Scottish School of Primary Care

Report

A workshop hosted by the SSPC

‘Quality after QOF’

23rd March 2016

Royal Society of Edinburgh

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Forward

The Scottish School of Primary Care (SSPC) facilitates collaboration between primary care academics and key stakeholders involved in policy and integrated health and social care service developments in order to provide evidence-based solutions. Further information about the school can be found at http://www.sspc.ac.uk/

On 23rd March 2016, SSPC hosted a workshop on 'Quality after the Quality and Outcomes Framework' at the Royal Society of Edinburgh. This brought together key senior stakeholders to discuss the issues around the new GP contract in Scotland, in particular the role of GP Quality Clusters. Those attending included senior representatives from the Scottish Government, the British Medical Association (Scotland), the Royal College of General Practitioners (Scotland), Health Improvement Scotland, NHS Health Scotland, NHS Education Scotland, the General Medical Services Reference Group, NHS National Services Scotland, GPs at the Deep End, and all members of the executive management group of the Scottish School of Primary Care. External speakers included academic and primary care leaders from Denmark, England, Switzerland and Wales. Details of attendees are listed in Appendix 1.

Feedback on the day has been extremely positive, and has already resulted in several important conversations and potential future developments around GP Quality Clusters in Scotland. We are extremely grateful to all our speakers for their informative presentations and for allowing us to circulate their slides (available at http://sspc.ac.uk/presentations), and to our international guests, as well as all the attendees, for helping to make this a thoughtful and positive meeting.

We would also like to thank SSPC Executive Management Group members (Professors Bruce Guthrie and Margaret Maxwell) for their help in recording essential information during the day and helping to write this report. Thanks also to Bridie Fitzpatrick and Alise Middleton for helping in the planning and organisation of this event, and to the Scottish Government for funding.

Professor Stewart Mercer, Director of SSPC

Dr John Gillies OBE, Deputy Director of SSPC

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Executive Summary

What has been learned from the past?

The Quality and Outcomes Framework (QOF) took a single-disease approach and incentivised quality for certain chronic diseases but marginalised quality improvement in those conditions not included in the framework. QOF stimulated electronic record development, and *initially* increased pay and recruitment, reducing variation between practices. However, changing population demographics and rising expectations have increased workload in general practice, while the percentage of NHS spend into general practice across the UK has fallen over the past eight years. A **key message** was that in any large scale change to the NHS, unintended consequences are inevitable. The recording of some elements of QOF measured quality is likely to decrease once incentives are removed.

What are GP Quality Clusters for?

Quality Clusters (QCs) have potentially important roles in quality improvement (QI) within general practice (internal role) and in helping to reorientate the NHS in Scotland towards integrated new models of primary care (external role). The challenges for the NHS require change across the whole system, not just in primary care and general practice. A **key message** was that there is a tension between the 'internal' and 'external' roles of GP QCs; intrinsic quality improvement may be easier to deliver but wider-scale QI requires an effective external role and engagement with multiple stakeholders.

What will GP Quality Clusters need to be effective?

QCs will need substantial central and local support to collate and responsively analyse appropriate data for QI. QC Leads will need training and support in data management, facilitation and change leadership. Much will depend on decisions on the future roles of QCs and responsiveness of the rest of the NHS to them. A **key message** was that to deliver QI, a national support network for QCs coordinating the contributions of HIS, NES, NHS Health Scotland and RCGP Scotland is required.

What are the key risks?

These were considered to be drift due to the loss of QOF and a lack of focus on the potential of clusters, lack of capacity in primary care, unrealistic expectations, and eventual disengagement by the key stakeholders involved.

A **key message** was that if the external role of GP QCs is not quickly developed, there is a risk of new arrangements with Integrated Joint Boards (IJBs) moving forward without GP involvement, worsening the engagement of general practice with the rest of the NHS. This would be detrimental to NHS working across systems, the 2020 vision and to integration of health and social care.

Introduction

The aim of the meeting was to bring together key senior stakeholders to discuss the issues and implications around the new GP contract in Scotland, and in particular the role of the GP in primary care 'Quality Clusters'. These are to be a key component of the new contract and the Scottish Government's vision for a primary care-led, integrated NHS. Shona Robison MSP, Cabinet Secretary, stated her vision as follows:

"a new world"

"My vision puts primary and community care at the heart of the healthcare system, with highly skilled multidisciplinary teams delivering care both in and out of hours, and a wide range of services that are tailored to each local area. That care will take place in locality clusters, and our primary care professionals will be involved in the strategic planning of our health services. The peole who need healthcare be more empowered and informed than ever, and will take control of their health. They will be able to directly access the right professional care at the right time, and remain at or near home wherever possible."

Shona Robison, Scottish Parliament, 15/12/15

Those attending included senior representatives from the Scottish Government, the British Medical Association (Scotland), the Royal College of General Practitioners (Scotland), Health Improvement Scotland, NHS Health Scotland, NHS Education Scotland, the General Medical Services Reference Group, NHS National Services Scotland, GPs at the Deep End, and all members of the Executive Management Group of the Scottish School of Primary Care. External speakers included academic and primary care leaders from England, Switzerland, Denmark and Wales.

The format of the meeting included presentations, open space discussions, panel discussion, and workgroups (see Appendices 3-5 for summary notes of the workgroup discussions). The numbers attending were deliberately capped at 30, and ground rules were established that encouraged open and frank discussion.

Key Themes and Messages

The key themes and messages that emerged from the day were:

Theme 1: What have we learned from the past?

QOF incentivised quality. However, evidence has shown this was already rapidly improving before QOF was introduced, reflecting the many other QI initiatives that were operating from the 1990s onwards.

QOF also stimulated electronic record development and use, *initially* increased pay and recruitment and provided a focus on improving quality for selected chronic diseases. Deprived areas generally did as well as more affluent in terms of QOF single condition measures. However, diseases not included in QOF framework were marginalised and it has been more difficult to maintain a holistic approach due to the single-disease focus. Later iterations of QOF were driven by poorer quality evidence, 'overcrowding' and political interference.

The perception by UK Governments that GPs had been overpaid when QOF was introduced has resulted in a gradual claw back of investment in general practice across the UK. Therefore, while the burdens of dealing with the ageing population, complexity, rising expectations and multimorbidity have risen, resources into general practice have fallen as a percentage of NHS spend. Job stress among GPs has more than doubled in the last ten years. NHS Scotland invests a consistently lower percentage of NHS spend in general practice than NHS England.

SSPC is undertaking a review of evidence from the QOF which will be available on the SSPC website when completed.

A **key message** was that in any large scale change to the NHS, unintended consequences are inevitable, and should where possible be anticipated. Evidence suggests that the recording of elements of QOF measured quality will decrease once incentives are removed.

Theme 2: What are Quality Clusters for?

NHS Scotland policy suggests that QCs have important roles both in QI within general practice and primary care (internal/intrinsic), and in reorienting the NHS in Scotland towards integrated new models of primary care (external/extrinsic). Currently, there is a lack of clarity about the relative importance of these internal or external roles, and/or the timescales over which QCs are expected to take them on (for example, initially focusing on intrinsic activity to build coherence).

There was lively discussion on this topic, with many expressing the crucial importance of the external role in terms of influence over, and evolution of, the acute sector and IJBs. It was repeatedly emphasised by several participants that the changes needed to deal with the challenges to the NHS, including addressing inequalities, could never be achieved solely by changes within primary care, but only by transformational change across the whole health and social care system. This has also been highlighted by Audit Scotland.

The view was also expressed that 'the GPs had to deliver' over the first 1-2 years of the new contract and thus they should (and would likely choose to) focus on the internal role initially.

QCs as currently conceived are focused on GPs (only GPs have any funded time to attend; there is as yet no obvious administrative or managerial resource for QCs to draw on), but their *internal* success will require engagement with practice managers and nurses and other health care professionals (HCPs), and their *external* success will require engagement with a wider range of external stakeholders. NHS levers and responsive IJBs will be required to make both these changes happen.

The **key message** was that there is a real tension between the 'internal' and 'external' roles of GP QCs, with important pros and cons attached to both. The

intrinsic quality improvement role is a replacement for QOF and likely to be more easily deliverable as it is more directly under QC members' control, but wider-scale improvement in care will require an effective external role requiring engagement with and by other stakeholders (acute care, IJBs, third sector etc). ***If the external role is not quickly developed, there is a risk of new arrangements with IJBs moving forward without GP involvement, worsening the engagement of general practice with the rest of the NHS. This would be detrimental to NHS working across systems, the 2020 vision and to integration of health and social care.***

Theme 3: What will Quality Clusters need to be effective?

A review of the international literature was presented and two models from London and Wales were discussed.

The Tower Hamlets (London) project has had substantial investment; including web enabled bespoke IT systems, local facilitation and financial incentivisation based on network (cluster) rather than individual practice performance, both driving collaborative working. Secondary care consultants are actively involved. The results are measurable and impressive although it was described in discussion as 'QOF-squared' because of the continued focus on single-disease measurement.

The NHS Wales Quality Cluster development has some similarities to the planned changes in Scotland, but a key difference is that Welsh clusters have been given control of over £40 million to invest directly in local improvement priorities either in general practice or in the wider system. What QCs in Scotland will need to thrive and contribute will depend on the balance between internal and external roles set out above. However, in Scotland, the current direct investment in clusters is relatively small and only for GP time. Both roles will require additional support and investment.

Data for improvement: QCs will require support to collate and analyse currently available quantitative data. QC effectiveness will be enhanced when central data analytic services are responsive to QC requests to develop bespoke analyses of existing datasets *and* develop new datasets where required (Appendix 3). QCs should also be supported to develop skills in using qualitative and quantitative data for reflection and improvement (for example, based on narratives or significant event analysis). Web based tools and dashboards will be needed.

Tools, skills and infrastructure: The priority will be to value, train and support QC leads in data management, facilitation and leadership for change. Vital areas are QI skills training, data management, organisational development and support (Appendices 3 and 4). Delays within the NHS Scotland funding system which can cause drift and disengagement by GPs and primary care should be acknowledged and addressed (Appendix 4).

Three levels of coordinated support were suggested:

- National (SG, NES, HIS, NSS, NHS Health, RCGP Scotland)
- Health Board/IJB level
- QC level.

Autonomy vs consistency: GPs have become deskilled from 12 years of QOF at setting *local* quality agendas. There is a need to recognise the great potential benefits of professional values in driving QI while acknowledging the need for accountability and delivery of improvement. Much will depend on decisions of the future roles of QCs and responsiveness of the rest of the NHS to them (Appendix 5).

*At the request of the SG, SSPC is compiling a series of briefing papers for QCs which will provide evidence based summaries on clinical conditions as well as problems like polypharmacy and multimorbidity. These will be made available on the SSPC website (*http://www.sspc.ac.uk/*).*

Theme 4: Risks

As well as the risks in relation to internal/external focus of QCs described above, numerous other risks to the success of GP QCs were identified and discussed. These included:

- Variability of speed of development (while allowing that local variation in different areas of QI was desirable to reflect local health needs)
- Drift – slow or minimal progress or going backwards—disappearance of QOF and therefore loss of anything measureable, but lack of focus on what QCs could or should achieve
- Capacity: not enough GP, nurse, management or administrative & support time to engage with and lead the process at IJB/HB and practice. Profile, investment and momentum are important here.
- Unrealistic expectations. QCs need time and support to develop.
- Disengagement—by Scottish Government, NES, HIS, NHS Health Scotland, BMA, RCGP Scotland, HBs/IJBs/ GPs themselves
- Risks of major change in GP clinical role and 'top of licence' working by all HCPs: fragmentation of care, loss of continuity and coordination and collusion of anonymity in responsibility for care.

Success in overcoming these difficulties will mean ensuring that behaviours are professionally focussed and are 'peer-based and values driven'. Competencies and regulation are also important and necessary but not sufficient.

A **key message** was the need to support and develop the central role of general practice in primary care; that of providing clinically competent and compassionate care for patients and carers in difficult circumstances. There is a core need to ensure that patients' narratives are captured and contribute to development and evaluation of new systems.

Experience of Quality Circles elsewhere suggested they needed mutual trust, active empathy, access to support, lenience in judgement and courage.

Conclusion

The meeting was successful in surfacing many of the complex issues surrounding the future roles of QCs. There was only limited discussion on health inequalities and the inverse care law in Scotland, and how QCs serving deprived areas might best be supported to help reduce health inequalities. There was no discussion on the practicalities of developing QCs in remote and rural areas, where populations and practices are widely dispersed. The potential of Out Of Hours GPs to be involved and contribute to QCs was not covered. It was clear from the Tower Hamlets experience that impressive improvements in quality of care in deprived areas are achievable. The amount and distribution of funding to practices and clusters in Scotland was not discussed in depth, although it was clear that substantial resource shifts will be required if QCs are to flourish in Scotland.

There was a 'quiet optimism' among participants. It was generally felt that the new GP contract in Scotland offered a major opportunity to take a big leap forward, but development of both intrinsic/internal and extrinsic/external roles is predicated on a radical reshaping of general practice, primary care and the whole health system. Quality should be thought of as both measurable by quantitative data on clinical and organisational dimensions of QC activity, and also by evidence of successful new effective interactions across the healthcare system, indicating a positive cultural shift. A strong concomitant focus on primary care research can also contribute to good health system outcomes. These changes will need visionary strategic leadership, commitment of resource and a clear top down narrative from Scottish Government.

Appendix 1: Workgroup 1: Data

Summary of key points

- A choice to be made about QC roles which will then drive data requirements
  - ⇒ Focus on improving quality in their practices (intrinsic; inward looking narrow focus but they can control and therefore deliver it)
  - ⇒ Focus on wider health service functioning (extrinsic; outward looking broader remit which will need support from and role changes for HBs and IJBs)
- Important to support clusters in delivering 'quick wins' in the first year.
  - ⇒ Those could be either internally focused in practices or externally focused on the wider system
  - ⇒ Internally focused is probably easier to do, but externally focused (if it can be pulled off) might be better for a sense of purpose.
- The way that data are presented is very important, and web-based and/or dash-boarding tools are needed: large volumes of complex data. Important to be selective and not just dump all the data that happen to be available onto QCs.
- Improvement via clusters doesn't have to be data driven. QCs can agree that they have a problem that needs fixing and set out to fix it (for example, consensus that they need a 'rapid advice' service from secondary care).
- Agreed that it was important that QCs decide what their priorities are and therefore what data they need, but some important tensions.
  - ⇒ In the short term, there was need to give QCs some data, the trick being to avoid it being seen as an implicit or explicit steer that they *must* focus on what was being measured (particularly since the national dashboard in year one is likely to be built primarily on secondary care data).
  - ⇒ In the medium term, QCs would be expected to develop their own priorities and request 'bespoke' analysis of existing data, but there was concern as to how responsive national services or Boards could be in servicing requests for new measures/indicators based on existing data. Building measures requires a combination of clinical and technical expertise.
  - ⇒ In the medium term, would QCS be able to request the creation of new datasets, for example in relation to care co-ordination or patient-reported outcomes?
- Clusters will need facilitation and support to create, interpret and respond to data (see Appendix 4).

Appendix 2: Workgroup 2: Skills, tools and infrastructure to support Quality Improvement work in clusters

Summary of Key Points

- Depends on the aim and purpose of QCs. Just a way to get rid of QOF? Are they primarily intended to have an intrinsic or extrinsic focus? If both, what gets prioritised?
- The current crisis in GP recruitment and retention constitutes a risk to QC development; difficult to free up sufficient GP time and energy from the need to deliver the core clinical service for patients. May be seen as distraction.
- QC leads will need training. Newham (London) offers a 3 day course which has been effective. Skills needed: confidence, emotional intelligence, commitment, numeracy/data skills, leadership and people management skills.
- QC leads will also need: coaching/support/mentoring, as well as skills development (see above) and administrative support

- There is currently a confusing landscape of offers for GPs and potential QCs for tools, skills and training in QI at present, with outputs from HIS, NES, Quality Improvement hub, NHS Health Scotland and RCGP Scotland.

- These organisations could collaborate to provide a **national network** to provide support to QCs. **The need is for a virtual presence with a national profile which is clearly orientated towards the development and support of QCs**. **ALL** QC leads should have brief training. All 100 leads (approx) should have training in groups. This would involve developing a curriculum, piloting it and rolling it out quickly.

- This support to QCs could comprise:
  - ⇒ Support to generate provide and interpret data, intelligence, knowledge from different sources for QI
  - ⇒ Skills in business case development for resource shifts
  - ⇒ Tools for QI: PDSA, Lean methodology etc in accessible formats
  - ⇒ Facilitation skills are essential to avoid dysfunctional clusters; facilitation skills training, probably through NES, needs to be a priority at national and probably IJB level

- The offer of the network should involve best practice from elsewhere in UK and internationally. This national level could also be a repository for sharing good practice as it develops through a website and regular meetings, face to face or through webinar.

- Health Board/ Integrated Joint Board level. To have an impact at their local level, QCs will need local support to move forward. This should include:
  - ⇒ infrastructure support — administrative office support to coordinate QC work within a IJB, including liaison among QCs within an IJB to share good practice etc. Infrastructure support is also necessary for liaison with locality networks, communities, acute sector, director of medical education and IJBs
  - ⇒ coaching and mentoring to help develop QC leads (probably with support from national level above)
  - ⇒ Using (and probably expanding) **protected learning time** (PLT) schemes to provide a focus for discussion of priorities/work to be undertaken
  - ⇒ Data/ intelligence support
  - ⇒ Local publicity to attract older GPs with relevant clinical/educational experience to contribute to both QCs and training/mentoring/coaching
  - ⇒ All of these will require levers to be created by Scottish Government to ensure the active involvement of IJBs/HBs in the roll out and development of QCs. Without this active involvement and support, they are unlikely to flourish or contribute creatively to the 2020 vision or to improving quality in primary care.

- **Cluster level:** The main role at this level is engagement with practices, through practice quality leads, but also through other means, eg PLT schemes, to set priorities and make decisions about which areas to focus on. There was a consensus that this could be a GP, other HCP or practice manager, also that the attendee could be different depending on need and stage of development.

To achieve results:

- **Active** engagement and support by HBs/IJBs (see above). Existing local practice manager networks may be of use here
- **Creative** use of available workforce, including older GPs with experience of groups and training who may have time to contribute further
- Material for practice to use to develop plans for QI work (**Intelligence led)**

Risks

We identified the following risks:

- Variability of speed of development (while allowing that local variation in areas of QI was probably desirable)
- Drift – slow or minimal progress
- Going backwards — disappearance of QOF and therefore loss of anything measureable while no focus on what clusters could achieve
- Capacity: not enough GP, nurse, management or administrative time to engage with and lead the process at IJB/HB and practice. Creating something new needs investment.
- Unrealistic expectations. QCs, as Adrian set out clearly, need time to develop.
- Disengagement — by Scottish Government, NES, HIS, NHS Health Scotland, BMA, RCGP Scotland, HBs/IJBs/ GPs themselves

These risks are very real but can be mitigated or abolished by a concerted commitment by all concerned, at all levels to move QCs forward. This involves creating a forward momentum to ensure that practices and wider primary care are aware of the role of QCs and that they are supported as set out above.

Appendix 3: Workshop 3: Autonomy of clusters versus consistency across clusters

Summary of Key Points:

- General agreement that there is an appetite in primary care in Scotland for change. Notions of agency and empowerment were prominent in the discussions: giving professionals the feeling that they can do something to change the way things are; and agency to change things.

- Autonomy has to be balanced with the need for governance and accountability. QCs should begin with a degree of freedom regarding how they develop and operate but with a clear view that they must be able to demonstrate at some future point, the difference that they have made. This will likely be in line with demonstrating that money invested in primary care has achieved certain objectives to justify any additional resource. This will likely be focused on demonstrating improved outcomes for patients and improved delivery of care at home (and thus an internal rather than external focus).

- QCs will be expected to make some system level changes e.g. to achieve more/better delivery of care at home. They will need authority and responsibility to make change and to change others. How can they be expected to achieve this without training and support?

- An overall 'quality' service may not always be under the direct responsibility of GPs. There will be many others involved in delivering care (and operating at the top of their licence). QCs may need to be interested in what a range of professionals are doing and their outcomes. Actions taken outside of the QCs may need to become part of the work (or at least of interest) of the QCs. However, it was recognised that this may likely take time for QCs to grow to have the confidence to tackle system wider problems [the external focus].

- The current 'quality' culture has been founded on GPs receiving direction on what targets to achieve. This may have de-skilled GPs in setting the quality agenda and what are important outcomes. It will take time to re-skill GPs, and local priorities may determine different outcomes as important (see Appendix 4).

- Once a 'collective confidence' is achieved then representation in other forums (extrinsic focus, such as advising IJBs and commissioning, locality meetings) will be much stronger and more influential.

- The Scottish Governments' vision for QCs is one which fosters local autonomy (rather than top down direction) with a transition phase to prevent unrealistic expectations in the early stages. Some participants at the workshop perceived this as a lack of clarity and a need for further guidance concerning the government's expectations of QCs.

Speakers Presentations

Powerpoint files for each speaker are available to download at http://sspc.ac.uk/presentations/

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Appendix 4 Workshop Attendees

Scottish Government	
Richard Foggo	Deputy Director, Head of Primary Care,
Dr Gregor Smith	Deputy Chief Medical Officer, Primary Care Division
Dr John Nugent	Senior Medical Officer, Primary Care Division
Dr Niamh O'Connor	Team Leader, Primary Medical Services
Alison Bell	Head of Primary Care Strategy Team
Sinead Power	Head of Primary Care Innovation and Improvement Team
Prof Sir Lewis Ritchie	Mackenzie Professor of General Practice, University of Aberdeen
Diane Campion	Team Leader NHS 24/Urgent Care Primary Care Directorate
British Medical Association (BMA)	
Dr Alan McDevitt	Chair of the Scottish General Practitioners Committee
Dr Andrew Buist	Deputy Chair of Scottish General Practitioners Committee
Scottish School of Primary Care (SSPC)	
Prof Stewart Mercer	Director of SSPC, Professor of Primary Care Research, University of Glasgow
Dr John Gillies	Deputy Director of SSPC, Honorary Senior Lecturer in General Practice, University of Edinburgh
Prof Bruce Guthrie	Professor of Primary Care Medicine, University of Dundee
Prof Margaret Maxwell	Deputy Director of the Chief Scientist Office Nursing, Midwifery and Allied health Professions Research Unit
Royal College of General Practitioners (RCGP)	
Dr Miles Mack	Chair of the Royal College of General Practitioners
Dr Jenny Bennison	Executive Officer for Quality Improvement at RCGP
Healthcare Improvement Scotland (HIS)	
Dr Brian Robson	Executive Clinical Director, HIS
Dr Neil Houston	GP Clinical Lead Scottish Patient Safety programme in Primary Care
NHS Education for Scotland (NES)	
Dr John McKay	Assistant GP Director Quality Improvement & Performance
NHS National Services Scotland (NSS)	
Dr Lucy Munro	General Practitioner, Associate Medical Director, Primary Care, Edinburgh
General Medical Services (GMS) Reference Group	
Eddie Fraser	Director of East Ayrshire Health and Social Care Partnership
NHS Wales	
Dr Richard Lewis	National Professional lead for Primary Care in Wales
DEEP END	
Dr Peter Cawston	General Practitioner at Garscadden Burn Medical Practice, Drumchapel, Glasgow
Dr John Robson	General Practitioner in Tower Hamlets, Clinical Lead for the Clinical Effectiveness Group, Queen Mary University of London
External Academics	
Prof Martin Roland	Special Advisor to RAND Europe, Professor of Health Services Research, University of Cambridge
Prof Martin Marshall	Professor of Healthcare Improvement, University College London
Prof Frede Olesen	Professor of General Practice, Aarhus University, Denmark
Dr Adrian Rohrbasser	Family Physician, MSc in Evidence Based Health Care, Switzerland
NHS Health Scotland	
Dr John Anderson	Primary Care Lead, NHS Health Scotland
Diane Stockton	Head of Evaluation, NHS Health Scotland