



REPORT TO NHS STOKE ON TRENT

SUPPORTING QUALITY OF CARE FOR PATIENTS IN NHS STOKE ON TRENT

Executive Summary

In December 2008, NHS Stoke on Trent placed a tender for the development of a Quality Improvement Framework (QIF). This was to include a review of all practices with the development of a Practice Development Plan for each. CHEC was awarded the contract and started work on January 6th 2009.

Over the course of four months CHEC delivered:

- The development of criteria, standards and evidence to be used in creating the baseline for all practices
- Support for the PCT in recruiting all practices to the scheme
- The development of questionnaires and data extraction inventories
- A visit proforma
- The setting up of a database from which each practice had a quantitative briefing sheet comparing it to local and national norms
- The recruitment and training of six experienced practice visitors/assessors
- 55 half day practice visits
- The creation of 55 draft Practice Development Plans
- Advice to the PCT on qualification for the QIF

This report shows how the project was delivered on time, within budget and to the quality expected by the PCT

Index of Contents

Executive Summary	1
Context	3
The CHEC Team that undertook this project	5
The enhanced team for this project	6
The project	8
Workstream 1: Development of the process for practice assessment	8
Workstream 2: Assessment of the 55 practices	8
Workstream 3: Feedback to the PCT	9
Workstream 4: Feedback to the 55 practices	9
Workstream 5: Development of Practice Development Plans for all 55 practices	10
Timescales and progress	10
Results	10
Recommendations	13
Appendices	Error! Bookmark not defined.
A1- Stoke Data Sources	Error! Bookmark not defined.
A2- Stoke Criteria, Standards and Evidence – The assessment framework Bookmark not defined.	Error!
A3- Stoke Data Sheet - example	Error! Bookmark not defined.
A4- Practice Questionnaire	Error! Bookmark not defined.
A5- Visit Proforma	Error! Bookmark not defined.
A6- Practice Development Plan	Error! Bookmark not defined.
A7- Time Scales	Error! Bookmark not defined.

Context

NHS Stoke on Trent operates within a national context. The *Next Steps Review* led by Lord Darzi, the final report of which is *High Quality Care for All* (Stationary Office, 2008), has emphasised the role of quality in service delivery and the need for world class commissioning. Every PCT is expected to ensure that all the services it commissions, including general medical services, are of sufficient quality.

This builds on a number of pre-existing agendas. These include clinical governance, clinical audit, evidence based medicine and guidelines, value for money, patient safety, practice based commissioning, patient choice, public and patient involvement, expert patients, self care, clinical incentives (QoF) and support for data quality.

Following the publication of the White Paper *Trust, Assurance and Safety* the scene is set for the introduction of enhanced appraisal for GPs in 2009 and revalidation of GPs from 2010. NHS Stoke on Trent must support its general practitioners to be in a position to be revalidated, or it will risk experiencing a medical workforce crisis.

As the Care Quality Commission develops its PCT assessments and the expectation that practices will be expected to undergo practice accreditation grows, the pressure on PCT Boards to place an increased emphasis on quality of primary care will build.

NHS Stoke on Trent had already recognised these imperatives and is actively planning to address them. It is piloting Map of Medicine and is an active partner in the Fit for the Future project which is redesigning care pathways. It commissioned a report *Improving Health Outcomes* from Professor Ruth Chambers and Zafar Iqbal¹. This paper set out a number of ways to address the quality and health inequalities agendas in Stoke on Trent.

The population of Stoke is characterised by widespread deprivation with the majority of people having poorer health outcomes compared to the rest of England. While the underlying causes of health inequalities predominantly rest with social determinants, there were significant opportunities for action in primary care. The detection and management of patients with long term conditions was not maximised, and primary care's ability to influence lifestyles and behaviour was not fully exploited.

NHS Stoke-on-Trent was also vividly aware that the developing agenda, from the *Next Steps Review* to the introduction of revalidation, required action on suspected long-standing unacceptable performance from a minority of general medical practices. So, while the main driver was to improve care for the population there was also a sharper focus on underperformance.

In response a Quality Improvement Framework (QIF) was to be managed by a new Primary Care Development Unit. The QIF will incentivise qualifying volunteer practices to reach, over three years, a range of aspirational targets. Support will be given to practices wishing to enter the QIF but which do not qualify.

¹ Improving Health Outcomes: setting aspirational standards in general medical practices in Stoke on Trent. Chambers R, Iqbal Z. NHS Stoke on Trent, 2008

In preparation a second report was commissioned which looked at contractual standards which practices should meet². The content of this report and the one on aspirational standards were central to the development of the QIF.

The work described in this report is the first step towards putting the QIF into operation. It established the baseline for practices and assessed all of them against the qualification standards for entry into the QIF. For those that qualified, it provided draft practice development plans which will allow NHS Stoke on Trent to agree with practices the steps towards the aspirational standards that each practice will need to make, year by year, to receive their QIF payments.

² Improving Health Outcomes: Setting a baseline for general practices in Stoke on Trent. Norton B, Pullen M. NHS Primary Care Contracting and NHS Stoke on Trent, 2008

The CHEC Team that undertook this project

CHEC is a not-for-profit social enterprise registered as a company limited by guarantee. It is allowed to use the NHS Logo. CHEC has been trading since April 2004 when it was set up with core funding by the (precursor of the) East Midlands Workforce Deanery. It was created with the overall aim of addressing the four “r”s – recruitment, refreshment, retention and re-tracking – in primary care in the East Midlands. Its vision is of a primary care based educational facility in which high quality multi-professional education occurs in a local setting. CHEC’s education is work based, flexible and relevant to the expressed needs of all clinical and non-clinical workers in primary health care.

The CHEC team for this project was:

Jacqui Smith – Manager of CHEC. Previously an Associate Director in a large acute Trust and a radiographer by profession, Jacqui has over 25 years NHS experience both as a clinician and in management and education. She achieved an MBA (Health Executive) in 2005. Specialising in service redesign and leadership, Jacqui is also a former finalist for CIPFA Public Servant of the Year 2004. She has previously been responsible for capital projects up to £12m and revenue £23m. In addition Jacqui has experience of assessment against quality standards being a former member of the Trent Cancer Standards team and a lead for ISO9002.

Jacqui took overall management responsibility for this project.

Professor Mike Pringle – Educational Director of CHEC. Mike is Professor of General Practice in the University of Nottingham; Strategic Director of PRIMIS+; former Chairman of the Royal College of General practitioners (1998-2001); ex-member of the General Medical Council; member of the council of the Medical Defence Union; and deputy chair of the board of UK Biobank. He is part-time Medical Director of the Revalidation Support Team and part time Interim Medical Director for Revalidation in the RCGP.

In this project Mike Pringle led several workstreams and provided key knowledge input.

Julie Reid – Director of CHEC. Julie returned to the NHS in 2001 following 6 years general management within warehousing and distribution. She is a former member of a Trent Breast Screening Quality Assurance team and Trent IHM regional committee member. Julie is Practice Manager at the Collingham Medical Practice and current chair of the Newark & Sherwood Practice Managers’ Forum and Newark & Sherwood PBC Consortium. She has experience of practice assessment visits (both provider and assessor) in the PMCPA pilots. She is co-founder of the original CHEC.

In this project Julie Reid had designated management responsibilities and was a Lead Practice Visitor.

Diana Kirk – Practice Management Consultant to CHEC. She is Practice Director at Lombard Street Surgeries in Newark. She has a particular interest in training and development and has recently led her practice to its third successful re-accreditation in Investors in People. She is a previous runner up in the Doctor ‘Practice Manager of the

Year' awards and an occasional contributor of articles for Practice Manager publications. She is a past Chair of the Newark & Sherwood Practice Managers' Forum and a member of the Trent re-approval visiting teams for GP trainers.

In this project she had designated management responsibilities and was a Lead Practice Visitor.

Rosie Aird – CHEC Education Coordinator. After 13 years in the WRAF, Rosie worked in the prison service, both private and public, for 14 years. The last 11 were in Australia. There she was responsible for organising, developing and delivering both initial and ongoing staff training, which included events for a variety of delegate numbers up to 150. Rosie joined CHEC as Events Coordinator in September 2007.

Judith Baron – CHEC Administrator. After 30 years working in secondary school education Judith decided to make a career change into a post where she could still apply her educational knowledge and principles. Judith gives administrative support to the CHEC Team.

In this project Rosie Aird and Judith Baron offered general office support.

Olivia Hart – After graduating in 2004 York St John's University, York, she has been employed in health care first with the elderly and then with mental health patients.

In this project Olivia Hart was employed full time as the Practice Visit Administrator.

The enhanced team for this project

In addition, CHEC employed staff on short term contracts specifically to deliver this project:

Liz Heath – Liz is Business Manager to the Medical Director in NHS Nottinghamshire County and previously was a Director of Clinical Governance. She has a wealth of experience in quality assessment, support for under-performance and GP appraisal.

In this project Liz Heath was a Lead Practice Visitor.

Rob Lawrence – Rob qualified in medicine from Manchester University in 1998 and did his GP vocational training in Lincoln. He attained the MRCGP in 2006 and since then has been working as a GP partner at the Collingham Surgery. As well as taking an active role in the local PBC cluster and working as vice chair of the Executive team, he has experience of practice assessment visits in the PMCPA pilots.

In this project Rob Lawrence was a Lead Practice Visitor.

Richard Widdison – Richard is an experienced NHS HR Director with 9 years operating at Board level, most recently in NHS Nottinghamshire County. He is committed to service improvement with excellent inter-personal skills, which he uses in his work as a management consultant.

In this project Richard Widdison was a Lead Practice Visitor.

Christine Johnson – Christine was a principal in general practice for 15 years before becoming a salaried GP to Nottinghamshire County PCT in 2003. She has supported a variety of practices during times of sickness, remediation of practitioners or expansion of services. Her university and deanery work has involved practical support to practices and doctors wishing to be involved in the teaching of students or training of young doctors. She has been a QoF assessor since the introduction of the GP contract in 2004 and more recently an IM&T DES assessor. Previously she was a QTD (Quality team development) and Primary Care Practice Research Accreditation assessor for the RCGP.

In this project Christine Johnson was a Lead Practice Visitor.

The project

The aim of this project was to assess the 55 General Practices in Stoke on Trent with a view to supporting them to develop a practice based development plan in order to achieve the quality standards and approach desired by NHS Stoke on Trent.

The contract was awarded to CHEC by NHS Stoke on Trent at the end of December 2008. CHEC started work on this project on 5th January 2009 and completed work, as contracted, on 30th April 2009. All planned deliverables were delivered to NHS Stoke on Trent to the agreed quality and to time.

There were five workstreams in this project:

Workstream 1: Development of the process for practice assessment

This workstream was led by Professor Mike Pringle and Jacqui Smith, with significant input by Julie Reid and Diana Kirk. It was conducted in the first four weeks of the contract and completed on schedule. The PCT and key stakeholders were consulted throughout and were involved in signing off the outputs. The documents resulting from this workstream are in Appendices A1 and A2

Workstream 2: Assessment of the 55 practices

The work in this workstream was led Julie Reid. She worked through the six Lead Practice Visitors (Julie Reid, Diana Kirk, Liz Heath, Richard Widdison, Christine Johnson and Rob Lawrence), and the Practice Visit Administrator. Professor Mike Pringle trained the practice visiting teams and addressed problems that arose.

CHEC attended a meeting of practice representatives on 3rd February 2009 and communicated with practices, at the practices' or the PCT's request, throughout.

Prior to the visits, clinical governance and other PCT information (including QoF) was used to populate the practice assessment spreadsheet. These data were then processed to produce a report for each practice that contained a representation of that practice's and comparative performance. For an example practice performance report see Appendix A3.

Each practice was approached, given a written briefing on the project and invited to fix a time for their visit. They were asked to complete a pre-visit questionnaire (see Appendix A4).

Six experienced practice assessors were recruited and trained. Professor Ruth Chambers, who advised CHEC throughout the project on behalf of the PCT, attended the training in order to ensure that the PCT's expectations were imbued.

Each visit was undertaken by a Lead Practice Visitor and the Practice Visit Administrator and lasted no longer than three hours. Normally there were two visits in a day. The CHEC visitors usually met at least one GP, one nurse and the practice manager.

In addition the Project Manager also attended a minimum of one practice visit with each Lead Visitor to ensure consistency of approach.

Both before and during the visit, the workload and disruption to the practice was minimised. The information collected on the visit was entered into the database.

A key deliverable from this workstream was a database containing data derived from the PCT, practice questionnaires and the practice visits. From the data in the database normative data (mainly means and quartiles) was derived. For each practice an individualised five page report was developed that presented that practices performance with comparisons to the performance of their peers. This database, with the underlying data and practice reports, has been provided to the PCT and can be updated and used over time.

This workstream started with the first visit on 9th February 2009 and was completed with the last visit on 23rd March 2009. The visits were completed ahead of schedule.

Workstream 3: Feedback to the PCT

This workstream was led by Professor Mike Pringle. An analysis of the information from every practice was distilled into individual practice reports. Key findings from the visits and the provided data were written and provided to the PCT. Examples of best practice were provided.

Using the data accumulated before the visits and during the visits, a descriptive report for each practice was generated each of which contained comparative data from the PCT as a whole. From these a Red/Amber/Green (RAG) spreadsheet was generated. This used the PCT's qualifying criteria to rank individual practices and to categorise them overall into one of three categories.

The underlying data base, the individual practice information sheets, the RAG status report and all the accumulated comments from the visits have been provided to the PCT before the project completion date of 30th April 2009. As requested, the RAG spreadsheet which allowed the PCT to identify qualifying practices was delivered before 31st March 2009.

PCT staff has been trained on the use of the database so that it can be used by the PCT in the future.

Workstream 4: Feedback to the 55 practices

This workstream was led by Diana Kirk, with support from Professor Mike Pringle. In meetings and correspondence with the PCT a format for a Practice Development Plan (PDP) was agreed. This took the baseline information for each practice from the previous workstreams and the aspiration standards for the QIF. For each of three years the practice's draft PDP sets out the steps to be achieved.

The PDPs will need to be discussed with the practices and agreed. This will be undertaken by the PCT after this particular project is complete. The PCT will then need to assess progress to deliver the PDP annually.

This workstream was completed on time by 30th April 2009.

Workstream 5: Development of Practice Development Plans for all 55 practices

This workstream was led by Professor Mike Pringle. The CHEC Team wrote 55 draft Practice Development Plans that were based on the baseline assessment of each practice, the aspirational standards set by the PCT and the three annual stages required for the transition.

The draft PDPs included three categories of standards. There were those that were core contractual standards that all practices should achieve as a baseline. Some were identified as “good practice”. These were achieved by some of the practices and were set at a level that all practices should attain them in the first years of the QIF. The last category was of aspirational standards. These were achieved by few or no practices at baseline. They were standards that reflected the aspiration of the PCT to address health inequalities and the developing quality agenda.

The PDPs were completed by Monday 27th April 2009, and emailed to the PCT. In addition hardcopies of the practice proforma were posted to the PCT.

Timescales and progress

The project commenced on 5th January 2009 and completed on 1st May 2009 as per the original brief. A breakdown showing key milestones can be found in Appendix A7

Results

Although some practices expressed initial reservations with regards to the process of assessment none refused to participate. All practices returned their completed questionnaires and participated in a practice visit within agreed timescales.

In addition all practices were extremely open in their approach and cooperated fully.

Key result areas have been shared with the PCT via the database and documents outlined in Workstream 3. However, several additional issues were raised during the visits which the PCT may wish to note:

- Correspondence from Secondary Care:

Practices reported delays (several weeks) in receiving hospital discharge letters and clinic letters (specifically referencing cardiology). Problems with receiving appropriate and timely A&E attendance information were also raised.

In addition references were made to poor speed of response and inappropriate triaging and referral by Mental health Services.

- Premises:

Several practices felt they had been “promised” new practice buildings for many years and had been let down on several occasions, particularly around the time of PCT reconfiguration.

However, the visitors also observed “victim” mentality with some practices appearing not to maintain, develop and utilise current accommodation effectively.

The quality of premises varied significantly, some practices clearly were not fit for purpose others were of a high quality.

- PCT Provided Training:

Several practices expressed disappointment that Protected Learning Time had been withdrawn 2 years ago. This was viewed as a missed opportunity for the PCT to support General Practice, maintain engagement and improve standards through education.

There was a general perception that there is insufficient training to meet needs and what is scheduled is often cancelled.

There was some evidence of staff delivering services with inadequate/no training e.g. admin staff undertaking role of chaperone.

PCT employed staff did seem to have good access to CPD.

A few of the Nurses said they had access to training through the PCT Nurse network but not all nurses appeared to be aware this was available.

Some Practices have no access to the PCT intranet/shared drive so do not have access to the full Child Protection Procedures, only having a flow chart that could not be verified as being up to date.

- Practice Managers:

There appeared to be some good quality PMs in the patch but overall knowledge and quality was variable.

Many appear to need specific development and support in:

- Business planning
- HR procedures
- Employment Law
- Producing and maintaining protocols

There appeared to be limited access to PM networks. Limited numbers of PMs meet regularly and by invite only “if face fits”. Opportunities exist for the PCT to make a significant contribution to improve networks and communicate important policies/strategies.

- Practice Based Commissioning (PBC):

Surprisingly few references to PBC were made. Whilst this assessment did not ask any questions specifically around commissioning, it would be expected that references would be made. It was unclear if this was due to lack of practice engagement, poor knowledge of the Practice Managers or just merely that this assessment did not probe related areas.

- QOF:

There appeared to be some discrepancies between evidence available for QOF and for this QIF assessment. Some practices appear to have scored full QOF points whilst not having the same evidence available for this QIF assessment.

Also some practices made reference to the fact that changes are often communicated late in the year.

- Protocol/ Policies:

There did not appear to be a standard format for protocols and very few were written or in an electronic version, many were verbal only. In some cases the protocols in existence appeared to have been hastily put together to meet QOF requirements (or the QIF visit).

Policies again were of variable quality (where in place) with no standard approach or templates.

Some examples of good practice were evidenced but do not appear to be cascaded/shared across the Health Community.

- Practice Development Plans:

There was no standard format and very few practices actually had a plan. There was a limited understanding in some practices regarding what was actually meant by a "Practice Development Plan".

- Strengths:

It is important to also note the strengths that were observed during the practice visits. Of particular note were:

- The quality of Practice nursing was generally high Support from PCT Modern Matrons (specifically) was noted as being very high
- Very loyal and committed staff (in a lot of cases going the extra mile) let down by lack of CPD and training opportunities
- Appraisal process (GP and other staff) appeared satisfactory (although some PMs appear to need training in undertaking the process). Many GPs using the electronic toolkit but will need more support to meet revalidation

Recommendations

Having completed this initial phase it is important to maintain momentum to ensure practice engagement. Regular monitoring of practice achievement against their PDP will be required.

To support the process the PCT may wish to undertake the following:

- Provide a training programme for Practice Managers to ensure they are competent to practice in today's climate
- Provide standard templates and protocols for practices to modify locally
- Consider re-instating Protected Learning Time education to provide a medium for practice education and for the PCT to engage with the practices.

Appendices

Removed to maintain confidentiality and copyright