the context of general practice.

There were some barriers to implementation – predominantly resistance to change and a lack of perceived need to measure the current and future status. The trust used a combination of senior leadership, facilitation and coaching within each activity to overcome these barriers.

Supporting quality improvement from outside general practice

It is critical that the external environment of contracting, performance management, regulation and professional bodies support and nurture professionalism in general practice as the basis for quality improvement. In the remainder of this chapter we consider the external environment in which general practice operates, and discuss how this could support quality improvement, focusing on the roles of:

- commissioners
- regulators
- professional bodies.
The role of commissioners

Pay for performance
One of the main incentives for quality improvement for general practice has been the introduction of pay for performance in the 2004 GMS contract under the QOF. We have already reviewed how quality is measured under this contract (see Chapter 3, pp 32–3). Here, we consider its impact on the quality of care.

There is evidence to suggest that the QOF has led to changes in the behaviours of GPs to improve the quality of care for a number of important medical conditions (Calvert et al 2009; Campbell et al 2007; Majeed et al 2007). However, QOF has also been criticised for skewing the focus of attention, with poorer performance on non-incentivised areas of care (Gillam 2010; Campbell et al 2009; Steel et al 2008). This reinforces a view that performance management of particular measures risks creating tunnel vision and crowding out improvements in other areas of care (Guthrie 2008). QOF is also reported to have limited participation in audit and to have created an expectation among GPs that they should always be paid for engaging in quality improvement, rather than seeing it as their core business.

For pay-for-performance systems to have a long-term sustained impact on quality, the actual benchmarks themselves need to be suitably ambitious. With most GPs scoring over 90 per cent, the National Quality Board (2010b) has concluded that QOF ‘is not sufficiently able to discriminate between performance’. There is evidence that the rate of improvement in QOF scores has slowed, ‘probably due to general achievement of maximum payment levels’ (National Audit Office 2010).

The ability to exclude patients from the pay-for-performance measure is justified in order to safeguard patients against inappropriate treatment, and to mitigate against the risk that practices shun ‘difficult’ patients. Monitoring of the use of exception reporting – where some registered patients can be excluded from the QOF calculations – found some evidence that a small number of practices had manipulated the figures in the first year (Doran et al 2006), but this did not persist (Doran et al 2008b).

While some exceptions are for clear-cut clinical or administrative reasons, there are also a large number of ‘discretionary’ exceptions (National Audit Office 2010). The challenge is to balance the realities of patient care (for example, avoiding a situation where an incentive will encourage a GP to continue prescribing statins to a terminally ill older patient, even though clinical judgement might indicate otherwise), while reducing the potential for a practice to manipulate its performance data or to exclude patients who are hard-to-reach.

Targets were set at below 100 per cent of registered patients, thus reducing the incentive for practices to proactively seek and treat patients once they have hit the target. Interviews with staff in practices in deprived areas suggest that QOF has not encouraged primary prevention or proactive case finding in general practice (Dixon and Khachatryan 2010). The National Audit Office highlighted the consequences for inequalities: ‘GPs can achieve full payment of the additional [QOF] income… without covering the entire practice population and as a result the hardest to reach and most in need groups may not be helped through this framework’ (National Audit Office 2010).

Overall, the experience with pay for performance ‘emphasizes that there is no magic bullet for quality improvement and that initiatives that produce long-term change are usually multiple in number and multilayered, and must be sustained over time to make a real difference’ (Doran and Roland 2010).

The reliance on externally defined quality objectives, and the use of periodic large-scale measurement, has stifled approaches which proactively seek continual small
improvements and which encourage local staff ownership of the problem and the solution (Dawda et al 2010). Finally, there can be a tension between GPs’ concern to earn QOF points for their practice and the development of more ambitious goals for the health of the practice population – something that general practices will need to embrace actively in the future as they take on a role as commissioners as well as providers of care.

Currently most of the financial incentives, including QOF, national enhanced services (NES) and directed enhanced services (DES), are nationally negotiated and specified. Although QOF Plus allows some thresholds and indicators to be locally selected, the services and prices are nationally specified and negotiated and, like NES and DES, they are not obligatory for practices to provide or for PCTs to commission.

Local enhanced services (LES) have potentially allowed PCTs to commission services to meet local needs. However, when compared to the value of the other elements of the contract, both LES and QOF Plus have provided relatively little leverage to local commissioners, and they have therefore been reluctant to set them up (Millett et al 2011). This represents a lost opportunity to encourage local service innovation and tackle local health priorities. Future contract negotiations need to enable greater flexibility for local commissioners (with local authorities) to set the priorities that are to be incentivised.

Under the new contract, a proportion of practice income will be in the form of a ‘quality premium’ linked to the outcomes practices achieve together as consortia. The measures used in the national contract will need to be aligned to the outcomes framework by which practice consortia and in turn practices are to be held to account, in future. It should also reflect public health outcomes and social care outcomes as appropriate. QOF is too narrowly focused on itemised care processes and intermediate outcomes for individual patients.

There is a risk that with the transfer of public health funding to local authorities, and the health premium rewarding local authorities for improvements in health outcomes, that consortia will have no incentives to take seriously their responsibilities for prevention and health promotion. We therefore recommend that:

- practices are given incentives to achieve a wider set of quality (process and outcomes) measures
- general practice should take responsibility for these measures – even where these require working beyond the organisational boundaries of general practice
- these incentives should reward improvement.

Contract management
Most GP practices are in a contractual relationship with their local PCT, based on either a GMS or a PMS contract. If the terms of the contract are breached, the PCT can terminate the contract, require the practice to stop undertaking any other business considered to be detrimental to their performance under the contract, or issue ‘contract sanctions’.

So, local commissioners of GP services have a crucial part to play in supporting quality improvement through contract management, peer review of performance, and providing additional incentives. As the three case study examples show (see pp 118–120), it has often been proactive NHS commissioners (in other words, PCTs) that have been instrumental in supporting and driving through quality improvements in general practice.

In future, GP practices will have a contract with the NHS Commissioning Board. The content of these new contracts – performance requirements and associated sanctions – can be determined by the Secretary of State, or delegated to the NHS Commissioning Board to negotiate. It is not clear currently how the commissioning board will monitor performance against the contract, although recent government plans suggest that it will be able to delegate responsibility for this to local GP commissioning consortia. Consortia
will be expected to play a key role in working with individual GP practices to drive up the quality of primary medical care, and the NHS Commissioning Board may ask them to carry out some contract management work on their behalf.

GP consortia will be well placed to establish clinical governance procedures and to judge practice performance. If quality improvement is to be reinforced, clinical governance frameworks must deal effectively with issues of poor performance. Such frameworks need to define:

- the circumstances under which sanctions will be applied to practices not meeting clearly defined standards
- who will implement those sanctions
- what those sanctions will be
- how the performance of individuals within practices will be monitored and dealt with.

Promoting quality improvement requires a timely mechanism for closing down unacceptably poor performers and removing individual practitioners whose care falls below acceptable standards. However, governance should be placed within the wider improvement remit in such a way that it performs the function of addressing specific problems in the minority of practices who give cause for concern, without stifling innovation and improvement in the majority that do not. Thus, governance arrangements should ensure that minimum standards are met, while other systems ensure ongoing improvement (Dawda et al 2010).

Case study: NHS Hammersmith and Fulham’s QOF Plus Scheme

NHS Hammersmith and Fulham’s QOF Plus initiative is a pay-for-performance scheme modelled on the existing national QOF for general practice. The initiative was launched in December 2008, with a three-year budget of £6.6m, and aims to improve the quality of care in general practice by:

- setting higher targets for a selected number of existing national QOF indicators
- introducing new evidence-based QOF Plus indicators reflecting specific local health issues
- opening new avenues for support and engagement with practices, including individual practice training budgets and IT support.

The decision to raise the standard for national QOF indicators was prompted by local practice performance already exceeding existing targets, leading to a concern that the modest national targets offered too much leeway to general practices to leave more challenging patients untreated, thereby increasing the likelihood that health inequalities would widen.

New indicators were developed after consultation with public health and general practice. High local rates of smoking and alcohol-related harm prompted the introduction of indicators rewarding smoking cessation and a programme of prospective screening for alcohol misuse. Cardiovascular risk assessment and intervention was also introduced and incentivised under the scheme. Non-clinical indicators focus on improved practice systems for communication with patients, responding to patient feedback, and promoting care for particular groups, including carers and vulnerable children. In total, 48 indicators were introduced for QOF Plus in 2008/09 and extended in Year 2.

All 32 practices in Hammersmith and Fulham have participated in the 2009/10 scheme. Performance data is collected directly from practice computer systems under
a data-sharing agreement, and is used to generate patient lists and reminders within practices as well as to support monitoring and payment. Resource materials, training and support visits are arranged by the PCT to support practices.

The new QOF Plus indicators have generated high levels of desired activity. For instance, the alcohol screening programme resulted in 15,000 people screened (where effectively no screening was done prior to the programme) and 2,300 brief interventions offered for identified alcohol misuse.

QOF Plus was developed jointly by NHS Hammersmith and Fulham and the Department of Primary Care and Public Health at Imperial College London, who will undertake a formal evaluation of the impact of the programme.

Case study: NHS Stoke on Trent’s ‘aspirational standards’

In order to incentivise improved quality of primary care in general practice, Stoke on Trent set up a voluntary process called ‘Quality Improvement Scheme: Exemplary general practice and aspirational standards’. The budget is £1.4 million for incentives plus £300,000 a year in support for at least the next three years. One-third of money up front will enable practices to take on additional staff to improve capacity and quality.

The scheme comprises two stages. First, practices compare themselves against descriptors of an exemplary practice. Then, they are assessed against a range of enhanced clinical aspirational standards.

A service-level agreement between the PCT and a participating practice defines the specific annual milestones that the practice should achieve. Practices must meet a range of pre-qualifying criteria in order to sign up for the incentive scheme.

‘Exemplary practice’ is assessed within the following categories:

- sustaining a robust clinical governance framework
- prevalence of patients with specific long-term conditions
- regular holistic structured reviews: all patients on specific chronic disease registers
- competence of staff delivering care
- capacity for provision of general practice care
- working with PCT to enhance service planning and improvement for the health economy
- continual work to minimise health inequalities
- patient and public involvement
- self-care.

For each exemplary standard there is an explicit explanation of how the PCT will judge whether the standard has been met. There are approximately 30 enhanced clinical indicators – some using QOF indicators, but with higher targets of achievement or tighter blood pressure or HbA1c targets. The points that are allocated to various fields and targets in the clinical aspirational component of the scheme will vary year on year, to match local and national priorities and the principle of continuous improvement.

Every practice has an 85-item practice development plan to achieve the health outcomes and exemplary standards over three years, with 100 points on offer for enhanced clinical targets.
Improving the quality of care in general practice

The role of regulators

Regulators have an important role in setting, monitoring and enforcing standards of care. From 1 April 2012, all general practices that provide regulated activities will be required to register with the CQC.

Since autumn 2009, doctors have been required to hold a license to practice from the General Medical Council. When revalidation is fully introduced, doctors will need to be successfully revalidated every five years in order to retain the licence. The process of revalidation will begin from late 2012. All doctors will need to demonstrate that they are practising in accordance with the generic standards of practice set by the GMC, as set out in Good Medical Practice.

While the focus of both these systems is on ensuring that minimum quality standards are being met, these standards and the way organisations and individuals are assessed can have a profound influence on the environment for quality improvement.

The CQC’s approach to registration for other providers is based on self-assessment against the standards, risk profiling and targeted inspections, with enforcement actions where they identify non-compliance. The body has already set out principles for how it will develop the registration standards for primary medical services (Care Quality Commission 2011). These state that it will:

Case study: NHS Nottinghamshire County’s ADVANCE scheme

NHS Nottingham’s Quality and Safety Team has developed the ADVANCE Quality Accreditation Scheme for general practice, to support the continuous improvement of the quality of care. The scheme for general practice operates with seven domains of quality:

- safety
- clinical and cost-effectiveness
- governance
- patient focus
- accessible and responsive care
- care environment and amenities
- public health.

Each domain has a set of quality indicators, spread across three levels of attainment, as follows.

- **Level one** contains indicators that have been selected as a priority, some of which also appear in the GMS contract or QOF.

- **Level two** contains indicators that will enable practices to reach the standard required by the CQC.

- **Level three** is an aspirational level as it enables practices to achieve a ‘gold standard’ based on best practice.

The indicators are largely procedural, rather than narrowly data-based.

By September 2010, around 80 per cent of the 94 general practices covered by NHS Nottinghamshire County had signed up to the scheme. Practices will receive £6,000 for compliance within four years.
seek to reflect the views of those who use the services and the outcomes they experience
engage stakeholders, including professionals and expert bodies
use timely, relevant and reliable information and work with others to reduce duplication and the burden on providers.

This emphasis on patient views and evidence of outcomes suggests that registration will encourage practices to gather and report data on these aspects of the quality of care. It will also require practices to strengthen their own internal reporting and audit systems. It will be important that the regulator monitors the requirements for new data collection, and ensures that this does not detract from practices using and acting on the information collected to drive quality improvements.

The collection of multi-source feedback from patients and colleagues could be used locally as the basis for self-reflection and critical appraisal, which could identify areas on which to focus quality improvement efforts. There are requirements to conduct audits, and in the latest guidance a quality improvement project has been identified as a suitable alternative to one of the clinical audits (Royal College of General Practitioners 2010b).

To help promote quality improvement, regulators need to take a joined-up approach to the assessment and assurance processes within general practice. The Care Quality Commission has set out its commitment to working with others to reduce duplication and unnecessary regulatory burden on practices and other providers.

The role of the professional bodies

Professional representative bodies can also play an important role in fostering enthusiasm in general practice for quality improvement. The RCGP – along with the other Royal Colleges and specialist societies – has an important role in supporting doctors in the revalidation process, in developing methods for evaluating specialty practice and in supporting those responsible for implementing revalidation – for example, through defining and interpreting specialist standards for GPs. It also has a wider role in standard setting and promoting quality improvement.

In 2011, the RCGP will launch a practice accreditation scheme that aims to promote a focus on team performance and learning organisations. The scheme was piloted in summer 2008, with 36 practices. The evaluation found that there were observable improvements in patient safety, quality of care and service delivery. Feedback from practices was that the accreditation scheme was worthwhile, and that it had provided a useful opportunity for the team to reflect on quality in primary care and to develop as a team (Royal College of General Practitioners 2010a). The accreditation scheme has great potential to encourage quality improvement by providing a structured process by which practices can benchmark their performance against quality standards and invest in the development of the practice team.

Professional bodies also have a role in promoting professional values of excellence – for example, through programmes of continuing professional development, and through developing standards of care. They also have a role in highlighting where these standards are not being met. They could take a leadership role in encouraging professionals to understand variations in quality of care and, where these cannot be justified, highlighting areas where there is room for improvement. Professional bodies can also support the development of skills in leadership and quality improvement (which in this report are identified as vital to the success of quality improvement in general practice) and can ensure that learning about successful quality improvement initiatives is rapidly disseminated.
Our research identified a vast array of initiatives designed to support the improvement of quality in general practice, including:

- QOF
- practice accreditation
- revalidation
- registration by CQC
- an array of local schemes linked to the peer review of performance and local strategies for change.

GPs remain sceptical about the value of many of these initiatives – particularly to those seen as top-down and geared to external performance management (Goodwin et al 2010b). These external drivers for improvement in quality were not necessarily seen to support efforts to improve quality within practices. National decision-makers need to be clear about how the systems of regulation, accountability, incentives and organisational structures support practices to improve the quality of care.

Conclusions

There are currently a range of barriers to the widespread adoption of quality improvement approaches in general practice. However, this chapter demonstrates the potential for this area of work, and highlights case studies in which general practice is already engaged in quality improvement initiatives that are delivering improvements in care. We have identified a number of ways in which practices can create an environment that supports quality improvement. These include:

- a culture that supports systems thinking, encourages peer review, is open about performance and variability, and that balances challenge against support
- the transparent sharing of data on performance at a local level with patients, the public and with professional peers
- strong professional leadership and a team ethos that puts the quality of care first and recognises the need to continually strive to improve
- team-based approaches that engage all staff in measuring, understanding and improving quality
- use of data and information tools, such as:
  - decision aids and best-practice guidelines that can prompt general practice professionals in clinical real time
  - data-analysis tools that allow benchmarking of performance between practices or predict the risk of admissions
  - statistical techniques that help triangulate performance data and monitor trends over time
- training and support for the acquisition of improvement skills
- support structures that promote the regular sharing of ideas and experience between practices
- protected time and incentives for individuals and the team to think, train and undertake quality improvement
- for the minority of practices that perform poorly, governance arrangements to enable effective and timely remedial action.

The organisational context in which staff work must support the delivery of high-quality care and efforts to continuously improve quality. Practices need to know how well they are doing compared to other practices. This will spur them on to improve. We believe that practice performance needs to be benchmarked against the best, rather than against the average. Time and resources need to be invested in order to ensure that facilities are adequate, IT and data generate relevant information, technology (both new and
old) is used to support new ways of working, and there are people with the right skills working effectively together. Practices need to ensure that time for audit, reflection and development are valued and protected.

We have also shown in this chapter how the external environment can support quality improvement in general practice. It is vital that the wider system in which general practice operates helps good GPs to be great, stops bad GPs from practising, and challenges those in between to sit up and take notice about their need to improve. We believe that different approaches are needed for practices at different points on the quality curve.

GP commissioning provides a new opportunity to create a platform through which to drive improvements in quality, as well as to challenge poor performance. The GP commissioning role needs to be genuinely influential in its relationship with general practice. GP commissioners need to be given the powers to support, develop and reward practices – but also to challenge, and to penalise where necessary.

The challenge is to achieve the right balance between external drivers of quality improvement, such as performance management and contractual incentives, and peer-led approaches, such as peer review, open reporting and transparency. Fundamentally, general practice must ‘own’ the quality agenda and take professional leadership for quality improvement. External standards, targets and incentives must support general practice in its quest for quality.

Approaches to quality improvement need to take account of the heterogeneity in general practice. The extent of clinical governance structures, peer review and audit processes will depend partly on the size of the practice and how it is organised. In the next chapter, we consider how the organisation of general practice might need to change in order to support quality improvement.

Key points

- Many general practices are engaged in quality improvement initiatives and are proactive in seeking to deliver improvements in care. However, quality improvement is not yet routinely embedded as a way of working. Practices need to be supported in creating an environment within which quality improvement can flourish.

- GPs are often unaware of the variations in quality that exist within and between their practices and those of their peers. Making clinicians aware of such variations is a first step to encouraging them to explore the reasons for variable performance, and to act accordingly.

- Practices need to use data and information tools to provide clinicians with the information they need to identify and to prioritise areas for quality improvement.

- Strong clinical leadership is essential to foster a clear vision and set of common values through which effective collaboration and teamwork can operate.

- People working in general practice need training and support in order to acquire the necessary skills to implement quality improvement.

- Protected time and incentives, both financial and non-financial, are required for individuals to think about, train for, and reflect on the quality of care.

- Excellence needs to be recognised and rewarded. High-performing practices need to use their skills to support those that are weaker, and should ultimately be given the ability to expand and/or take over failing practices.
Developing an environment for quality improvement also requires action to be taken at many different levels. Policy-makers, regulators, commissioners and the professional bodies all have roles to play in creating a better environment that supports general practice in its quest for quality.

There is an opportunity for GP commissioning consortia to be provided with the levers to drive improvements and challenge poor practice. Member practices need a system of rewards and penalties that is genuinely influential and that focuses on local priorities.

GP commissioning will create a responsibility among member practices to be accountable for the quality of care they provide and to take action where such quality is sub-optimal.

An open culture needs to be developed that balances the ability to challenge as well as support practices. General practice is more likely to become engaged in driving improvements in care where there is transparency in the sharing of data at a local level with patients, the public and professional peers.

Fundamentally, general practice must own the quality agenda and take on professional leadership for quality improvement.