

## Setting the strategy for Quality in Scotland's General Practices

### 'Every system is perfectly designed to deliver the results it gets'

This well known quote from Paul Batalden (1), an expert on quality improvement in healthcare, is our starting point. At RCGP Scotland we have a responsibility to discover and apply the knowledge, tools, skills necessary for leading the innovation and continual improvement of health and health care. This will require a dramatic change across the NHS in Scotland in order to achieve and sustain high quality care, and 2016 presents us with a unique opportunity in primary care.

### 1. Challenges

The dismantling of the Scottish Quality and Outcomes Framework (QOF) in 2016/17 (2) grants us an unprecedented opportunity to shape the governance of Scottish general practice. However, timescales are very short, and the landscape is shifting rapidly.

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.

RCGP Scotland will need to support GPs and practices of all types and at all stages of development:

- GP partners as well as GPs working on a salaried or sessional basis.
- Out of hours services and the GPs working within them.
- Practices in affluent areas and in deprived areas.
- Those in urban areas and those in rural areas.
- Those that are struggling as well as those that are leaders and innovators.

## 2. The Scottish Context

This year, 2016, will be a year of enormous change for general practice in Scotland. The General Medical Services (GMS) contract with the demands of the QoF is to be phased out, and negotiations are underway for a new 2017 GMS Contract (2). We are privileged at RCGP Scotland to have been asked to help with the development of the part of this new contract relating to Quality and QI.

The Scottish Government's Healthcare Quality Strategy (4), and subsequent 2020 vision paper in 2011 (5) set out a future for health in Scotland where more patients would be cared for 'at home or in a homely setting', with a focus on prevention, anticipation and supported self-management, keeping hospital admissions to a minimum. These aims are further identified and expanded in *Realistic Medicine* (6), the recent Chief Medical Officer's Annual Report for Scotland in which Catherine Calderwood identifies 'changing our style' to Shared Decision Making, and building a personalised approach to care as her first two challenges. Both are highly relevant in primary care. Primary care, and especially GPs, also play a major role in the CMO's third challenge: reducing harm and waste. This can be achieved by clinicians with longitudinal knowledge of patients and a key role in use of health and care resources, from prescribing to referrals. There remains considerable variability between GPs in prescribing rates (7) and referral behaviour (8), and the reasons for this are not yet completely clear. GPs have a track record in working with patients to reduce risk and also understand and reduce unwarranted variation, two further challenges identified by the CMO. This paper also sets out the importance of GPs developing and maintaining skills in QI, the final component in Calderwood's *Realistic Medicine*.

The National Clinical Strategy (9) sets out the context and drivers for transformative change and positions primary care at the leading edge of change. GPs will build on their central contribution to the support and management of complex patient care in the community to:

- Reduce strain on secondary care.
- Deepen collaboration with team-based clinical care.
- Advocate and support enhanced links with community assets and non-healthcare resources.

A further document recently published by the Scottish Government is the *Review of Public Health* (10). The focus on health inequalities is important, and this issue will need to be addressed by various groupings in primary care working collaboratively: '...specific opportunities arising from closer integration between the NHS and Local Authorities, including working together for shared outcomes.' This will require meaningful engagement from GPs, which in turn will rely on protected time being available. Patients too will require opportunities to understand their developing role in their own healthcare.

These key policy documents set a direction of travel requiring the role of GPs and general practices to be strengthened within the wider context of healthcare in Scotland. Marshall (11) points out that 'GPs should bear some responsibility for the position that they find themselves in. The discipline as a whole has consistently failed to find ways of persuading policymakers and health system leaders that those issues which are not readily defined or tightly contained really do matter'. The current system of incentivisation in general practice pushes GPs towards achieving control in certain areas of their patients' lives, but this is often at odds with the lived experience of the patient and his or her immediate priorities. At the same time there is the conflict between trying to do what may be right for the individual and what is evidently

right for the population as a whole. Marshall describes these boundaries and uncertainties very clearly.

**RCGP Scotland will influence the further development and implementation of the above strategies and supporting policies, and take on an active, visible leadership role in designing and delivering these national developments.**

Many practices, and individual GPs, are already under considerable pressure from the compounding problems of an increasing workforce shortage and unsustainable workload. The British Medical Association (BMA) has worked hard for GPs in Scotland to identify a modernised role for GPs, which, it is hoped, will improve recruitment and retention, as well as strengthening the role of the GP in the wider health and social care system. GPs are expected to spend more of their time as experts (12) (13), or 'senior decision makers' (2), with a focus on complex care in the community and undifferentiated presentations in the context of whole system Quality Improvement and clinical leadership. At the same time, GPs are required to cover Out of Hours services and filling these roles is becoming ever more challenging.

RCGP Scotland is tasked with identifying a quality strategy that includes QI and governance measures that are relevant, meaningful and achievable. This will rely on GPs working together in a peer based and values led fashion. Peer based working means GPs coming together in an atmosphere of equality and trust. GPs, wherever they work, already demonstrate a range of particular skills in their daily clinical work, and these skills and associated values, unique to each clinician, are also relevant in the roles of clinical leadership and the commitment to learning shown by effective improvers. These particular skills have also been highlighted as being essential in achieving the goals of realistic medicine set out in the recent CMO annual report.

'Making improvement happen also requires leadership that enables connections between the aims of changes and the design and testing of those changes; that pays serious attention to the policies and practices of reward and accountability; and unshakeable belief in the idea that everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it.' (6)

GPs as senior clinicians in primary care will be involved in assessing the performance of their own practice, practices within a local cluster, and the wider community team, with the focus on outcomes for patients, and ways in which these can be improved in a continuous process with further evaluation and improvement following on. This is clearly not a change that can come about overnight, and it will require concerted efforts at all levels, along with financial support.

**RCGP Scotland will work with Scottish Government, Scottish General Practitioners Committee (SGPC), Healthcare Improvement Scotland (HIS) and others to establish a workable framework for self/peer assessment in order to support practices and clusters to 'know how they are doing' and identify areas for improvement.**

Resources already available to us in taking this work forward include various important national documents:

- *Developing a Quality Framework for Scottish General Practice*, jointly developed by Healthcare Improvement Scotland and RCGP Scotland, and published in July 2014 (14).

This document, available as an interactive version online, sets out the contribution already made in primary care to high quality general practice, as well as opportunities for further evolution.

- *Quality Improvement for General Practice* (15) – a guide for GPs and the whole practice team, this publication details tools for practitioners wishing to plan, implement and embed new approaches into practice.
- *Distilling the essence of General Practice: a learning journey in progress* (16).
- *The Future of General Practice in Scotland: a Vision* (17).
- *Driving Improvement in Healthcare: Our strategy* (18).
- *Care Planning: Improving the Lives of People with Long Term Conditions* (19).

### 3. What needs to be in place to make quality happen?

What can ‘Quality Improvement’ mean in general practice, and in the NHS in Scotland, at a time when practices are facing the many challenges associated with providing core services, within the context of increasing public and political demands and expectations? Somehow a realistic balance needs to be found between the dual imperatives of doing the day job, and improving how we do the day job.

The term quality improvement, as defined in the RCGP guide (15), describes a commitment to the continuous improvement of the quality of healthcare, focusing on the preferences and needs of those who use the service. QI encompasses:

- A set of values, including a commitment to self-reflection, shared learning, the use of theory, partnership working, leadership and an understanding of context.
- A set of methods, including measurement, understanding variation, cyclical change, benchmarking, and a set of tools and techniques.

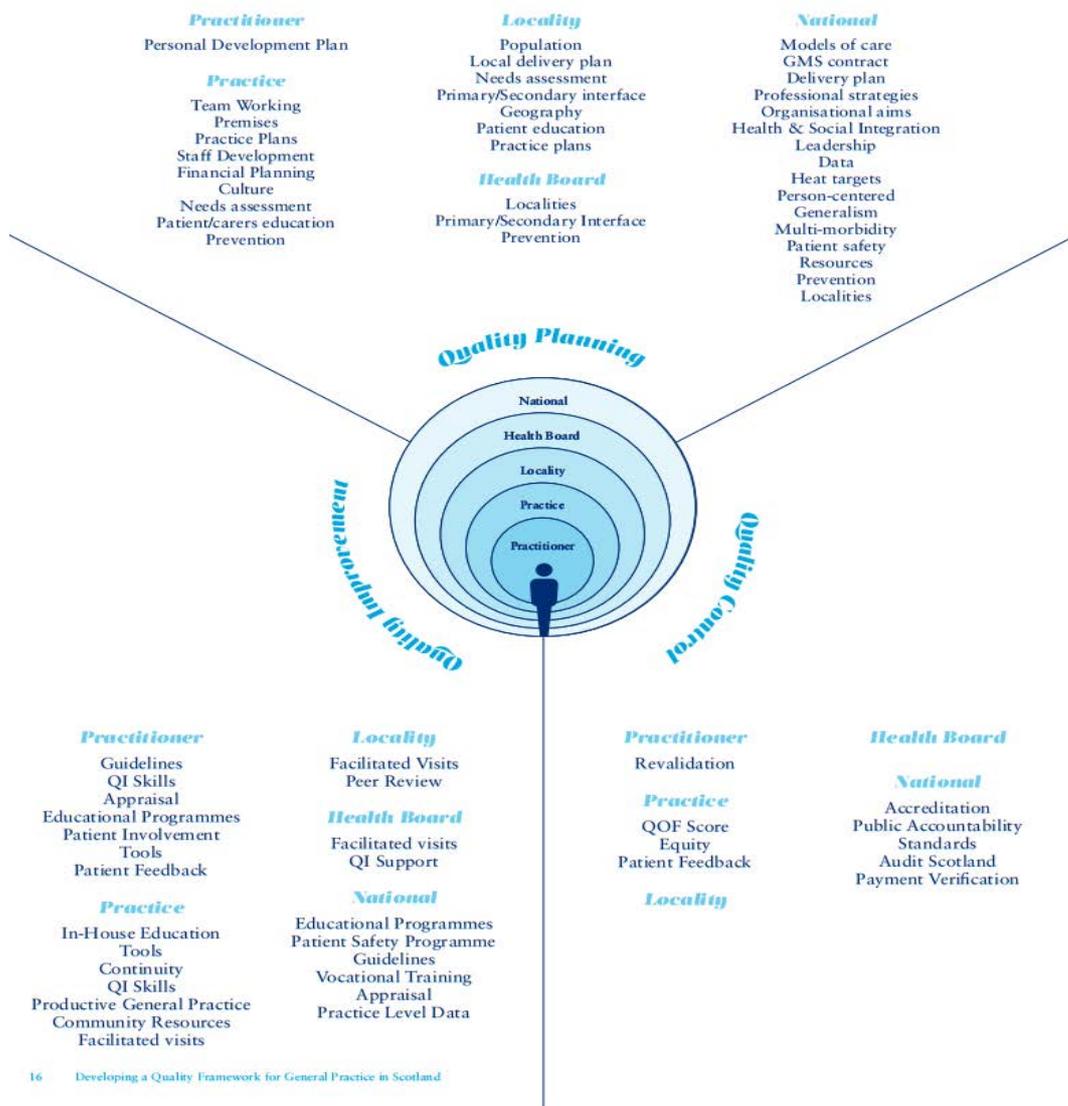
As outlined in the Quality Framework (14), the Juran trilogy (20) provides a helpful way of understanding quality management as a whole, and the processes involved. Quality planning and quality control need to exist alongside quality improvement.

1. Quality Planning – understanding need and designing systems and services effectively and efficiently to meet that need.
2. Quality Improvement – using systematic approaches to improve the quality of care.
3. Quality Control and Assurance – monitoring and assuring the quality of care.

These are concepts that need to be generally understood and applied within general practices as well as at broader local and national levels – combined together they form a ‘quality management system’ or quality approach which RCGP Scotland believes will be helpful as the new ways of working (systems of care and service delivery) evolve.

The diagram following (14) shows how the various components of the trilogy can be understood in relation to some of the different levels existing in healthcare.

# Organisational levels



The introduction of *Quality of Care Reviews* (21) in Scotland offers an opportunity to consider the balance of external scrutiny by HIS and others and internal scrutiny by peer review, RCGP Scotland activities and self assessment.

Patient involvement at every level is crucial in helping to ensure that service users are heard and listened to, and various different groups and structures will be required to support this. New models of care should as a matter of course include patient representation.

The transition to a model of care where quality is at the very centre of primary care will require a range of developments. These can be arranged under the headings of the Juran trilogy, as follows:

**Quality Planning - understanding need and designing systems and services effectively and efficiently to meet that need:**

- a. GPs must have a meaningful role in the new Integrated Joint Boards for health and social care to ensure that quality is placed firmly at the forefront of their work.
- b. The RCGP should have continuing influence on the GP contract, particularly around QI.
- c. Developments that allow GPs to develop professionalism and to be in control of their own working practices. Quality initiatives should be sufficiently flexible to allow this autonomy and promote involvement at all levels.
- d. Develop effective interface working and shared understanding of generalist skills.

**Quality Improvement - using systematic approaches to improving the quality of care:**

- e. Capacity building for quality in primary care: this must include an articulation of the habits that improvers need to have, so that teaching and learning can be focused on these. See figure below (22). Support for the continued development of the patient safety programme in primary care, at all times seeking to reduce waste in the process.

**Quality control - monitoring and assuring the quality of care:**

- f. A governance structure which is practical, effective and sustainable, and acceptable to GPs in Scotland.
- g. Development of a set of standards for clusters, which is self-assessed and peer reviewed.

**All three areas:**

- h. Increased patient involvement and engagement at practice, cluster, locality and national levels.

**RCGP Scotland will continue to use the framework to orientate our thinking as the new systems of delivery and governance evolve, and specifically will look for appropriate balance and proportionality in systems of assurance and review. We will learn from the experience of Care Quality Commission (CQC) inspections in NHS England.**

Lucas (23) agrees that 'Healthcare services will never realise their full potential until improvement becomes part of every worker's day job', and describes behaviours that healthcare staff will need to learn (and perhaps unlearn) in order to achieve this paradigm shift. This can then avoid the potential for the growing interest in QI tools and techniques to lead to an understanding of quality as a 'project' rather than a habit embedded in professional life. It is acknowledged that GPs will require some help with finding the protected time required for QI activity, and it is essential that the 2017 contract allows for this. Effective improvers demonstrate five core habits of mind: learning, influencing, resilience, creativity and systems thinking. These are illustrated below, with further clarification of the sub skills associated with each of the core habits.

Figure 1 – The habits of improvers



From Lucas (22).

#### 4. Proposed model

To meet the challenges outlined in the key requirements above, we need to draw on existing knowledge, skills and experience, at the same time as filling possible gaps.

- **Values**

GPs are at the hub of primary care, which itself acts as the first port of call and the site of continuing lifelong care for nearly all patients in Scotland. The role of the GP has therefore developed, and will continue to develop and change, as in some ways distinct from that of other doctors. GPs hold a set of values, which is in part distinct from, but also overlapping with, that of fellow healthcare professionals. Sometimes where values clash, for instance where different systems hold differing professional boundaries, governance systems or performance targets, problems in communicating across these interfaces can lead to error and poor outcomes.

The development of a GP workforce fluent in the ideas of quality management relies on a system of shared values as identified in the RCGP work about the essence of general practice (16). 'GPs [also] recognise that the inherent strength and complexity of the doctor–patient relationship supports quality at a much deeper level. There are growing anxieties that the focus on the QOF, driven by financial incentives, may lead to the loss of something important but hard to measure in general practice.'

The challenge is to identify and surface these values, often fiercely held, in a way that can be developmental and supportive, avoiding blame and criticism. Tools such as significant event analysis (SEA) (24) and enhanced SEA (eSEA) (25) are valuable in unpicking the detail behind complex events, and the QI model allows for reflection and learning to be shared within and across teams. Further tools (including process mapping, the Plan-Do-Study-Act (PDSA) cycle, driver diagrams and run charts) are outlined in the RCGP Quality (15) document, and will require further training for many of our members. Combined, these

methods can be used for the reflective and constructive examination of elements of care, especially where outcomes are at variance with the expected. Ultimately this will drive up the quality of care.

- **Active, informed patient involvement**

Patient Partnership in Practice (P<sup>3</sup>), the patient involvement group of RCGP Scotland (26) represents an important aspect of the patient voice in Scotland, developing ideas and leading activities that encourage GPs to work in partnership most effectively with patients and the public and ensuring the activities of the College respond to patient needs. The input of P<sup>3</sup> has been sought on quality from patients' perspective, and the qualities they identify as quality practice, along with possible areas for QI.

We need to work with our patient or public partners to develop realistic and meaningful ways of looking at the patient experience, and using the intelligence gained to inform future developments. 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.

**RCGP Scotland is committed to ensuring that patients and public partners will be actively involved in the quality agenda, at practice, cluster and locality levels.**

- **Cluster working**

Clusters are groupings of practices covering a population of 20-50,000 patients. Their role will be to deliver a model of quality governance, which will replace QOF, and will be led by GP peers, using a values based approach to define and prioritise areas relevant to the cluster for quality planning, quality control and quality improvement.

Each practice will have at least one representative (the Practice Quality Lead or PQL) involved with the relevant local cluster, and each cluster will identify a QI lead (the Cluster Quality Lead or CQL). Each PQL will also have a role as the link with a liaison officer from the local Health and Social Care Partnership. Structures also need to accommodate the requirements of GPs working in out of hours or sessional posts, who may not be formally attached to a practice. This will involve close working between cluster leads and local providers of unscheduled care, as well as with local and national networks for sessional GPs.

Exact arrangements will vary across Scotland; the size and arrangement of clusters may depend on factors such as remoteness and rurality, and shared experience, for instance high levels of deprivation in the Deep End (32) (33) practices of Scotland. It will be important to ensure that those in particular circumstances, such as remote and rural practices, are protected so that a lack of nearby colleagues does not limit their involvement in QI activities. We propose that the majority of RCGP Scotland contribution around QI in general practice in future should be carried out at cluster level. This minimises any waste of effort at individual practice level, and allows for sharing of local knowledge and experience, as well as learning and future development.

We also recognise that all improvement is local: improvement has to happen where care actually takes place and therefore establishing effective mechanisms for supporting QI within participating practices is essential. This concept of practice-based facilitation, data and improvement is referenced in the Quality Framework (14).

Experience elsewhere in Europe has shown that small groups of six to twelve clinicians from similar backgrounds meeting in Quality Circles (34) and Peer Review Groups (35) are associated with improved patient outcomes, but the exact mechanism by which these improvements are achieved remains unclear. The Practice Based Small Group Learning (PBSGL) scheme (36) is well established in Scotland, and includes modules related to leadership and patient safety. Over 25% of all GPs in Scotland are now involved in PBSGL and the number continues to grow. Multidisciplinary learning is now also possible using PBSGL (37) (38). The principles and experience of PBSGL could be applied to learning within clusters, and training for facilitators is already available (38).

**RCGP Scotland is committed to supporting on-going and new training for QI work in practices and at cluster level, working alongside NHS Education for Scotland (NES), HIS and the Scottish Government.**

**RCGP Scotland will ensure that doctors in sessional and out of hours posts are also enabled to participate actively in QI training, and future QI work at cluster level.**

- **Interface working**

RCGP Scotland has chosen Interface Working as one of its key priority areas because it is estimated from national patient safety data 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. The safety and effectiveness of these interfaces therefore becomes increasingly important to understand and manage as GPs take a more important role in the ever more complex and sophisticated care of patients with complex health and social care needs in the community. Whilst risks exist across any interface in patient care, we believe that the particular interface between primary and secondary care currently represents the greatest clinical risk to patients.

Local pilots have shown that analysis of themes emerging in primary care Significant Events Analysis (SEA) is a very valuable way of highlighting areas of potential concern and QI

around the interface. A recent Scottish RCGP membership survey (response rate 16%) concluded that there is a consistent lack of dedicated forums to discuss and improve primary-secondary care interface issues, and that there is a strong professional desire to improve this. One of RCGP Scotland's manifesto (39) recommendations for 2016 was that every health board area should be supported to establish rigorous methods for the systematic collection of data around adverse events occurring at the primary-secondary care interface, and also to have a resourced dedicated forum for the discussion and resolution of these issues.

Currently, there is little formal overlap between critical event reporting and analysis in primary and secondary settings. Access to the Datix incident reporting system varies across different health boards in Scotland, for instance (40). Constructive systems analysis across different groupings would help to support more effective interface working. New structures must support open and honest discussion not only across the primary-secondary care interface, but also between in hours and out of hours work, between patients or public and medical staff, and between GPs and other team members.

Continuing input in this area will require understanding and involvement from secondary care colleagues. A start has been made in this area with the BMA guidance on managing workload (41) but this is an important area for further development. As well as the approach to improving interface working provided by analysis of SEAs, RCGP Scotland, in partnership with the SGHD Quality Efficiency Support Team (QuEST), will also develop a QI learning module which will allow individual practices to meet with individual consultants to share local interface issues and possible solutions to these. Training in the use of the module, which will be available as part of the Health Improvement Scotland (HIS) Quality Improvement Hub (42) and will be offered to each health board in Scotland.

The development of improvement programmes relating to pathways of care, or segments of pathways of care, aimed at reducing variation, improving quality and efficiency offers further opportunities for RCGP to add value and improve care through the interface work stream.

**RCGP Scotland will work with colleagues at the Academy of Medical Royal Colleges and Faculties in Scotland (Scottish Faculty) (39), HIS and other groups to identify and share important issues arising at the interfaces, and to develop and enable potential solutions.**

- **Use of existing QI support and tools**

Many of the requirements for QI can be met with the use of tools already tried and tested, perhaps with some adjustment for local use.

These tools include:

- Significant Event Analysis (SEA) and Enhanced SEA (eSEA) (43) (25).
- Practice Based Small Group Learning (PBSGL) (36).
- QI modules on RCGP Quality website (44).
- NHS Scotland Quality Improvement Hub (42).
- RCGP Quality Improvement Programme for GP specialist trainees (45) (46).
- The Scottish Patient Safety Programme (47).
- Scotland's House of Care (48).
- Scottish Primary Care Information Resource (49).

Many of these are clearly outlined in a practical and realistic manner in the RCGP guide (15) along with a host of newer methods, and other websites also collect useful resources, for

instance the Quality Improvement Hub (42) and especially the QI e-learning section of the hub (50).

Scotland's House of Care (48) represents a tangible and proven approach that allows healthcare to embrace Care and Support Planning and fulfil its responsibilities to support the self-management of people living with multiple long term conditions. This approach supports and enables people to articulate their own needs and decide on their own priorities, through a process of joint decision-making, goal setting and action planning.

A new Scottish Government project, the Scottish Primary Care Information Resource (SPIRE) (49) will be another important source of information and support, both for individual practices and clusters, through seizing the opportunity to unlock the potential in the prodigious information in GP records. SPIRE will provide a simple and secure way to extract information from GP electronic records for practice use, for various purposes (for instance audit, disease surveillance, benchmarking, planning and research) to support any new contractual arrangements with GPs through the provision of data and business intelligence. SPIRE will simplify and standardise the operation, with new processes for handling requests for information, guaranteed security, access to specialist advice and a dashboard for viewing their information. SPIRE will also provide assurance that rules around information governance are followed, releasing individual practices from time-consuming work.

- **Training in QI methods**

QI training should not begin in general practice, but should be embedded throughout both undergraduate and postgraduate training for GPs and other healthcare professionals, and the Academy of Medical Royal Colleges has produced a framework (51) to embed improvement methodology as a core competence in practice for all doctors. In Scotland, the Leadership and Management Programme (52) has recently been redevelopment at NES. For GPs in training, the Quality Improvement in Practice programme (45) will be central, and could move from being optional to being an essential part of training.

RCGP Scotland has a history of innovation and leadership in this area, with successful programmes including the Quality Practice Award and Practice Accreditation (53). More recently, training has been provided for the methods outlined in Productive General Practice (54) and implementation of the RCGP Scotland Treating Access toolkit (55). We are in an excellent position to provide training for QI work in future, and developments are already underway in this area.

HIS has a growing role in the design and development of tools in QI, and will also be in a position to offer training in QI methods. HIS could provide training across all the different disciplines involved in healthcare in the community. A wide selection of e-learning modules is already available through the NHS Scotland Quality Improvement Hub (42).

**RCGP Scotland will work with Universities, NES, HIS, the Scottish Government and other stakeholders to provide training in QI methods for potential PQLs and CQLs, as well as other members of primary healthcare teams and those from social care.**

## **5. Opportunities**

Existing programmes and expertise can be used in meeting some if not all of the challenges above, and further training will be developed collaboratively by RCGP Scotland along with other stakeholders.

GPs who are not directly involved in clusters will also play an active part in QI work, in particular by taking part in various projects and initiatives within practices, and potentially

also within out of hours organisations and other groupings of GPs who are not directly associated with a practice. These in turn can feed into cluster activity, as well as to their appraisal preparation.

There will be more opportunities than ever for multidisciplinary working: clusters can also provide a forum for bringing together non-GP members of the team to learn from one another and develop new ideas.

**RCGP Scotland is committed to building QI activities into the role of all members of the primary health care team and to the inclusion of the patient/public voice in designing QI activities at all levels from individual practices to national organisations.**

## **6. Actions**

Next steps must include a rapid transformation of ideas into action.

- a. RCGP Scotland will influence the further development of implementation of Scottish Government strategies and supporting policies, and take on an active, visible leadership role in designing and delivering these national developments.**
- b. RCGP Scotland will work with the Scottish Government, SGPC, HIS and others to establish a workable framework for self/peer assessment in order to support practices and clusters to 'know how they are doing' and identify areas for improvement.**
- c. RCGP Scotland will continue to use the framework to orientate our thinking as the new systems of delivery and governance evolve, and specifically will look for appropriate balance and proportionality in systems of assurance and review. We will learn from the experience of CQC inspections in NHS England.**
- d. RCGP Scotland is committed to ensuring that patients and public partners will be actively involved in the quality agenda, at practice, cluster and locality levels**
- e. RCGP Scotland is committed to supporting on-going and new training for QI work in practices and at cluster level, working alongside NES, HIS and the Scottish Government.**
- f. RCGP Scotland will ensure that doctors in sessional and out of hours posts are also enabled to participate actively in QI training, and future QI work at cluster level.**
- g. RCGP Scotland will work with colleagues at the Scottish Faculty Academy of Medical Royal Colleges and Faculties in Scotland (Scottish Faculty), HIS and other groups to identify and share important issues arising at the interfaces, and to develop and enable potential solutions.**
- h. RCGP Scotland will work with Universities, NES, HIS and the Scottish Government and other stakeholders to provide training in QI methods for potential PQLs and CQLs, as well as other members of primary healthcare teams and those from social care.**

- i. RCGP Scotland is committed to building QI activity into the role of all members of the primary health care team and to the inclusion of the patient/public voice in designing QI activities at all levels from individual practices to national organisations.**

**‘General practice will only thrive and deliver benefit for individuals, communities, the health system, and wider society when its role as boundary specialists is made more explicit by GPs themselves, and is understood and valued by others’ (11).**

J Bennison, Executive Officer (Quality), RCGP Scotland  
June 2016

## **Glossary**

Chief Medical Officer - the most senior advisor on health matters in a government.

Clinical leadership – leading and managing systems of health care on various scales and understanding pathways and systems of care in order to lead effectively in a clinical setting.

Cluster – a grouping of practices covering a population of between 20,000 and 50,000 patients. Their role will be to deliver a model of quality governance which will replace QOF; this will be led by GP peers, using a values-based approach to define and prioritise areas relevant to the cluster for quality planning, QI and quality assurance.

CQC – Care Quality Commission, the independent regulator of health and social care in England.

CQL – Cluster Quality Lead.

Community assets - land and buildings owned or managed by community organisations. These assets cover a wide spectrum and include town halls, community centres, sports facilities, affordable housing and libraries.

Datix incident reporting system – software for the reporting and analysis of incidents and assessing risk factors in both clinical and non-clinical environments.

Enhanced SEA – a form of significant event analysis that aims to avoid blame by using human factors to look at an incident in detail, identifying multiple factors that might have affected the outcome

Driver diagram – a mapping tool that translates high-level improvement goals into a logical set of goals and projects. The diagram consists of three columns (outcome, primary drivers and secondary drivers) and a list of actions.

Integration Joint Boards - responsible for the strategic planning of the functions delegated to it and for ensuring the delivery of those functions.

GMS – General Medical Services is the term used to describe the range of healthcare that is provided by GPs as part of the NHS in the United Kingdom. The NHS specifies what GPs as independent contractors are expected to do and provides funding for this work through arrangements known as the General Medical Services Contract.

GMS Contract – the contract between general practices and the NHS for delivering primary care services to local communities.

GP peers – fellow GPs working at the same or similar levels of responsibility.

Health inequalities – differences in health status or the distribution of health determinants between different population groups.

HIS – Healthcare Improvement Scotland, national healthcare improvement organisation for Scotland and part of NHS Scotland, one of the Special Health Boards in NHS Scotland.

Interfaces – points at which systems of primary and secondary care, or other services involved, need to interact to share information about patient care.

Juran trilogy – an improvement cycle designed to reduce the cost of poor quality by planning quality into the process. The three parts are: quality planning, quality control and QI.

NES – NHS Education for Scotland, one of the Special Health Boards in NHS Scotland.

Out of Hours services – care provision outside the key contract hours for in hours general practice (8am – 6pm Monday-Friday).

PBSGL – Problem Based Small Group Learning, PBSGL is an innovative approach to CPD for GPs and other healthcare practitioners that originated in Canada and has grown rapidly in Scotland over the last seven years.

Peer review groups - medical peer review is the process by which a group of doctors examines the work of a peer or peers and discusses, in good faith, the quality of the care or service provided.

P3 - Patient Partnership in Practice, RCGP Scotland's patient group.

PQL – Practice Quality Lead.

Plan-Do-Study-Act cycle – a method for testing ideas in a small scale, cost effective and controlled way. Consists of four stages comprising: identification of desired change, collecting baseline data, introducing change, assessing new data, determining success or failure of change and using results of one PDSA cycle to inform further cycles..

Quality circles – small groups of 6-12 professionals from a similar background who meet at regular intervals to discuss and review their clinical practice.

QOF - Quality and Outcomes Framework, the system by which general practices were incentivised in the GMS contract 2004 – 2016.

Run charts - used to study variation over time and to identify unusual data and events.

Sessional GP – a GP who works flexibly rather than as a salaried GP with a contract, or a GP partner.

SGHD Quality Efficiency Support Team (QuEST) –supports the delivery of quality and efficiency within NHS Scotland by coordinating the implementation of the NHS Scotland Efficiency and Productivity Framework and provides support to NHS Boards through benchmarking and data development.

SGPC - the Scottish General Practitioners Committee of the BMA.

Significant Events Analysis – analysis of an event thought by anyone in the team to be significant in the care of patients or the conduct of the practice, using a structured format to identify learning points.

Supported self management - supporting people to manage their own health is a key part of the healthcare response to long term health conditions.

Undifferentiated presentations - Undifferentiated conditions refer to ambiguous, uncertain, unexplained and undiagnosed symptoms, problems, conditions and illnesses presenting to the clinician.

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Version Date: July 2016

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Published by:



Royal College of  
General Practitioners

**RCGP Scotland**  
25 Queen Street, Edinburgh. EH2 1JX  
Telephone: 020 3188 7730  
Fax: 020 3188 7401  
Email: [policy@rcgp.org.uk](mailto:policy@rcgp.org.uk)  
Website: [www.rcgp.org.uk](http://www.rcgp.org.uk)

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