

Improving together

A National Framework for Quality and GP Clusters in Scotland

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IMPROVING TOGETHER:

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Introduction

For over 10 years, the Quality and Outcomes Framework (QOF) largely defined the approach to “Quality” in General Practice. It was introduced in the 2004 nGMS contract with the intention of providing improved, or consistently high, quality of care, whilst offering GP practices an opportunity to increase funding via an incentivised payment scheme.

Whilst the quality of care delivered in general practice has undoubtedly improved since the beginning of the century, it is contentious to what extent QOF contributed to this effect. There is some evidence to suggest that in the early years it accelerated the pre-existing trajectory of improvement being seen in managing those chronic diseases that were included, and achieved greater equality in the standard of care across practices but that over time, and for a variety of reasons, this small effect became further diluted and was perhaps even achieved with the unintended consequence of crowding out other chronic conditions not included¹.

Beyond this, voices within the profession began to express concerns about the volume of bureaucracy associated with QOF, and the effect that it was having on the consultation model with patients. Many expressed concern that this was directly influencing the profession towards a disproportionate emphasis on a biomedical model of care, which was less consistent with the values of general practice, and less fulfilling as a doctor to provide.

Over this same period, there has been an expansion of interest and understanding in the approaches to quality improvement in healthcare, and Scotland has been at the forefront of this. More recently, feedback following the publication of Realistic Medicine² in Scotland has demonstrated that doctors want to provide a more personalised approach to care and to tackle unwarranted variation in care, harm and waste within our healthcare system.

The healthcare system is changing in response to the demands placed upon it. The National Clinical Strategy for Scotland signals the transformation required in Primary Care so that it may fulfil its potential at the heart of this system. With the formation of GP Clusters in localities there is a need, and opportunity, to reconsider how we approach quality.

In his recent article in the Journal of American Medical Association, Dr Don Berwick suggested that it was now time for “Era 3” medicine; guided by updated beliefs and free of both the professional protectionism of era 1, and management reductionism

¹ Guthrie B, Tang J ; What Did we learn from 12 years of QOF?; Literature Review Series, Scottish School of Primary Care; Available from http://sspc.ac.uk/media/media_486342_en.pdf

² Realistic Medicine: The Chief Medical Officer’s Annual Report 2014-15; <http://www.gov.scot/Publications/2016/01/3745/downloads>

of era 2³. To do this, requires a rejection of the controlling power exerted by exponents of these past eras, whether they be formed from professional trust and prerogative, or scrutiny and incentive. Instead, these should be replaced by beliefs and behaviours defined by a moral approach to medicine that has better, more realistic and appropriate, high quality, high value care as its aim.

This philosophy provides the context for this national framework to support the work of GP Clusters throughout Scotland. It is a step change to the approach for continuously improving the quality of care offered to our citizens and to improving the health and wellbeing of the Scottish population. It outlines the contribution of NHS Health Boards and Health and Social Care Partnerships in supporting GP clusters to fulfil this role and to enable meaningful GP participation in local planning that underpins the purpose of health and social care integration.

Improving Together will complement the development of the Scottish national GP contract that sets out the role of GPs and their important contribution as clinical leaders and expert medical generalists working in a community setting. This framework will be reviewed by the Scottish Government and the Scottish General Practitioners Committee of the BMA on a periodic basis, attentive to feedback from those involved in delivering its intent. As such, it is a framework that will develop to its full potential over time, as elements of the transformation of primary care in Scotland create the capacity to do so.

I am grateful and pay tribute to the commitment and dedication of the broad group of colleagues who have collaborated meaningfully to this framework and for their individual and collective support during its development.



Dr Gregor Smith

Deputy Chief Medical Officer for Scotland

³ Berwick DM. Era 3 for Medicine and Health Care. *JAMA*. 2016;315(13):1329-1330. doi:10.1001/jama.2016.1509

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On behalf of HSCP Chief Officers Group



Royal College of
General Practitioners

Background

Since 2012, the GP contract in Scotland has increasingly developed its own characteristics, showing divergence from the GMS contract in the rest of the UK. The Scottish Government and BMA Scotland have agreed to develop a Scottish GP contract aligned with the Scottish Government's 2020 Vision of Health and Social Care that will deliver positive outcomes for our citizens, helping GPs to fulfil their potential in addressing the health and wellbeing of their patients and communities in a sustainable model of care.

NATIONAL OUTCOMES					
Our children have the best start in life and are ready to succeed	We live longer, healthier lives	Our people are able to maintain their independence as they get older	Our public services are high quality, continually improving, efficient and responsive		
We start well		We live well		We age well	
PRIMARY CARE VISION					
Our vision is of general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right person at the right time and will remain at or near home wherever possible. Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of our services.					
HSCP OUTCOMES		People can look after own health	Live at home or homely setting	Positive Experience of Services	Services improve quality of life
Services mitigate inequalities	Carers supported to improve health	People using services safe from harm	Engaged Workforce Improving Care	Efficient Resource Use	
PRIMARY CARE OUTCOMES					
We are more informed and empowered when using primary care		Our primary care services better contribute to improving population health		Our experience as patients in primary care is enhanced	
Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care		Our primary care infrastructure – physical and digital – is improved		Primary care better addresses health inequalities	

Fig 1 Outcomes

This will support GPs to care for their patients and address the health needs of their local communities better, and to help exploit the opportunities that are created by health and social care integration and closer working with colleagues across the whole system of services from whom our communities receive care.

Caring for an increasing population, which is living longer, and more often with multiple conditions; together with addressing the underlying determinants of ill health and the health inequalities that are experienced by some communities has been a challenge. However, by supporting practices through a suitable contract and approach to quality that better recognises and addresses the needs of its local population and workforce, there will be a greater opportunity to respond to these issues at an individual and community level.

It is, therefore, critical to preserve and nurture the generalist approach to providing longitudinal care across the ages, so that our citizens are supported to Start Well, Live Well, Age Well, and, indeed, Die Well.

GPs cannot address all of these issues by themselves. It is by strengthening the role and professional relationships of the entire multidisciplinary team in Primary Care; by enabling better informed and empowered patients; by improving the interfaces of care between professionals and between sectors; and making best use of the therapeutic and supportive assets within communities, that this becomes possible.

There is over a decade of experience from the current GMS contract, and much innovation within the general practice profession from which to learn. The Quality and Outcomes Framework, from 2004 – 2016, defined for many Quality in General Practice, but in reality touched only upon a little of what GPs' everyday experience of delivering high quality care actually was. Indeed, much of this care is difficult to measure in any quantitative way, but we must learn from experience in other countries and industries how best to do so in order that we can improve.

As professionals, clinically ambitious to provide high quality care for our communities, it is well recognised and understood that the approach taken in the

Quality and Outcomes Framework did not universally support GPs in using their experience and expertise across this diverse population of people and complex workload.

GP Clusters require:

*Data;
Health Intelligence
Analysis;
Facilitation;
Improvement Advice;
Leadership.*

Improving Together offers an alternative route to continuously improve the quality of care that citizens receive by facilitating strong, collaborative relationships across GP Clusters and localities with, at its heart; the intention of learning, developing and improving together for the benefit of local communities.

To realise this potential fully requires support; relevant and timely data; analytical expertise to assist in its interpretation; facilitation of constructive conversations; and implementation of appropriate improvement strategies. Without these components, there is a credible risk that they will fail in their intention.

Improving Together offers an alternative route; facilitating collaborative relationships; learning, developing and improving together for the benefit of local communities

Common Purpose

In describing this common purpose and to ensure a transparent and unrelenting approach that improves the health and wellbeing of the population, a series of principles and values will underpin this framework:



- Respect the professionalism and clinical ambition of GPs and practice staff in their pursuit of continuously improving the quality care that they provide.
- Recognise this by a proportionate and an appropriate use of data and/or indicators with greater focus on system-wide care and outcomes where this is possible.
- Utilise GP Clusters as the means of establishing peer-led, values driven quality improvement activity with both a focus on practice based (intrinsic) quality and contribution to system based (extrinsic) quality.
- Establishes a sound and proportionate approach to internal quality assurance and shapes the necessary external quality assurance approach in Scotland
- Provide for local flexibility; enabling use of evidence to identify local clinical priorities and also proper engagement with local communities about *what matters to them* in the interactions that they have and services that they receive from their GP practice.
- Promote a more equal partnership with patients in decisions relating to their care, encouraging shared decision making and a stronger emphasis on conversations that establish what is important to individuals, their families and their carers.
- Be complementary to the new ways of working within Health and Social Care Partnerships and facilitate the key leadership role of GPs in shaping and monitoring the quality of services provided by those partnerships, in both primary and secondary care settings.
- Recognise that continuing and developing the generalist approach, which encompasses both biotechnical and psychosocial aspects of care, is essential for the future of high quality care in GP clusters.

Common Values that underpin this framework

- To provide open, consistent, high quality and accountable public services.
- To encourage mutual respect between all stakeholders, encompassing health care and staff governance.
- To ensure openness in appropriate and proportionate transparency of necessary information.
- To encourage partnership in local needs assessment, and strategic planning with the shared ambition of improving population health.
- The application of joint approaches across primary, secondary and social care to common problems.
- The provision of best value and best use of available finite resources, recognising the need for choices to be made in how resources are used in primary healthcare.
- To promote continuous improvement in citizens' experience of care and transparency and candour in our interactions with other professionals and the public.
- To ensure that the GP cluster supports the sustainable delivery of high quality healthcare in a community setting, based upon identified local community needs, and contributes towards addressing the NHS Board and Health & Social Care Partnership priorities.
- To recognise that evaluation and research are essential to support an evidence-based approach to quality improvement.

In articulating this common purpose and values, those organisations involved in the development of this framework demonstrate their commitment to Realistic Medicine and to achieving the triple aim of improving citizens' experience of care, the health and wellbeing of the population and the pursuit of high value care whilst also creating a professional working environment that is more attractive in which to practise.

Governance and Administration

The ethos of this transformed model of care, in which general practice is integral, is based on an accessible multidisciplinary approach fully integrated into local NHS Health Board and Health and Social Care Partnership (HSCP) arrangements.

Responsibility for overall clinical governance will lie with the designated organisational Clinical Lead(s) within the Health Board or HSCP (according to local arrangements) but individual Health Care Professionals will have personal responsibility to ensure that the quality of care to patients is in line with professional requirements.

As such, each service provider will ensure that they can demonstrate clear management accountability and clinical governance arrangements if called upon to do so. This may include providing evidence of internal practice assurance meetings and protocols, demonstrating reflection and necessary actions.

The aim is to provide a service to the public consistent with the national quality aims, for safe, person-centred and clinically effective care, delivered in a timely manner, with efficient use of resource and addressing any inequalities in health/healthcare.

In doing so, practices will need suitably trained clinical staff, that may include doctors, nurses, pharmacists and AHPs, to meet the specific healthcare needs of citizens in their practice population, compliant with the agreed roles and professional requirements outlined in their contract.



Each organisation responsible for contracting with general practice will have a designated organisational lead (or similar) who will have an overall strategic responsibility that ensures key processes are in place to provide quality of care support for those within the service and a framework for clinical governance within local governance structures. They will ensure that systems, processes and procedures are in place to support General Medical Services and receive assurance on the delivery of safe, person-centred and effective care. Any model of delivery must promote equity of access, and respect for individuals not compromised by physical, language, cultural, social, economic and other barriers.

The GP Cluster

As senior clinicians, in their role as expert medical generalists where continuity of care and the longitudinal therapeutic relationship with patients remains important, GPs are ideally placed to be able to contribute effectively within a quality framework that is contextualised locally. The Scottish GMS contract will therefore facilitate and encourage some GPs to take on a greater role in the assessment and monitoring of quality within the systems in which they work as Practice Quality Leads and Cluster Quality Leads as part of the internal quality assurance of local services.

GP clusters were introduced in Scotland in the 2016/17 GMS agreement between the Scottish GP Committee of BMA Scotland and the Scottish Government⁴ in the context of health and social care integration and formation of localities within HSCPs. The agreement specifies that each GP practice will have a Practice Quality Lead⁵

that will engage in a local GP cluster. Each GP cluster will have a GP designated as a Cluster Quality Lead who will have a coordinating role within the cluster⁶.

Definition

A GP cluster is a professional grouping of general practices, represented at periodic meetings by Practice Quality Leads (PQL), which may take place either face to face or by video conference depending on individual circumstance or need. Each GP cluster will have a Cluster Quality Lead (CQL) whose role is to facilitate and guide the members and liaise with locality and professional structures.

To do so fully and effectively, there must be adequate infrastructure that supports the cluster and those assuming roles as PQLs and CQLs. This includes resource for protected time within their contract, and an infrastructure that supports leadership, assists data provision and analysis, facilitation and improvement activity, with appropriate and robust local governance structures in which they can operate.

Clusters may be of different sizes, influenced by the local circumstance and geography. As a principle, they should be viable for small group work, with typically a

⁴ Communication on Supporting Materials in relation to Transitional Quality Arrangements (TQA) for the 2016/17 General Medical Services Contract: [http://www.sehd.scot.nhs.uk/pca/PCA2016\(M\)05.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2016(M)05.pdf)

⁵ **Practice Quality Lead** - One GP from each practice (not necessarily always the same GP) will have the responsibility and protected time to link with the Cluster Quality Lead. Under the requirements of the GMS contract the PQL might reasonably spend two hours per month reflecting and preparing practice responses to data provided by the cluster.

⁶ **Cluster Quality Lead** - A GP nominated by the cluster with responsibility and protected time to provide a Continuous Quality Improvement leadership role in the GP cluster. The CQL will liaise between practices and the NHS board/Health and Social Care Partnership on quality improvement issues.

membership of between 5 and 8 practices. The purpose of these clusters is to provide a mechanism whereby GPs may engage in peer-led quality improvement activity within and across practices and also contribute to the oversight and development of care within the wider healthcare system. These purposes may further be described as intrinsic and extrinsic quality roles:

Intrinsic	Extrinsic
Learning network, local solutions, peer support	Collaboration and practice systems working with Community MDT and third sector partners
Consider clinical priorities for collective population	Participate in and influence priorities and strategic plans of Integrated Authorities
Transparent use of data, techniques and tools to drive quality improvement – will, ideas, execution	Provide critical opinion to aid transparency and oversight of managed services
Improve wellbeing, health and reduce health inequalities	Ensure relentless focus on improving clinical outcomes and addressing health inequalities

Fig 2 Roles of the GP Cluster

Each Health and Social Care Partnership is divided into localities, and it is perhaps within these that the majority of GPs will make their most valuable contribution. Given this intention, the geographical alignment of practices within these localities is important. Though it is recognised that at the outset some practice boundaries may extend across localities, practices should be members of a cluster within the locality that their main premises and / or majority of patients are based.

This arrangement will build upon existing clinical governance and quality structures within health boards and Health and Social Care Partnerships, but more fully involves GPs in the discussion, using the data that they hold alongside data and intelligence from other sources.

The purpose of these locality quality structures is to use data and health intelligence at a local level, cognisant of local priorities, to facilitate assurance and to drive improvement in the quality of care provided by different parts of the health and social care system.

Where this assurance is not evident, further information may be requested or specific actions mandated to the practices, clinical or management teams, in line with the

established purpose and principles of the framework. A route of escalation within the local governance arrangements is necessary and may best be provided via the clinical and care governance structure of the integrated authority, or its local equivalent.

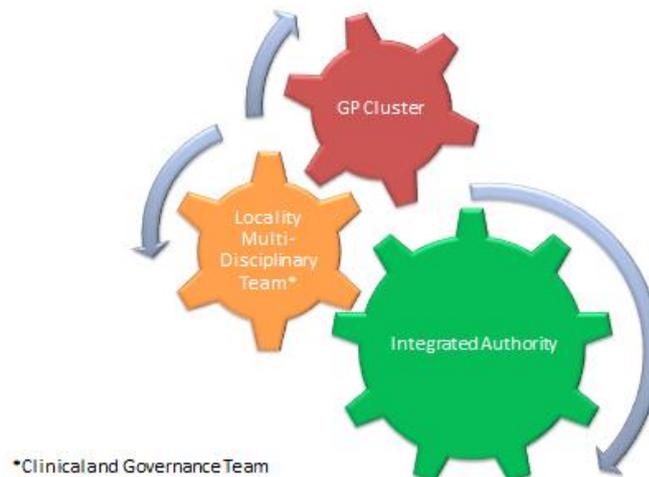


Fig 3 System of Influence

Figure 3 demonstrates schematically the potential system of influence between these different groups within a Health and Social Care Partnership structure; each has influence on each other, regardless of “size”. The cluster quality leads have an important role in the GP cluster, in particular by demonstrating leadership in how discussions and activity here link to the wider clinical priorities, quality structures and to the locality management team. This allows optimal communication, analysis and discussion about all aspects of care within the locality and its linked community services and hospital(s). Experience in the transition arrangements already demonstrates the value of integration of public health practitioners with their expertise proving valuable to aid understanding and discussion on local population health within clusters.

Utilised in this way, each Health and Social Care Partnership may receive internal assurance about the care in each locality, be made aware of any action plan necessary to address identified gaps, or influence resource necessary to address this. Links between the locality quality group and the locality management team will allow clinical risk associated with any perceived issues or problems to be managed, with a clear structure of escalation where this cannot be addressed at the locality level.

In order that this is fully effective, there needs to be appropriate, open and transparent sharing of agreed datasets within these networks for public and patient benefit. Alongside this, agreed mechanisms of escalation and response should be

identified in the event that progress to address acknowledged actions or gaps be incomplete.

National Support for Improving Quality in GP Clusters

The quality framework for General Practice developed by Royal College of General Practitioners in Scotland and Healthcare Improvement Scotland provides a useful reference for the aspects of quality that GP clusters may need support from national organisations.⁷ The framework is based on the Juran Trilogy processes of:

- Quality Planning
- Quality Improvement
- Quality Control

The framework outlines the activities in each of these processes that General Practice could be supported to undertake as follows:

Quality Planning

Quality Planning is a structured process for designing and organising services that meet new goals and ensure that patient needs are met. There are various steps which include: setting the aim, identifying the practice population, identifying patient and carers needs, developing a process to meet the need, and developing checks to ensure that the aim is met.

Through this process General Practice will be supported to:

- Set quality improvement goals
- Identify strategies, infrastructure and resources required
- Build interest, motivation and ownership
- Align with existing national and local quality initiatives

Quality Improvement

Quality Improvement can be defined as a set of processes within general practice which includes training in specific improvement methods and approaches, the creation of improvement teams, data feedback, tailored facilitation and support. This ensures that the individuals who provide care have the necessary skills in improvement techniques and are able to adopt various approaches including improvement tools, self-reflection and benchmarking in order to understand and address the reasons for variations in quality, and to identify areas where acceptable

⁷ Healthcare Improvement Scotland, RCGP Scotland. Developing a Quality Framework for Scottish General Practice [Internet]. HIS; 2014. Available from: http://www.rcgp.org.uk/rcgp-near-you/rcgp-scotland/~/_media/Files/RCGP-Faculties-and-Devolved-Nations/Scotland/RCGP-Scotland/RCGP-Scotland-QFGP%20interactive.ashx

quality can be improved further. They can then implement corrective measures, and devise new approaches to improve quality of care (Kings Fund 2011).

The Institute of Medicine conceptualised quality as having six dimensions: safety, timeliness, effectiveness, efficiency, equity and patient centeredness – sometimes referred to as the STEEP acronym (IOM, 2001).



Through this process General Practice will be supported to:

- Understand and use the appropriate quality improvement tools / methodologies
- Define improvement projects: What parts of the process are not working?
- Diagnose the problem: What is the root cause of the problem?
- Identify the changes required to address the problem
- Confirm that the change was effective
- Communicate and share best practice.

Quality Control

Quality Control is a process for meeting quality aims by measuring actual performance and planned performance and taking action on the difference. Quality control encompasses a range of activities across a number of levels from national oversight and inspection through to local practice / practitioner evaluation and peer group review. This level of local data collection and monitoring instils a strong degree of ownership and helps promote a practice culture of continuous quality improvement. Through this process General Practice could be supported to:

- Undertake self-evaluation and take part in peer group review of quality and safety in the practice
- Measure current performance and its variance from expected or intended performance
- Describe variability in processes, understanding and interpreting that variability, reducing or eliminating unnecessary or inappropriate variation, and expanding or maximising positive variation
- Provide feedback comparing actual performance to intended, achievable outcomes.

- Use data to manage the process, evaluate effectiveness, maintain quality improvement gains, and facilitate further planning and improvements.

Within the context of this quality framework there are several national organisations that will contribute to supporting GP clusters including:

- Healthcare Improvement Scotland
- NHS National Education for Scotland
- NHS National Services Scotland
- Scottish School of Primary Care
- The Royal College of General Practitioners

Healthcare Improvement Scotland

Healthcare Improvement Scotland provides support across Health and Social Care through the following functions:

- Evidence
- Improvement
- Quality Assurance
- Scottish Health Council

Staff from across the organisation will work together, and where appropriate with other agencies and organisations, to support CQLs and leaders across primary care apply the quality framework outlined above in two ways:

- Design and deliver national improvement programmes that address common challenges across Scotland (testing and spreading at scale)
- Provide tailored and responsive improvement support to enable the health and social care system to deliver against key local improvement priorities

National improvement programmes

HIS will continue to support the development and delivery of improvement programmes that will enable GP practices, GP Clusters and primary care services to work together across Scotland on common issues and challenges

The design of the programmes will be done in partnership with CQLs and leaders in primary care services to ensure that:

- The issues being addressed are informed by local priorities emerging from the new GP cluster arrangements as well as national priorities that will emerge from the developing evidence base and policy from national organisations and Scottish Government.
- The scale of testing is suited to the issues being addressed so that small scale proto-typing is considered when exploring new issues and scale and spread is adopted when appropriate.
- There is sufficient and appropriate flexibility for GP clusters to choose local improvement priorities from national programmes.
- The method for working collaboratively is suited to a distributed workforce but makes use of, and where necessary supports development of, local quality improvement infrastructure including GP clusters to enable efficient and effective collaboration from practice to national level.

This will build on HIS experience of running improvement programmes for a distributed workforce such as the Scottish Patient Safety Programme in Primary Care.

Tailored and responsive improvement support

GP clusters are intended to enable practices to work together on common issues and challenges, eg. through national or local improvement programmes, whilst also recognising there will be variation in the challenges different clusters and practices will face.

HIS will play an important role in supporting CQLs and leaders in primary care services to develop their role in supporting improvement in GP clusters whether through extensive programmes across several or all clusters to individual initiatives in one cluster or perhaps practice. To do this HIS will need to understand the needs of CQLs, leaders and primary care and respond to this in a tailored way. This will include:

- Providing development support in relation to specific needs of each board/partnership and its GP clusters (as described below)
- Bespoke support through providing skills, expertise and/or resources to address specific problems identified by board/partnership and GP clusters

To do this effectively will require strong relationships and good on-going communication between HIS and CQLs and leaders in primary care.

Core quality support functions

HIS will provide support to GP clusters through national improvement programmes and tailored responsive support. The detail of the support available is given below:

Building the knowledge and skills to do the work of improvement

HIS will work closely with NHS Education for Scotland to:

- Support the design and delivery of a range of resources that facilitate the development of the knowledge, skills and competence in leading and doing the work of improvement with a focus on developing the capacity of CQLs and leaders in primary care services to support GP clusters to;
 - apply improvement methodology to redesign and continuously improve services
 - participate in highly effective strategic commissioning
- Support implementation of change and improvement methods through coaching, facilitating, mentoring and providing consultancy support to CQLs and leaders in primary care services.
- Provide „faculty“ to support delivery of national improvement training focussed on CQLs and leaders in primary care services and local improvement training focussed on GP clusters and delivered by CQLs and leaders in primary care services.
- Support a range of networks and communities of practice involving CQLs, PQLs and leaders in primary care services which are focused on improvement.

Providing expertise in evidence, evaluation and measurement for improvement

The partners contributing to the supporting infrastructure will:

- Conduct rapid reviews of evidence for CQLs and leaders in primary care services to inform improvement work locally.
- Conduct rapid reviews of evidence on topics emerging at national level from GP clusters and partnerships/boards.
- Provide advice and support to CQLs and leaders in primary care services on how to pragmatically embed evaluation across improvement work including support for developing the business case for improvement.
- Developing the capacity of CQLs and leaders in primary care services to use and facilitate use of data (qualitative and quantitative) in GP clusters to identify opportunities for improvement and to understand whether changes

are leading to improvement. As part of this provide advice and guidance on using data to better understand population need.*

* This would draw on SPIRE and analytical support provided by National Services Scotland

Innovation and Horizon scanning

- Support work to design and test innovative solutions to common improvement challenges emerging from GP clusters, localities and boards/partnerships that involve primary care services.
- Develop tools and guidance to support the work of improvement to suit the needs of GP clusters.
- Horizon scan to identify promising practices across Scotland and internationally that are relevant to GP clusters and primary care services.
- Convene experts and frontline staff from across the system to provide 'thought leadership' to GP clusters and primary care services as required.

Creating the Conditions for Improving Outcomes

- Work with partners to identify and remove any national level barriers and to enhance national level enablers for GP cluster working.
- Provide a „boundary spanning“ function across GP cluster, localities, boards/partnerships and national organisations to support improvement in outcomes.
- Support CQLs and leaders in primary care to develop and run campaigns focused on building social movements for change in context of primary care services and GP clusters.

Clinical Guidelines

Working with other agencies where appropriate, HIS will respond to the emerging needs of GP clusters to prioritise and develop clinical guidelines in formats that support them in delivering the quality framework.

Quality Assurance

HIS will work with national organisations and GP clusters to develop proportionate quality assurance that is based on the principles and values of this framework. Quality assurance may include a combination of internal and external mechanisms to ensure that GP clusters, health boards and health and social care partnerships are able to understand and review the quality of care, both independently and with the support of others, to drive quality and improvement with GP clusters.

National Services Scotland

Information & Intelligence to support GP Practices and GP Clusters

The Scottish Primary Care Information Resource (SPIRE) is a new, successfully tested, development and will be available to use in GP practices in 2017. SPIRE is a user friendly simple way to look at the information practices have on in their own systems⁸. More information on SPIRE can be found [here](#).

The first round of SPIRE searches have been designed in conjunction with GPs, pathfinder practices in Scotland, the Scottish Patient Safety Programme, GPs from SCIMP and Health Improvement Scotland. At the click of a button, these initial searches will include for example; identifying people with multiple morbidity, a flu immunization dashboard and high risk medicines monitoring.

In the future, the SPIRE team will work with local information services and GP cluster representatives to make sure that SPIRE is providing the right information to support quality in primary care in a practical and useful way. This could include, for example; workload analysis, patient safety searches, and identifying those who would most benefit from anticipatory care planning.

SPIRE also contains a module which practices can use to improve their data quality, an important part of quality in primary care.

The SPIRE service will simplify and standardise the process for reporting on, and extracting from, data held within GP practice systems. This will help unlock the valuable source of information which is held within GP records, information which has the potential to provide a greater understanding of the health needs of the population and how best to address these needs.

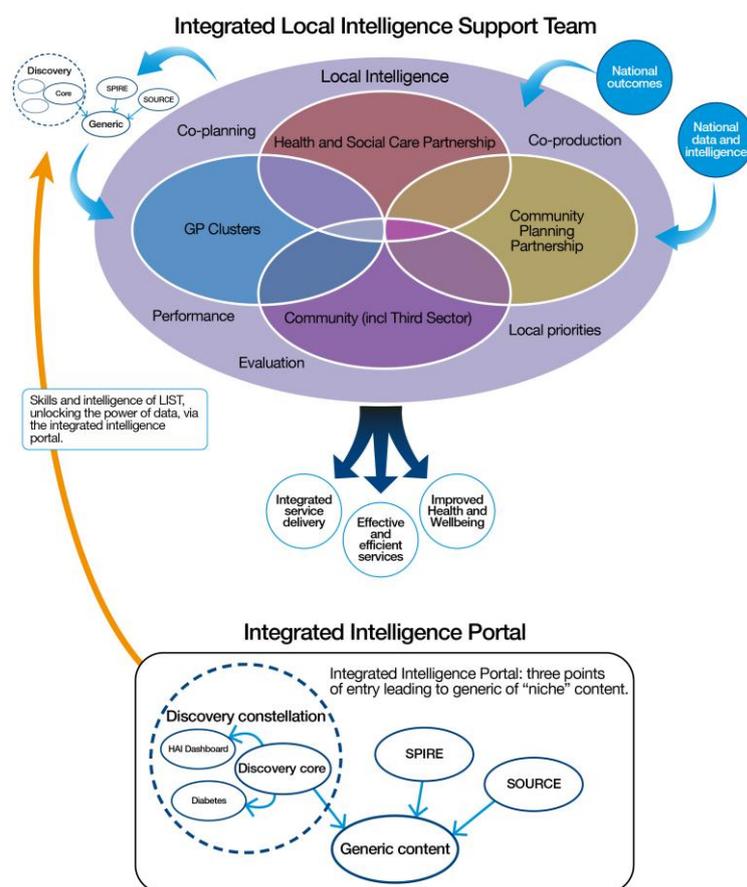
SPIRE will support cluster working by being able to present information at a cluster level. Thus if a cluster identifies a clinical priority, both an internal practice search and a cluster search could be undertaken. This will require safe electronic data extraction from the practice to a safe haven. This will be done at the discretion of the practice thus practices will have to opt in to enable data extractions. The information governance protocol for SPIRE also includes an opt out for individual patients for which there will be an information campaign [safeguarding information](#). This is approved and endorsed by the Scottish General Practitioners Committee and Royal College of General Practitioners, The Information Commissioner and Patient Groups.

⁸ More information on SPIRE is available from <http://www.spire.scot.nhs.uk/>

LIST

The Local Intelligence Support Team (LIST) was deployed across Scotland from April 2015 to support Health and Social Care Integration. The team provides on-site expert analytical support. The LIST service has provided local decision-makers with meaningful and actionable intelligence, leading to improved outcomes for service-users and citizens. In several areas of the country GP practices are actively involved in successful projects with LIST. The service will be expanded more formally into Primary Care and will support Cluster Quality working, in particular, intelligence led influence and decision making.

The future aspiration is an intelligence led service which is joined up across health and social care including GP practices and GP clusters; there are a range of tools and information sources which could be, in time, pooled together, for example, SOURCE⁹ an intelligence service already used by Health and Social Care Partnerships and Discovery¹⁰ one currently used by secondary care.



⁹ <http://isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Health-and-Social-Care-Integration/>

¹⁰ <http://www.isdscotland.org/Health-Topics/Quality-Indicators/Discovery/>

Facilitation

Working and learning in GP clusters is new. The transitional arrangements for Quality put in place during 2016-17 recognised that this style of working will need time, and require patience, as these clusters form and begin to adjust to a completely new approach to improving Quality.

Developing constructive conversations around local priorities and improvement aims, using intelligence and data from a range of sources, and building relationships internal to the cluster, and with other parts of the health and social care system merits support, and in some places may require formal assistance.

Facilitation, alongside support for data analysis and improvement advice, will greatly enhance the output of these clusters and allow them to become productive more quickly.

Recognition of this is critical, and during the development of this framework it is judged to be important to signal to GP Clusters and to Integrated Authorities that investment in facilitation, either from internal resources or from the range of organisations able to provide this, will enhance the output of these clusters and allow them to become productive more quickly.

Supporting Cluster Quality Leads in running productive meetings, both practically and developmentally, and ensuring access to leadership training and appropriate administrative support will all contribute to the success of GP cluster working and are central components of the necessary infrastructure.



NHS Education Scotland and the Scottish School of Primary Care

Personal Development, Learning and Research

Across Europe, there are examples of small groups of health professionals who meet together regularly to disseminate learning in primary care. This is an important function of GP clusters, facilitating improvement in measurable quality (eg harmful prescribing), but also learning through audit, adverse event review, human factors and ergonomics, decision support aids and educational materials .

NES have a variety of learning resources based on a blended learning approach to include Workshops, E-learning, Train-the-Trainer sessions and Formative Assessment. These resources aim to support Multi-Disciplinary Education and Training which can be adapted to suit the appropriate healthcare professionals involved.

Examples of resource include:

<p>Leadership Development</p> <p>Facilitation Skills</p> <p>Understanding Why Things go Wrong in Complex Systems</p> <p>Enhanced Significant Event Analysis</p> <p>Patient Safety in Primary Care</p> <p>Evaluation of Improvement Interventions; Qualitative and Quantitative Methods</p> <p>Prospective Hazard Analysis</p> <p>Incident Reporting and Learning Guidance</p>	<p>Quality Improvement Skills</p> <p>Human Factors and Ergonomics</p> <p>How to Respond When Things go Wrong</p> <p>Systems Thinking and Approaches</p> <p>Safer Systems for Test Results Management</p> <p>QI Tools (e.g. Care Bundles, Audit, PDSA Cycles, Trigger Review, Safety Checklist)</p> <p>Process Mapping</p> <p>Safe Practice in Medicines Reconciliation</p>
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In addition, there are a number of validated safety and improvement tools that NES have developed which may be useful to GP practices and clusters when assessing and planning improvement in the care that they provide.

Safety Climate Reflection and Learning
Structured Review of High Risk Patient Records
Enhanced SEA
GP Safe System Checklist
Criterion Audit and Care Bundles
Formative Peer Review System (QI Projects including criterion and care bundle audits and SEA)

Always Events
Never Event's and Serious Patient Safety Incidents to inform guidance on
Reporting and Learning System Engagement.

The Scottish School of Primary Care has produced a series of briefing papers on areas in quality and safety on which clusters could usefully focus their improvement activity¹¹. Each paper summarises research, guidelines and other evidence about areas of care that can be improved, and improvement methods and interventions.

Over time, these will gradually be added to as GP clusters and others identify areas where they would find further briefings useful.

Initially, the areas covered will include:

Prescribing Safety
Chronic Pain
Managing Multimorbidity
Recognising and Managing Patients with “medically unexplained” physical
symptoms
Partnership working with pharmacists
Improving management of long term conditions; the role of telehealth
Asthma
Care of refugees, asylum seekers and undocumented migrants
Mental health
Palliative and anticipatory care
Treatment burden

With the development of GP clusters and this style of working, comes also an opportunity to strengthen the role of general practice in epidemiological research. There is a close, synergistic relationship between clinical quality, clinical research and health system research, and potential to use this to improve the organisation of care and clinical outcomes. GP clusters offer a mechanism to encourage more of those with an interest in clinical academic practice to participate, and to improve the proportion of research funding in primary care.

¹¹ GP Cluster Briefing Papers, Scottish School of Primary Care; available from http://sspc.ac.uk/publications/briefing_papers/

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