RCGP Scotland response to Health and Sport Committee’s Clinical Governance call for views

RESPONSE FROM RCGP SCOTLAND

The Royal College of General Practitioners (RCGP) is the academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the ‘voice’ of general practitioners on education, training and issues around standards of care for patients.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College’s interests within the Scottish Health Service. We currently represent over 5100 GP members and Associates in Training throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

1) Are services safe, effective, and evidence-based?

RCGP are the professional membership body and guardian of standards for family doctors in the UK, working to promote excellence in primary healthcare.

Key drivers for General Practitioner professionalism are the ability to deliver safe, effective patient centred and compassionate care. Tools have evolved in practice to identify and reduce risk. The introduction of such patient safety tools, including practice safety culture measures, trigger tools and enhanced significant event analysis, implemented within a landscape in which measuring quality outcomes has been embedded in routine practice, has generated a culture in which the delivery of clinical care has become increasingly subject to internal scrutiny. Such measures and activities which contribute to quality improvement are now part of the regulatory framework for licensing of GPs by the GMC. As such, GPs strive to deliver the highest quality of care to patients and it is generally accepted that knowledge of the evidence is embedded in clinical decision making and supports good clinical practice.

Measures of effective care in the general practice context span across a number of parameters. Improvements in health outcomes across some disease areas have unquestionably been a positive result of the Quality Outcomes Framework in General Practice (QOF) but there is now recognition that the systems supporting health improvement are sufficiently embedded for chronic disease monitoring and management and this model for further quality improvement can now be considered too linear for continued gain and carries significant risk for over diagnosis as well as over treatment and significant potential conflict with the principles set out in Realistic medicine. Delivery of effective care is also reflected in the ageing population, with people living longer with their...
long term conditions. Their remains a huge challenge for effective care in the existing social and geographic inequalities which continue to challenge consistent quality across all social demographics. The health economic investigations of Dr Helene Irvine, Consultant in Public Health, have provided substantive evidence of the cost effectiveness in the care delivered by General Practice.

Quality standards for delivery of the service in General Practice are set by our college through continuous work within and out with the organisation and are defined by the available evidence. Educational resources to support the General Practitioner are provided by our organisation and are essential to CPD and the quality of patient care. Achieving improvement in standards must be delivered through ‘evidence informed’ quality improvement.

As defined in ‘Quality improvement for General Practice – a guide for GPs and the whole practice team’, quality improvement describes “…a commitment to continuously improving the quality of healthcare, focusing on the preferences and needs of the people who use services.”

In the modern day, primary care context, quality improvement must however be delivered in the face of a reduction in funding for general practice and increased public and political demands on the role of the GP. It is therefore important to strike a realistic balance of what GPs can deliver in terms of quality improvement whilst ultimately prioritising patient safety.

RCGP Scotland believes that the replacement of QOF with the creation of GP clusters will increase the effectiveness and evidence base upon which clinical governance will be conducted. RCGP Scotland had long advocated for the replacement of QOF, believing it to have out-lived its effectiveness and latterly contributed disproportionately to the increasingly unnecessary administrative burden that it put on the already extremely stretched GP workforce. In the College’s 2016 Scottish Parliamentary manifesto we called for QOF to be replaced with a framework which, ‘will meet quality ambitions and ensure patient safety while minimising administrative duties.’ In essence, we hoped this would be a system of professional, peer-led, values driven governance to better meet the local needs of patients and health care service. The College advocated for the formation of clusters of GPs which should be defined as groups of GP practices within a geographic locality (community) covering between 20-50,000 patients. The College was therefore extremely encouraged when the Scottish Government announced that QOF would be dismantled in 2016/17 with the formation of GP clusters taking its place and we have been grateful to the Scottish Government for our involvement in this transition.

Although still in the early stages of development, we believe that the formation of GP clusters will aid the effectiveness of the quality systems in place. GP clusters have the opportunity to build a platform upon which practitioners, through the Practice Quality Leads and Cluster Quality Leads roles, are able to share knowledge and best practice. The geographic locality of clusters will enable information sharing between local practices, which will be of particular importance to the local population. In the context of general practice, the creation of GP clusters presents an exciting opportunity to improve the effectiveness and safety of GP practices through information sharing.

It will be essential that sufficient resource is invested in supporting cluster working to ensure a robust clinical governance structure which assures continued safe, effective and evidence informed patient care.
Evidence has indicated that a significant proportion of patient safety incidents identified in general practice occur at the interface between Primary and Secondary care prompting a survey by Dr Carey Lunan, EO for Interface and Chair Elect, on behalf of RCGP Scotland to explore this with members. The survey which was responded to by 619 members, with representation from across all fourteen Health Board areas, identified issues relating to the breakdown of care, communication and system errors at the interface. The survey also highlighted the desire to improve interface working. Addressing the issues that exist across the various interfaces in health care is now a priority for RCGP Scotland and is promoted through our ‘Effective Interface’ modules which aim to assist GPs and consultants to identify and provide solutions to problems that exist at various interfaces in care.

The campaign to call for 11% of the annual NHS Scotland budget to be invested in general practice is essential in achieving a robust clinical governance structure for continuous quality improvement in General Practice.

2) Are patient and service users’ perspectives taken into account in the planning and delivery of services?

GP Practices across Scotland use a variety of ways of engaging patient feedback, contribution and participation in development of services within their respective practices. Our own Patient Partnership in Practice (P3) Group has had a loud voice in many existing and developing initiatives at a national level and in 2012 led a piece of work to explore the level at which Patient Participation Groups existed in Practices. This identified scope for improvement, but highlighted the importance of flexibility in the methods of patient engagement and a need to be aware of the potential pitfalls of assumptions about what effective patient participation should look like.

RCGP Scotland is committed to ensuring that patients are actively involved in setting the quality agenda, at practice, cluster and locality level. Dr Jenny Bennison’s paper, “Setting the strategy for Quality in Scotland’s General Practices” (2016) summarises the current involvement of patients in the planning and delivery of services in primary care. This states,

“The use of patient experience surveys is widespread, but there is no evidence that information from these surveys is associated with service improvement. Whilst surveys can endorse existing high quality service provision, it is not clear how results can be translated into service improvement (27). Interestingly, a large study of patient experience surveys in England (28) has concluded that communication with the doctor is the most important factor for patients’ overall satisfaction, followed by the helpfulness of reception staff. Measures of access, including the ability to book appointments in advance, were poorly related to satisfaction.

The Scottish Health Council (SHC) (29) (30) also offers support for the patient voice in Scotland and RCGP Scotland has collaborated with SHC in recent years to explore how to maximise the patient voice in general practice. On-going work in this area will be essential as the landscape changes.

Patient Partnership Forums (PPF), until now managed by the former Community Health Partnerships, usually consist of members of the public. It is unclear so far whether these will continue with the advent of integrated health and social care (31) in Health
and Social Care Partnerships (HSCP). PPFs can make an important contribution, and we recommend that these should be a mandatory part of each HSCP.

The joint SHC and Scottish Government ‘Our Voice’ proposal (29) underpins the Scottish Government policy commitment to strengthen the voice of the patient in their local services.

The role of Patient Participation Groups (PPGs) (30) or PPFs for clusters and the role for patient representatives in clusters is a very important area of consideration. The existence of a funded PPG or PPF at cluster level should be mandatory. These groups can have an important role in the assessment and sharing of quality data. PPGs at practice level will clearly have an important role too, but the huge variation in practice type, size and demographic could mean that making PPGs mandatory at this level would be unfeasible.”

In summary, at present although there are means by which patients can feed into the planning and delivery of services, it is often the case that there are not the vehicles and processes in place to effectively follow-up such input to ensure that the final service accurately reflects patients’ input. RCGP Scotland believes that patient involvement is of paramount importance and we believe that the creation of GP clusters presents an important opportunity for patients to become more effectively involved in general practice. This is an opportunity which must be seized to ensure that we do not slip towards the ad-hoc involvement as highlighted by Dr Bennison in the above excerpt.

3) Do services treat people with dignity and respect?

RCGP Scotland firmly believe our core values as set out in the ‘Core Values’ paper are congruent with treating patients with absolute dignity and respect.

Patient safety is at the core of the work of GPs and clinicians strive to ensure that all services provided represent the best possible care and safety standards for the patient. However, due to the current financial constraints and continued disinvestment in general practice, more could be done to ensure that the services provided to patients treat them with dignity and respect. A key example of this is the use of standard 10-minute consultations in general practice. RCGP have been clear in our opposition to the use of such time-constrained appointments as they are becoming increasingly inadequate to fulfil the needs of the consultation and meet the needs of patients and do not allow for the type of in-depth conversations required in managing complex health matters. We believe that such a system does not allow for the dignity and respect that clinicians would like their patients to receive, which is why RCGP have called repeatedly for the resource investment which would allow 10 minute consultations to be scrapped.

From the perspective of Quality Improvement within general practice, the decision to replace QOF has been well received by clinicians. Our members consistently reported that they felt that the previous system undermined the authority of the GP, reducing the complex nature of Quality Improvement to nothing more than a ‘tick box’ exercise. RCGP Scotland is hopeful that the move away from QOF will increase morale and ultimately increase the respect felt by clinicians for their professional autonomy by the services and systems that are in place.
4) **Are staff and the public confident about the safety and quality of NHS services?**

Quality is at the heart of all work carried out by GPs and is woven into the fabric of RCGP Scotland through the College’s [strategic plan](https://www.rcgp.org.uk/). All GPs strive to provide the best possible care for patients, families and communities. However, the ability for GPs to deliver the standard and quality of service that they aspire to must be balanced against the current climate that they are working within. As is widely reported and acknowledged, GP practices and individual GPs are working under considerable pressure from the compounding problems of an increasing workforce shortage, unsustainable workloads and an increasing expectation of what is expected in the role of the GP.

The confusion over the amount of funding that the Scottish Government intends to invest in the future of general practice continues to be of concern to general practitioners as they look towards the future of general practice. RCGP Scotland have been consistent in our calls for 11% of the total, annual NHS budget to be delivered to general practice. The investment of 11% will help to deliver the quality required to ensure that patients and staff alike can be confident in the quality of general practice.

The replacement of QOF with a new approach to quality based on innovation and continual improvement, achieved through the small GP cluster approach which adopts a peer led, values driven approach will, we hope, lead to an increase in confidence among clinicians in delivering high quality care to patients.

Of course, many challenges lie ahead for the future of general practice, especially given the integration of health and social care. The move towards an integrated model of care is the correct direction of travel, however in order for full confidence to be placed in the model, the interface must be improved. National patient safety data show that 50% of medical errors occur at interfaces, where patients move from one area of healthcare to another. Around one third of these happen at the primary-secondary care interface. Improvements must therefore be made to this interface, as the delivery of healthcare becomes increasingly complex to ensure that clinicians working across the interfaces are confident in the safety and quality of the services that they are delivering. A proposal has been put forward through the ‘Improving General Practice Sustainability Group’, for the creation and implementation of Primary-Secondary Care Interface Groups in every health board across Scotland. It is intended that the establishment of such groups will help to strengthen the inter-professional relationships across Primary and Secondary care, improving the communication across the interface.

Similar communication problems also exist in the interface between in-hours general practice and out-of-hours. Such problems must be rectified in order to improve the confidence in the integrated system as a whole.

RCGP Scotland have been clear in our commitment to ensuring that patients are actively involved in setting the quality agenda at all levels. The college believes that this is the best means by which the public’s confidence in the health system can be improved and it is hoped that this will ensure that the final product is reflective of the needs of the patients.

5) **Do quality of care, effectiveness and efficiency drive decision making in the NHS?**
Helene Irvine’s research provides compelling evidence for the benefits to the effectiveness and efficiency that can be achieved by investment in General Practice and the negative outcomes of disinvestment. Much has been made of the proposed new models for Primary Care based on the effectiveness of multidisciplinary teams but GPs have been working as part of multidisciplinary teams for more than two decades and what has already been evolving in many practices across Scotland is an enhancement of these teams which more recently has been stalling through lack of investment. RCGP Scotland welcomes the plans for new investment but remains uncertain about the benefits to the quality, effectiveness and efficiency of primary care services if these teams become fragmented across health and social care partnerships and existing efforts to enhance skills and to expand and consolidate effective teams are stagnated through the proposed developments. We anticipate significant risk to the continuity and consistency of arrangements for professionals working in the evolving multidisciplinary teams challenging the ability to build effective working relationships and trust if these professional colleagues are not reliably attached to practices with any degree of consistency.

RCGP Scotland have been instrumental in ensuring that quality of care is at the forefront of developing evolving models of care. Together with Healthcare Improvement Scotland (HIS), RCGP Scotland published “Developing a Quality Framework for General Practice in Scotland” in 2014. In developing this framework the College and HIS successfully brought together all existing quality improvement activities within general practice, while determining where the gaps in those activities were and making a number of recommendations for future priorities.

As GPs, we are committed to ensuring that Quality Improvement is at the heart of the work that we carry out. There are however clear challenges in achieving this, as Dr Bennison explains:

“In future we need to be in a situation where quality improvement (QI) activity is an essential and integral part of the role of all clinicians in primary care, rather than an optional add-on with which individuals may or may not engage.

In order to build quality teams in primary care, General Practitioners (GPs) must also have a role in ensuring that generalist skills are recognised, developed and protected in other clinical colleagues; this should happen within existing teams, as well as across the various interfaces. Practice Managers are also an important group to consider when planning training requirements around QI: their role will change as we move away from current activities around the QoF.

There is a need for all GPs to recognise, understand and accept their role as experts; Reeve (3) describes this challenge as ‘translating expert generalist medicine’ and describes the various barriers to this. The trustworthiness of decision-making needs to be established, and awareness of the concept of expertise will need to be shared more confidently. The transition to new models of care needs to be managed carefully in order to avoid ‘change fatigue’, and this will require strong collaborative leadership, and involvement of patients and other members of the primary healthcare team, as well as GPs. GPs at practice, cluster and locality levels, and cluster quality leads, will require training; at the current time GP skills in the area of QI are variable, despite the introduction, in the 2014/2015 QOF year, of new indicators in this area.”
6) Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

Assessing the extent to which elements of high quality care are delivered is an important pre-requisite for improving them. Some of the elements of high quality care can be measured with a reasonable level of scientific rigour and in some cases datasets are available that allow judgements to be made about unwarranted variation in quality. For others, current measures may not be robust. For an important part of what GPs do, such as managing uncertainty, there may be no reliable or valid measures but these nevertheless need to be valued.

The move towards a peer-led, values-driven form of cluster working presents a great opportunity to develop assurance frameworks through which practitioners will be able to develop confidence that the correct systems are in place to detect when things go wrong. Clusters will provide a very useful forum to facilitate the sharing of existing tools which have been proven to successfully identify areas where care has been less effective or suboptimal, such as significant event analysis. Application of an enhanced method using a systems based approach underpinned by human factors science is becoming more widely used in general practice as an effective method of implementing improvement in quality.

RCGP have developed a range of Quality Improvement toolkits with leading third sector, public and governmental bodies which aim to provide support and shared experience on a range of topics to help enhance the amount and dissemination of quality information available for clinicians.

RCGP Scotland looks forward to working with partners and the Scottish Government to develop further frameworks as the new model develops.