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Editorial

Quality improvement projects for appraisal and revalidation of general practitioners

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Revalidation of doctors, including general practitioners (GPs), is soon to be delivered after a gestation of over a decade.[1, 2] The expressed aim of revalidation is to ensure that doctors are up-to-date and continue to maintain their fitness to practise.[3] It is currently proposed that this will be achieved through annual appraisal and a five yearly review of appraisal portfolios and other routine clinical governance information. In general practice, appraisals will be carried out by a local appraiser and the revalidation review will be conducted by a senior clinician appointed as a local responsible officer. The responsible officer will review the appraisal portfolio of each doctor and will decide, based on information contained therein and local intelligence about complaints and concerns about performance, whether a doctor is to continue to practise.[4]

Most GPs have welcomed appraisal because it has provided an opportunity to discuss their work as well as successes and challenges in confidence with a colleague.[5] Appraisal has been professionally led, developed locally under national guidance, supportive and largely formative and this has been largely in keeping with the wishes of GPs.[6] Whether these positive attitudes will change because of delays in agreeing the process of revalidation and recent changes to appraisal remains to be seen. Appraisal now also includes an element of summative assessment of a number of mandatory criteria: appraisers check whether a specific number of educational credits (50 per year) have been achieved, a minimum number of significant event audits (two per year) conducted and a five yearly patient satisfaction survey, multisource feedback and clinical audit completed.

GPs who have been interested in and championed quality improvement recently suggested, to experts writing the guidance for revalidation of GPs, that a quality improvement project could be accepted as an alternative to clinical audit as part of the evidence for revalidation. As a result, the Royal College of General Practitioners (RCGP) guide was amended to state that 'GPs should be able, if they wish and they have the expertise, to include a quality improvement project as their audit'. The broad details are included in the guidance (see Box 1).[4]

Although some GPs will have participated in a quality improvement collaborative, few will have had experience of conducting a quality improvement project themselves; most do not have knowledge of the tools and techniques involved and only a small minority have formally applied these methods to solving problems in their practice.[7] Here is a real example of a quality improvement project that was conducted in my practice and which was submitted for appraisal (Box 2).

The Kings Fund in its recent report into 'Improving the quality of care in general practice'[15] expressed a hope that the new primary care organisations would develop better systems to identify inappropriate variation, discover gaps in care, and address these through

Box 1 Quality improvement projects

Description of a quality improvement programme (QIP) should include the:

- title of the QIP
- reason for the choice of topic and statement of the problem
- process under consideration (process mapping)
- priorities for improvement and the measurements adopted
- techniques used to improve the processes
- baseline data collection, analysis and presentation
- quality improvement objectives
- intervention and the maintenance of successful changes
- quality improvement achieved and reflections on the process in terms of:
- knowledge, skills and performance
- safety and quality
- communication, partnership and teamwork
- maintaining trust.

Box 2 Example of a quality improvement project

Title: Improving practice management of insomnia in the practice

Date completed: 1 May 2011

Description: This was a quality improvement project focusing on improving management of insomnia and reducing inappropriate hypnotic prescribing in the practice.

Reason for the choice of topic and statement of the problem: Inappropriate benzodiazepine and z-drug prescribing is common and potentially harmful.[8, 9] There are considerable variations in prescribing of hypnotics and although these are partly due to socioeconomic differences and differences in casemix[10] much of the variation is due to practitioner behaviour.[11, 12] This was conducted as part of a wider quality improvement project involving 32 Lincolnshire practices. The project was funded by the Health Foundation under its Engaging in Quality in Primary Care Awards.

Process under consideration (process mapping): The practice was part of a Quality Improvement Collaborative involving eight Lincolnshire practices. We discussed how we currently managed insomnia and how we might improve care for patients presenting with insomnia. A process map showed that the usual approach was a sleep hygiene leaflet, refusal of a prescription or prescription of a short course of hypnotic drugs.[13]

Priorities for improvement and the measurements adopted: The aim of this quality improvement project was to improve management of insomnia and to reduce long term and inappropriate hypnotic benzodiazepine and z-drug prescribing. We used focus groups to determine priorities of patients and practitioners; critical to quality were the following: listening to patients, empathy and taking the problem seriously; more careful assessment of comorbidity (anxiety, depression, physical illness), severity and pattern of insomnia; offering non-pharmacological treatments for insomnia.[13] The detailed justification can be found at the following website: www.restproject.org.uk/.

We measured monthly prescribing rates of hypnotic benzodiazepines (ADQ per STAR-PU).

Baseline data collection, analysis and presentation: The first data collection from 1/3/07 to 31/8/07 presented in run and control charts showed large month-on-month variations in prescriptions of hypnotic benzodiazepines and z-drugs for the practice (Figures 1–4).

Quality improvement objectives: By assessing sleep problems more carefully, using psychological therapy, cognitive behavioural therapy for insomnia (CBTi), we planned to improve patient experience of care and reduce inappropriate and long term prescribing of z-drugs and benzodiazepines.[14]

Techniques used to improve the process: We used a logic model, process maps, Plan-Do-Study-Act cycles and critical-to-quality trees to improve the process of the consultation for insomnia. We used free software (BPchart 4.1) to present the data as run and control charts. We introduced the Insomnia Severity Index and sleep diaries for better assessment of insomnia and now routinely use CBTi in the consultation. Practice nurses and nurse practitioners provide sleep hygiene advice and refer patients with insomnia to the GP for further assessment and treatment.

The results of the second data collection: The second data collection from 1/9/07 and subsequently (Figures 1–4) showed that prescribing of hypnotic benzodiazepines had fallen significantly; z-drugs continued to be prescribed with considerable month-to-month variation. Most of the variation was due to intermittent prescribing and suggested that there were few repeat prescriptions. The impression was that much z-drug prescribing at the practice was related to specialist care but we also needed to be vigilant with prescribing when new doctors started or locum doctors visited the practice.

Intervention and the maintenance of successful changes: We provided better and more consistent care for insomnia using non-pharmacological methods and have achieved reductions in prescribing of hypnotics. There was still work to do to reduce prescribing of z-drugs but prescribing of these agents was often influenced by hospital prescribing for psychiatric conditions.

Quality improvement achieved and reflections on the process in terms of knowledge, skills and performance; safety and quality; communication, partnership and teamwork; maintaining trust: This quality improvement project enabled me to implement learning from this into practice. It improved my knowledge and skills in this area and was relevant, not just for management of primary insomnia, but also for treatment of insomnia associated with depression, anxiety and long term physical conditions. This has led to higher quality, safer care for patients who are happier with the care that they receive. The nurses and nurse practitioners in the practice feel able to refer patients with sleep problems to the GP after advising on sleep hygiene and this has contributed to better teamworking. An e-learning package has been developed for other GPs and primary care staff which has been disseminated to colleagues at the practice, other local practices and more widely: http://elearning.restproject.org.uk/.

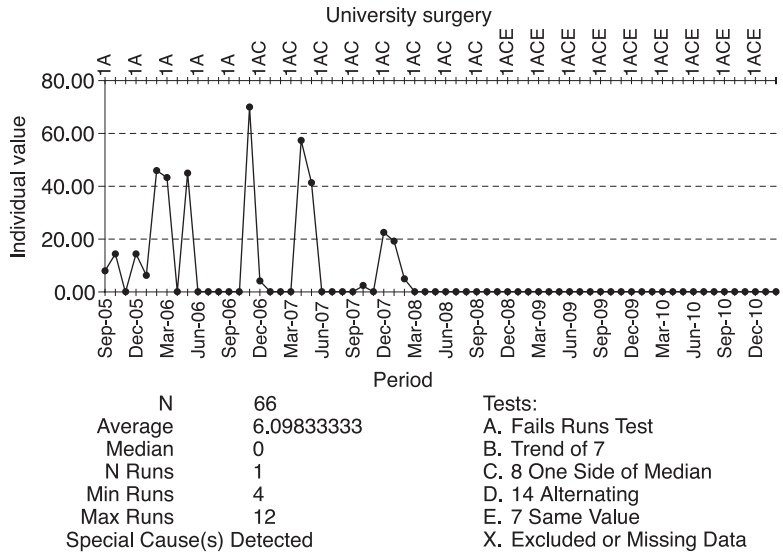

Figure 1 Benzodiazepine (ADQ per 1000 STAR-PU) prescribing run chart

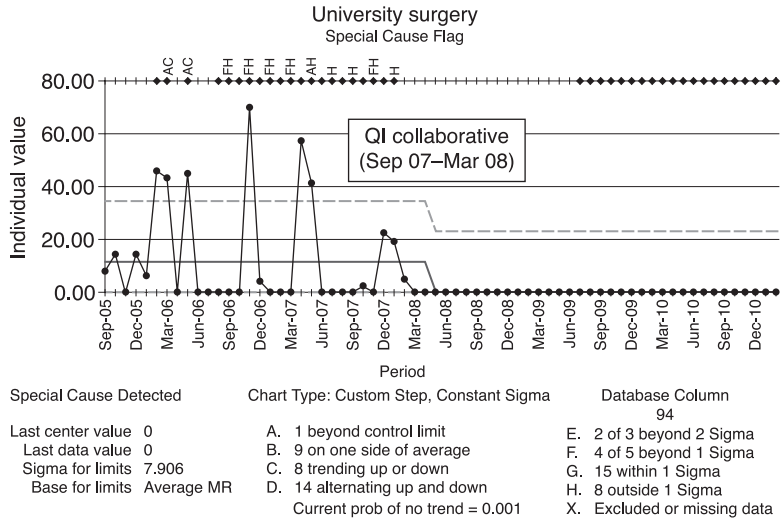

Figure 2 Benzodiazepine (ADQ per 1000 STAR-PU) prescribing control chart

wider use of quality improvement methods. Unfortunately, this is unlikely to occur unless knowledge and application of quality improvement methods increases, and leaders in the new organisations support this development.[16] These methods could prove valuable for improvement but also to evaluate innovations and changes in services.[17]

Wider use of quality improvement projects for appraisal and revalidation as an alternative to clinical audit will require considerable investment in education and training of general practitioners in quality improvement methods during vocational training and afterwards as part of continuing professional development. Whether the promise of higher quality in the health system will be a consequence of the labour pains of revalidation remains to be seen.

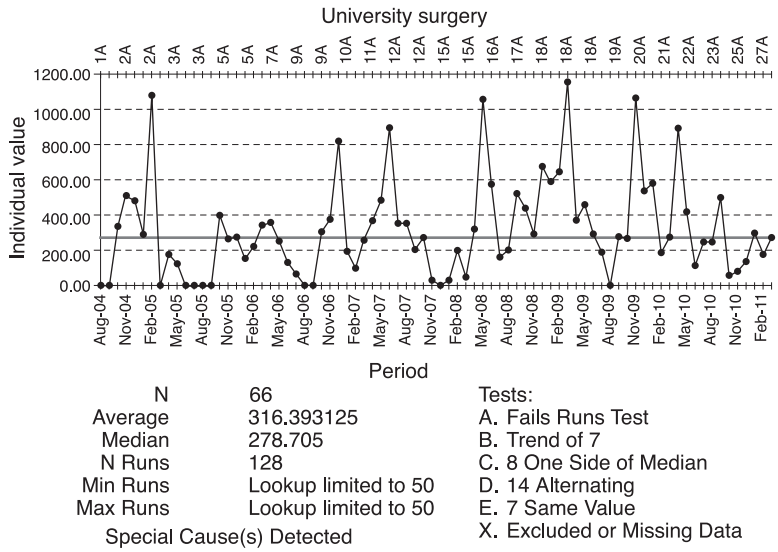

Figure 3 Z-drug (ADQ per 1000 STAR-PU) prescribing run chart

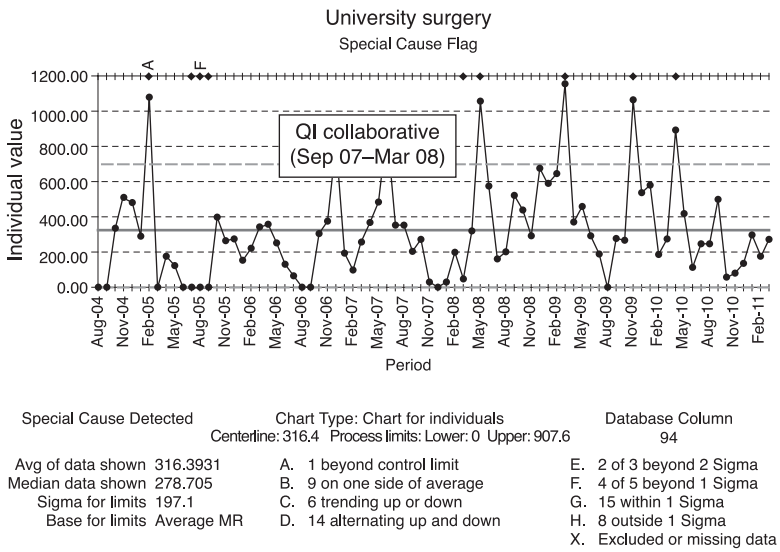

Figure 4 Z-drug (ADQ per 1000 STAR-PU) prescribing control chart

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PEER REVIEW

Commissioned; not externally peer reviewed.

CONFLICTS OF INTEREST

None.

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