

Research papers

Achieving practice participation in a quality agenda: The Somerset Practice Quality Programme 1998-2003

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ABSTRACT

Background Many barriers exist to improving the quality of primary care. A range of initiatives have been tested in the past to achieve improvement. No one model has been found to be particularly useful or effective. All existing models have defects.

Setting The old Somerset Health Authority area in the West of England, UK.

Method Comparison of quality improvement schemes in the primary care organisations (PCOs), and with the new general practitioner (GP) contract quality and outcomes framework.

Results The practice quality programmes of three of the four PCOs evolved from a core practice quality plan (PQP) produced by the old Somerset Medical Audit Advisory Group. They were funded to different levels, and have developed differentially over five to six years. The other PCO eventually opted out of the PQP system and has encouraged its

practices to undertake the Royal College of General Practitioners' (RCGP) Quality Practice Award. All practices within the three PCOs with PQPs participated in the last year reviewed. There is much overlap between the three PQPs, and also with the quality and outcomes framework of the new GP contract.

Conclusion The Somerset practice quality programme was an effective way of improving practice participation in quality activities within Somerset. Thus, practices in Somerset were well placed to achieve the quality markers of the new GP contract. Such a PQP should be attractive to other PCOs in the UK and could be used to encourage greater participation in quality activity, especially in terms of local quality initiatives.

Keywords: healthcare improvement, primary care, quality

Introduction

Everyone concerned with healthcare has the laudable aim of improving the quality of patient care. However, how this should be achieved in practice, and in particular how general practitioners (GPs), and practices can be encouraged to be engaged in a quality agenda is uncertain. The implementation of the new GP contract, in which up to one-third of income is related to quality criteria is heartening. However, how PCTs and politicians can best promote the quality

activity needed to address the wider quality agenda is unknown.

What is known is that there are many barriers to improving the quality of care in the health service. This includes adequate time, adequate resources, adequate support and leadership, team approach, cultural change, organisational change and an appropriate educational framework.¹⁻¹¹

Various initiatives have been attempted in the past. It appears that written information or guidelines alone are of little help, as is reflection with peers.^{4,5,12,13} It is

thought it is important to build on existing activities, and that various frameworks could be used for addressing the quality agenda; these can be disease focused, patient focused or population focused.⁹ Supplying adequate information, and recording information well, are very important for improving the measurement of quality of care.¹⁴ There is some evidence that quality improvement has occurred over the past few years, by improving the care provided by the worst practices, and reducing the variability between practices.¹⁴ Indeed, the introduction of a clinical governance framework was based on the assumption that this would improve quality both at the individual, practice, and primary care organisation (PCO) level.¹¹ A range of quality improvement schemes have been around for many years.⁹

The Somerset Practice Quality Programme (PQP) was initially set up by the Somerset Medical Audit Advisory Group (MAAG) in 1998/1999. This multidisciplinary group wished to provide a tool by which practices could demonstrate that they were providing high-quality care. The principles underpinning the Somerset MAAG PQP were that it should be: optional, funded adequately, facilitated by skilled GPs, flexible, graded, based upon externally accepted criteria, and capable of development over time. The initial basic PQP was designed by extracting a small number of criteria from an external quality award, the Royal College of General Practitioners' (RCGPs') Quality Practice Award. It was funded, facilitated and offered to practices through the MAAG framework. Its aim was to enable practices to opt into a quality programme by which it could demonstrate to itself, to its patients, to other practices and to the health authority that they were providing care of a high quality and in a way by which they could compare itself with other practices. It was hoped that such a voluntary but funded programme would enable practices to work towards external quality awards.

This paper describes its development as a quality improvement framework and its wide uptake by practices, and PCOs, and the funding that was provided to support its uptake and development.

Method

Copies of all PQPs were obtained by the authors from a variety of sources: MAAG records, the four primary care trusts (PCTs) of the old Somerset Health Authority, and from practices. Data on practice funding to undertake the PQPs and the level of uptake by individual practices were obtained from MAAG records and from the existing PCOs.

They were compared in terms of their content, practice requirements (mandatory and optional

sections), quality areas, funding provided, and uptake by practices.

Results

There were three phases to the development of the PQP. Initially it was a short document with a relatively small number of quality areas which practices could choose to undertake (see Table 1). This changed little over two years, during which time it was funded by the Somerset MAAG (which was ultimately funded by the old Somerset Health Authority). It was variably taken up by practices across Somerset in the four areas which were eventually to become the PCOs.

The second phase of the PQP started in 2000/2001 with its development into a larger programme and a doubling of its quality areas by one PCO. To do this a number of sections were expanded as were the number of criteria (see Table 1). Criteria were taken from a number of external sources principally. These included the RCGPs' Fellowship by Assessment, Quality Practice Award, Quality Team Development and Membership by Assessment of Performance. Some were taken from training practice criteria and others from the minimal quality structure of the old GP contract (the 'Red Book'). Finally a small number were written by individual MAAG members to produce a rounded programme that could be offered to practices. The new feature of the full PQP was that each section or quality area had three levels; a, b and c (later four levels, see Box 1). These were designed to be increasingly difficult to achieve but also at the same time to encourage practices to join at a level appropriate to the stage of their quality development.

This was offered to practices that year and also the following year, through their primary care group/trust. It was at this stage that the four PCOs diverged in how they utilised the PQP. Two of the four organisations opted out and tried to engage practices through different quality mechanisms. Mendip told its practices that they were individually to undertake criteria towards the RCGPs' Quality Practice Award *per se*. South Somerset used other mechanisms. Taunton slightly modified the old MAAG PQP for a further year, and Somerset Coast built a larger PQP based around the old MAAG one. In doing so, they acknowledged that practices would need to undertake a high level of quality work and increased markedly the funding to practices (see Table 1). The following year again, only two of the four organisations used the PQP as an instrument for promoting quality in practices. However, both Taunton and Coastal built on the core PQP, expanded its quality areas, and increased payments for practices to engage with the programme.

Table 1 Outline, funding and uptake over time of the Somerset Medical Audit Advisory Group Practice Quality Programme (PQP), by the four primary care organisations^a within the original Somerset Health Authority

Description	Brief PQP 1998/1999		Full PQP		Individual PQP			
			1999/2000	2000/2001	2001/2002	2002/2003		
Uptake by:								
Mendip Area	9/16		13/16	NA	NA	NA		
Somerset Coastal Area	9/23		21/23	All	All	All		
South Somerset Area	14/16		12/16	NA	NA	All		
Taunton Area	11/22		21/22	All	All	All		
Format of PQP:								
Sections	5		10	6	6	9	6	
Quality Areas	25		18	21	43	45	47	
Mandatory	0		1	9	9	14	12	
Optional	5		4	3	3	6	4	
Levels	1		1	3	3	3	3	
Funding	£500–£1380 (for 1 wte ^b)		£500–£770 (for 1 wte)	£500	£1550–£4000, depending on size	£3750 for 1 wte rising to £7250 for 8 (£500 steps)	£3500–£10 000 depending to £7250 for 8 (£500 steps) on size	As last year flat payment £1000

^aThe four PCOs in Somerset are/were: Mendip, Somerset Coast (abbreviated as C), Taunton Deane (T) and South Somerset (SS)

^bPractices were paid pro-rata depending on their size. This money was not to replace GP time but simply a way of allocating limited funds to practices on a sliding scale based on practice size wte: whole-time equivalent

Box 1 Sample section from 2002/2003 Taunton Practice Quality Programme. This section refers to National Service Framework (NSF) quality activities; mandatory areas are in bold

1.1 NSF for Mental Health

- a The practice has developed a READ code policy and disease register for patients with enduring mental illness.
- b Management plans exist for depression, schizophrenia, anxiety, and dementia with linked agreed practice formularies.**
- c The practice has a call and recall system for patients with enduring mental illness and has copies of relevant care plans in their notes.
- d Carers needs have been assessed in the last year.
- e Women in the postnatal period have been re-audited for the detection and care of postnatal depression (ongoing module from 2002/2003).

1.2 NSF for Coronary Heart Disease

- a The practice has a READ code policy and disease register for coronary heart disease.
- b Management plans exist for four relevant conditions (post-myocardial infarction (MI), angina, peripheral vascular disease and cerebrovascular disease) and these are linked to agreed practice formularies. The practice has an established call and recall system for these conditions.**
- c Management plans exist for a further two conditions (atrial fibrillation and heart failure) as above.
- d The practice has carried out an audit of patients with coronary heart disease (CHD) in the past year.

1.3 NSF for the Elderly

- a The practice has carried out a medication review of all patients over 75 years on repeat medication in the past 12 months and in the past 6 months for those on four or more repeat medications.**
- b The practice has a written policy to identify and address the health needs of patients over 75 years.
- c The practice has achieved >70% flu immunisation in patients over 65 years.
- d The practice has a written policy for identifying those at risk of osteoporosis and those at risk of falls and offers active intervention.

1.4 NSF for Diabetes

- a The practice has developed a READ code policy and disease register for patients with diabetes.
- b Management plans exist for this condition and are linked to practice-based formularies.
- c The practice has an established call and recall system.
- d An audit of diabetes care has been carried out in the last 12 months.**

1.5 Cancer

- a The practice has developed a READ code policy and disease register for patients with (or who have in the past had) a diagnosis of cancer other than non-melanotic skin cancer.
- b The practice has a policy and an established call and recall system for screening for cervical and breast cancer.
- c A survey of cancer patients has been carried out within the past two years.
- d The practice has a list of carers for patients with cancer and has undertaken a survey of their needs within the past two years.

In the third phase of the PQP, there became more consistency across the three PCOs in Somerset who were utilising the PQP instrument. The two PCOs who had been developing the PQP over the past two years continued to fund it appropriately. South Somerset PCT re-engaged with the PQP model and provided moderate funding for practices to engage with the programme (see Box 2). The other (Mendip) PCO not involved in the PQP continued to instruct its practices to undertake work towards the Quality Practice Award. There is now much overlap between the three PQPs and the Quality appendix of the new GP contract (see Table 2).

Box 2 Summary of South Somerset Practice Quality Programme Quality Areas for 2003/2004

1 Health promotion

- 1.1 Smoking
- 1.2 Health promotion
- 1.3 Alcohol, body mass index (BMI) and blood pressure
- 1.4 Immunisation
- 1.5 Travel advice

2 The NSFs

- 2.1 NSF Mental Health
- 2.2 NSF Coronary Heart Disease
- 2.3 NSF Elderly
- 2.4 NSF Diabetes
- 2.5 Children

3 Routine clinical care and audit

- 3.1 Significant event audit
- 3.2 Treatment and management of chronic conditions
- 3.3 Standard audit
- 3.4 Cancer services
- 3.5 Terminal illness

4 Relationship with patients

- 4.1 Discrimination
- 4.2 Assessment of services
- 4.3 Patient information
- 4.4 Complaints

5 Working with colleagues

- 5.1 Office procedures
- 5.2 Health and safety
- 5.3 Team communication
- 5.4 Referrals
- 5.5 READ code policy
- 5.6 Records and summaries

6 Education and training

- 6.1 Learning needs assessment
- 6.2 Personal and professional development plan (PPDP) and linked education
- 6.3 Educational support

7 Access, IT and security

- 7.1 Appointments
- 7.2 Consultation duration with both GP and practice nurse
- 7.3 Information sharing
- 7.4 Risk assessment
- 7.5 Computer security and IT

8 Emergency care

- 8.1 Emergency care
- 8.2 Treatment and management of acute cases
- 8.3 Anaphylaxis
- 8.4 Emergency drug bag

9 Prescribing

- 9.1 Controlled drugs
- 9.2 Repeat prescriptions
- 9.3 Prescribing data and formularies
- 9.4 Prescribing policy
- 9.5 Prescribing safety
- 9.6 Drug addicts
- 9.7 Patient group directives and nurse prescribing

Discussion

The development of the Somerset PQP by the multidisciplinary Medical Advisory Group was welcomed by practices, professional organisations (Local Medical Community, RCGP, practices nurses' group and GP tutors) and the health authority when it was set up. These professional organisations were represented on the MAAG Steering Group, and provided letters of support in favour of the development of the PQP. Over time it showed itself to be useable, flexible and acceptable to practices who, through participation in the PQP, have been able to demonstrate to themselves, their patients and their PCOs that they are engaging in a quality agenda that should lead to an improved quality of care over time.

Because the individual PCOs have developed their own PQPs from the same core document, and they are similar in their demographic and healthcare needs, there is still a large amount of overlap across the four PCOs in terms of the quality areas in which they are working (see Table 2). With suitable facilitation and exchange of information it should therefore be possible

Table 2 Areas of clinical and organisational activity addressed by the Practice Quality Programme, as it developed over five years, and in relation to the new GP contract

Facilitation and funding by:	1998/1989		1999/2000		2000/2001		2001/2002		2002/2003 PCT			New GP contract Practice
	MAAG	MAAG	MAAG	MAAG	PCO (T)	MAAG (C)	PCO (T)	PCG (C)	T	C	SS	
Clinical care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Education and training	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical audit	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Risk management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Office procedures	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Records	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Access	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health promotion	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chronic care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referrals	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Users	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NSFs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Acute illness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

MAAG: Somerset Medical Audit Advisory Group; PCO: primary care organisation; C: Somerset Coast Primary Care Group/Trust; T: Taunton Primary Care Group/Trust; SS: South Somerset Primary Care Group/Trust

for individual practices to compare their clinical governance activities with most of the Somerset practices, which they were able to do in the previous coherent world when all practices were under the guidance of one health authority. It is hoped with the institution of the new Somerset and Dorset Strategic Health Authority that other PCTs may wish to consider utilising the core PQP and its principles to offer coherent developable quality programmes to their practices. Such programmes will need to be funded, skilfully facilitated, offer choices to practices and be sufficiently flexible in terms of evolution, speed of development and practice choice. They could still be used across the whole of a strategic health authority area to enable practices and PCTs to make valuable formative comparisons to develop primary care and enhance its quality. A modified PQP could be a valuable tool, if adequately funded and facilitated, to enable a PCT to enhance quality locally in areas outside of the new GP contract quality and outcomes framework. The GP contract framework still only covers a small proportion of the range of care that GPs and their practices provide.

Those practices that have actively engaged with the PQPs over the last 5–6 years were well placed to address the quality agenda of the new GP contract and/or an external quality award.¹⁵ There is clearly overlap between the quality appendix of the new GP contract and the PQPs in use in Somerset, but there are many areas where practices and/or PCOs will wish to undertake incremental development work to enhance the quality of care that they provide; the PQP is flexible enough to be further developed to meet these needs. Immediate examples of areas of care not covered by the quality appendix are emergency and acute care, referrals, the National Service Frameworks, and many other chronic disease and illness areas. PCOs could modify such a PQP to incorporate these areas, plus local areas where quality work needs to be done but which is not covered in the new GP contract quality appendix.

The Somerset PQPs have overcome barriers to engaging practices in the quality agenda in Somerset. In doing so they are likely to have produced a cultural change in the views of GPs and organisational change at practice level, through a funded, quality framework.^{1–5,8,11} We believe that its success has been due to its incremental nature, freedom of practices to opt in and opt out at whatever level suits them, adequate funding and suitable facilitation by GP peers.^{1,5–8} Such a multi-choice, multi-level, multi-focus quality framework should be attractive to other PCOs as they seek to encourage practices to improve the quality of care they provide not only in terms of the new GP contract, but also in terms of local health needs.

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CONFLICTS OF INTEREST

None.

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