Quality in Primary Care 2007;15:353–9

Research paper

Identifying the barriers to implementing a quality initiative in primary care: the views of practices in Scotland on the Quality Practice Award

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ABSTRACT

Background There are many quality initiatives available to primary healthcare teams which should improve the quality of care given to patients. Engagement with these initiatives is often lower than expected. The Royal College of General Practitioners (RCGP) Quality Practice Award (QPA) has been achieved by only 8% of Scottish primary healthcare teams. The barriers that prevent teams completing this award were not known, though anecdotal evidence suggested that the intense workload over a short period of time was an issue.

Aim The aim of this study was to identify the barriers to completing the QPA and to ascertain the acceptability of a modular approach to the process.

Method An electronic questionnaire to each general practice in Scotland, providing quantitative and qualitative data.

Results The main barrier identified was the time commitment required. This was followed by the cost to the practice. Particular problems with respect to smaller practices completing the QPA were identified. Other barriers included the need to involve all team members including attached but not employed nursing staff, a sense that clinical governance needs were already being met, and that the QPA gave no perceived added benefit. Fifty-five percent of practices indicated an interest in doing the QPA if a modular version were available.

Conclusion RCGP (Scotland) will work with other colleagues in the field of quality improvement to develop a modular version of QPA and will investigate means of reducing its cost to a practice.

Keywords: barriers, primary health care, quality improvement

How this fits in with quality in primary care

What do we know?

The barriers that prevent primary healthcare teams from engaging in quality initiatives have been described, but on the basis of small samples. Most studies have sought the opinions of higher-level organisations rather than those of practices which are ultimately the organisations which have to carry out the project.

What does this paper add?

This study demonstrates at a national level the barriers that prevent primary healthcare teams from engaging in a quality initiative with significant implications for the team. Time constraints followed by the financial considerations are the main barriers identified, though other barriers also affect the decision not to take part. The availability of a modular approach is seen by practices to be one way of potentially overcoming the barrier of lack of time.

Introduction

The Royal College of General Practitioners (RCGP) Quality Practice Award (QPA) is a criterion-based quality-accreditation process undertaken by primary healthcare teams (PHCTs).[1] It is recognised as the gold standard of quality in primary care in the UK. It includes a wide range of criteria in 21 sections covering aspects of both practice organisation and the clinical care provided to patients. On average, a practice takes 18 months to undergo any necessary changes and produce the written evidence needed to be in the position to have a QPA practice visit. A multidisciplinary team of external assessors, including a lay assessor, then assesses the written evidence provided by the practice and visits the practice to ensure that every criterion is met. As well as this summative function, the visit also acts as a developmental experience for the practice, with the assessors providing formative peer advice. The scheme recognises the commitment of the entire PHCT in providing a high quality of care for patients within a learning and adaptive environment. It focuses on what are considered to be the key functions of a practice, and strives to view these from a patient's perspective. The award is given for a period of five years. As of June 2007, 180 practices in the UK had achieved the award. Of these, 24, having held the award for five years, had been re-accredited. When this study took place, a practice was required to pay a total of £3600 to undertake the process.

The uptake of the QPA across the four countries making up the UK is not equivalent, with proportionally more practices having been awarded it in Scotland (8%) and Northern Ireland (3%) than in England (1%) or Wales (0.2%). No specific research to identify the reasons for this variable uptake has been undertaken to date. Furthermore, despite having a higher proportion of QPA practices than elsewhere, Scotland still has the potential for more practices to do QPA. There is currently no evidence as to why those practices in Scotland that have the capability of passing the QPA choose not to do so.

Quality improvement in health care occurs when the drivers and incentives for change outweigh the barriers and resistors. Drivers for change can be both internal and external to the practice. External factors include financial rewards, comparison of performance with peers and achievement of standards required for continued registration. Internal drivers include the professional desire to improve patient care, the wish to receive positive comments from patients, and the presence of an organisational culture that values quality and views goal achievement as a means of improving teamworking. With the exception of financial incentives, all of these drivers for change may influence a practice in the decision to engage in the QPA process. This particular work, however, focuses on the other side of the equation, the barriers that prevent engagement.

There is published evidence that describes some of the barriers to implementing quality initiatives in primary care.[2–7] Common themes emerge whether the research has been carried out in the UK, US, New Zealand or Holland. The barriers described include workload implications, lack of resources, organisational limitations particularly around information technology, competing priorities and the attitude of the staff. The barriers are also similar when the research has examined these with respect to different types of quality initiatives such as improved chronic disease models of care,[5 6] improving the management of depression,[4] or organisational improvements such as RCGP Quality Team Development.[7] These studies have, however, usually focused on higher-level organisations such as primary care organisations or associations of medical practitioners. Those that have had practices as the subjects have sought the opinions of 20 or fewer practices. In the UK, it is the practice that ultimately chooses whether or not to try to achieve the QPA. The RCGP in Scotland has the aim of improving the quality of Scottish primary care. As a means of progressing this, it was, therefore, considered appropriate to approach each practice in Scotland to ascertain the perceived barriers to engaging in the QPA process. At the same time, as a result of evidence on the benefits of introducing quality improvements in smaller steps,[3] and an awareness of anecdotal feedback of such an approach, the views of the practices on the development of a modular approach to the QPA were also sought.

Methods

A questionnaire asking for practices' views on the barriers to doing the QPA and the practices' views on a possible modular version was devised. Responses were sought using a mixture of five-point Likert scale answers and free-text entries. The questionnaire is included as an appendix. During February 2007, it was sent by email to each of the 13 health boards in Scotland for onward electronic transmission to the 1030 individual practices. The practices returned the questionnaire directly to the RCGP (Scotland) for quantitative analysis and qualitative analysis by the identification of themes.

Results

Responses were obtained from 197 (19%) of the practices. Practices from all but one health board area replied. Respondents came from the full range of practice sizes. There was a proportionally higher response from training practices (39% of respondents were training practices while 27% of practices in Scotland are currently training practices), and 88% of responding practices had scored over 1000 out of 1050 points in the Quality and Outcome Framework (QOF) in the NHS new general medical services contract in the previous year.[8] The QPA had already been achieved by 17% of the respondents.

Table 1 indicates the percentage of practices that consider these factors to score four or five (high score) on the scale of significance as a barrier.

Analysis of the written comments provided further insights into these perceived barriers. The comments underwent a process of content analysis and were categorised into themes. The figures in brackets indicate the number of times these barriers occurred in the responses. Workload and the time involved (14) was the commonest theme identified followed by the problems of tackling QPA when the team was small in size (7). Cost (6) was indicated as a barrier. Other barriers identified from these comments were the consequences of too much change (5), lack of organisation to carry out such a project (4), poor current facilities (2) and the need for too many assessments (2).

Table 1 Percentage of practices considering the potential barriers to doing the QPA to rate 4 or 5 on a scale of 1–5

Barrier	%
Time commitment	61
Cost	41
No perceived benefit	29
Clinical governance needs met by QOF	27
Need for involvement of attached staff	24
Need for involvement from each individual in the team	23

What changes would make practices consider undertaking the QPA?

As part of the questionnaire, some potential changes to QPA were suggested to the practices which could result in it becoming a more attractive proposition. The results to the question 'What changes to the QPA process would make your practice consider undertaking the QPA?' are shown in Table 2.

Analysis of the comments on potential changes was carried out to identify themes. Again, the figures indicate the number of times these themes occurred in the responses. The main theme identified was cost (13), followed by having a longer time to do it (9). Other areas identified include support for smaller practices (4), more linkage to other quality initiatives (4) and work to make it clearer what the benefits are to a practice in doing the QPA (2).

A modular version of the QPA

One way of making the process less daunting would be to develop it as a modular process. Practices were asked if they would be interested in doing the QPA if a modular version was made available. The results were that 55% of respondents replied positively, 27% were not interested in a modular version, while 17% did not respond to that question.

Analysis of the written comments identified the themes listed in Table 3. They are divided into positive, negative and neutral responses.

Table 2 Percentage of practices responding to 'What changes to the QPA process would make your practice consider undertaking the QPA?'

	Yes (%)	No (%)	No response (%)
Fewer criteria	57	20	23
Presenting the evidence as an electronic submission	50	26	24
More reflective criteria (around individual and practice learning needs)	40	36	24
Removal of QOF indicators from the process	25	51	24

Table 3 Themes identified concerning a proposed modular version of the QPA

	Number of times mentioned
Positive comments	
Manageable chunks	43
More time to do it	9
Spreads cost over time	4
Helpful for smaller practices	3
Negative comments	
Same barriers exist	25
Prefer current format	8
Neutral comments	
Not enough knowledge to comment	7
Other comments	19

Discussion

It is acknowledged that efforts to improve the quality of primary care are hampered by many barriers. It is also clear that, in order to overcome these barriers two processes are needed. Firstly, the barriers must themselves be properly identified, and then secondly specific and targeted interventions need to be focused on each barrier identified. Many attempts at quality improvement are unsuccessful because these two aspects have not been considered.[9,10]

This study is the first to examine the barriers to implementing a quality initiative in primary care by seeking the views of all general practices in one country. The QPA is a challenging process and is not an appropriate approach for those practices that are not already well organised. Training practices made up 39% of the responding practices, and 88% of the practices scored over 1000 points in the most recent QOF. These are likely to be well-organised practices able to tackle the QPA. This indicates that many of the responses came from those practices in which it is especially relevant to identify the barriers.

The issue of increased workload being seen to be a barrier replicates findings in other studies.[2,4,6,7] In this cohort of practices it appears to matter more than the financial implications. The concept of tackling the project in 'bite-sized chunks' was raised by several respondents. In view of this and the very positive response to the questions on the practices' views on a modular QPA, RCGP (Scotland) proposes to work with other colleagues in the field of quality improvement so that such a version of the QPA can be developed. It is proposed that the current QPA criteria are divided up into six domains which become stand-alone modules. The suggested domains are patient centredness, management of illness, records, special patient groups, the learning organisation and the practice team. Less-well-developed practices would have the option of tackling a smaller number of modules. This would provide evidence to the practice, their patients and the primary care organisation that a defined level of clinical governance was being achieved. In particular, it would have the advantage of clinical governance being carried out beyond the range of QOF activities. Those practices that are more able to demonstrate the delivery of high-quality care would have the opportunity to pass all six modules at their own pace. When all six are passed the practice would then be invited to undergo a QPA visit which, if successful, would lead to the award of the QPA. Critics of such a system include those who, from an elitist perspective, wish to retain the QPA as a major challenge to a practice, to be worked at and achieved over a short period of time. To counter this argument, it is suggested that both the traditional and modular routes will be offered.

Cost remains a barrier as in previous research,[6] and again overcoming this will require working with other stakeholders in primary care so that financial barriers can be minimised. However, this is a complex area and solutions may be difficult to achieve.

Smaller practices find the QPA a particular challenge as the cost is proportionally greater and there is not the facility to share the workload among team members. This barrier has been partially addressed by adjusting the fee for the process when a practice has fewer than 5000 patients.

Previous research has identified attitudinal aspects, particularly among physicians, as being a significant barrier to implementation of quality-improvement projects.[2,4–6] This work did not specifically address these issues, though a small number of negative comments do indicate that such attitudes do exist. Further research by interview would help to determine the extent of this barrier. However, targeting interventions to alter attitudes is a much more difficult proposition than allowing for workload or cost.

This work has focused on the barriers that prevent a practice from doing the QPA. However, if change is to occur by more practices doing the QPA, tackling the barriers is only one side of the equation. The RCGP must also highlight to practices the benefits of doing the QPA, such as improvements in teamworking,[11] and meeting clinical governance needs.

Conclusion

This study has identified the barriers that prevent Scottish primary care teams from deciding to engage in the QPA programme. The main barriers are lack of time, the cost and specific problems for smaller practices.

These issues can be individually addressed by working with partners in the field of quality improvement in primary care in Scotland. In particular, this study provided evidence that a modular approach would be acceptable and of benefit. It is hoped that by identifying the barriers to doing the QPA and specifically addressing them that more practices in Scotland will feel able to demonstrate that they are providing the gold standard of primary care. Previous research indicates that such a process is likely to succeed.[9,10]

ETHICAL APPROVAL

Ethical approval was not required.

FUNDING

This research was funded by RCGP (Scotland). The data collection was carried out by Ms Diane Rich and Ms Allie Page of RCGP (Scotland).

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CONFLICTS OF INTEREST

Dr Ken McLean is Joint Chair of the RCGP QPA and Dr William Taylor is Past Chair of the RCGP QPA.

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Received 17 July 2007
Accepted 5 September 2007

Appendix: Quality Practice Award (QPA) questionnaire

The Quality Practice Award (QPA) is a quality-assurance process undertaken by general practices which recognises a high standard of quality patient care delivered by every member of the practice team. The QPA is recognised by the RCGP as the gold standard of patient care in the UK. Since 1996, 70 practices in Scotland have successfully passed QPA.

RCGP Scotland is keen to develop the QPA to meet the needs of current general practice in Scotland. We wish to find out why some practices opt to take on the challenge of completing the QPA while others do not. Hence, we would be grateful if you could take a few minutes to complete this questionnaire. Please either reply by email or fax. Your reply will be anonymised on receipt to maintain confidentiality.

Practice details

Q1: Please state your health board:

Q2: Please indicate your area:

Urban/Semi-urban/Rural

Q3: Is your practice a training practice:

Yes/No

Q4: Please mark which list size your practice falls into:

0–2500	2500–5000	5001–7500	7501–10 000	Over 10 000

Q5: Please mark how many QOF points your practice achieved on 31 March 2006:

<900	900–1000	1001–1045	>1045

The Quality Practice Award

Q1: How knowledgeable are you about the QPA? Mark which box best reflects this:

Very knowledgeable	Knowledgeable	Some knowledge	Little knowledge	No knowledge

Q2: Has your practice achieved the QPA?

Yes/No

If yes, which version/s?

Q3: Is your practice currently working towards the QPA?

Yes/No

Q4: We are keen to identify what are the barriers to doing the QPA. Please mark the most appropriate box for your position for each possible barrier:

	1: not a barrier	2	3	4	5: significant barrier
Cost					
Need for involvement from each individual in the practice team					
Need for involvement of attached staff					
Time commitment					
No perceived benefit					
Clinical governance needs met by the QOF					
Other (please list)					

Q5: What changes to the QPA process would make your practice consider undertaking the QPA?

	Yes	No
Fewer criteria		
Presenting the evidence as an IT submission		
More reflective criteria (around individual and practice learning needs)		
Removal of QOF indicators from the process		
Other (please list)		

QPA modular version

At present, when a practice notifies the college it intends doing the QPA, it has 18 months to produce the folder of written evidence. A visit is then arranged to complete the process.

Q1: There is a move to develop the QPA into five modules that could be taken separately over a period. Advice would be given at a minimal cost to practices and certificates of completion would be issued for each module. If all five modules were achieved, the practice could then opt to have a visit to attain QPA status. Would you be interested in this type of QPA process?

Yes/No

Please comment on your answer:

Q2: How long should be given to complete all 5 modules?

3 years/4 years/5 years

Thank you for completing this questionnaire.