QUALITY MANAGEMENT IN GENERAL PRACTICE

Dr JP Nagle
CEO, Alpha Primary Care

1. INTRODUCTION

Quality is a word from which few managers can hope to escape from for long these days. It has been introduced to the NHS through high profile reports such as the Darzi Report – “High Quality Care for All” ¹ where Lord Darzi speaks of “high Quality Care for patients and the public” and promotes the concept of “Quality at the heart of everything we do”. He goes on to state that the NHS is about providing the highest quality of care for patients and the public citing his personal experiences and feedback from staff and patients that it is the quality of care that really matters to people.

The Government has re-affirmed the need to place quality of care at the heart of the NHS. The White Paper, Equity and Excellence: Liberating the NHS (July 2010) makes it clear that quality can be delivered by focusing on outcomes, giving real power to patients and devolving power and accountability to the frontline. This puts the patient at the heart of the system advocating patient choice and input as fundamental.

NHS chief executive David Nicholson put quality firmly at the top of the healthcare agenda in issuing a QIPP challenge to chief executives throughout the NHS in 2010. He stated that the radical changes planned for the NHS represent a significant delivery challenge that will not happen without clarity and focus on every point in the system. It requires a relentless focus on implementation of a patient led service, local empowerment, clinical leadership and sustained focus on improving outcomes.

So what does “Quality” mean and in the context of general practice and practice management what are the implications of Quality being promoted so forcefully at a governmental and NHS national level?

A frequently used definition of quality is “Delighting the customer by fully meeting their needs and expectations”. These may include service, appearance, availability, delivery, reliability etc. So if an organisation, practice, is to deliver a quality service it must understand the true needs and expectations of its patients.

1.1 The Development of Quality Standards & Total Quality Management

The development of quality standards is widely associated with the Japanese and dates back to the 1950 and 60’s when “quality thinking” became a major focus in Japanese management philosophy which drove the introduction of quality control and quality management. The need for quality was seen by the Japanese as their best response to their worldwide reputation, at the time, for cheap imitation products and poor standards.

¹ High Quality Care for All – NHS Next Stage Review Final Report June 2008
Total Quality Management was the focus of these initial efforts. The British Standards (BS) 5750 for quality systems was published in 1979 and a National Quality Campaign was launched in 1983\textsuperscript{2}. Since then the international standardisation organisation (ISO) 9000 has become the internationally recognised standard for quality management systems. It comprises a number of standards that specify the requirements for the documentation, implementation and maintenance of a quality system.

1.2 **Total Quality Management**

Total Quality Management (TQM) is a philosophy that enables the management of people and business processes to ensure complete customer satisfaction. TQM focuses on prevention rather than cure, relentlessly eliminates waste and inefficiencies, involves all staff and has a total focus on the customer.

For general practice this means:

- Focus on the patient,
- Eliminate inefficiencies,
- Involve all staff,
- Share best practice,
- Set standards,
- Monitor and review performance

Adopting and implementing a TQM philosophy has the following essential building blocks:

- Understanding of the basis and background to TQM – as a philosophy
- TQM processes,
- Tools & Techniques to help deliver improvements
- People & teamwork
- Quality Management system
- Performance measurement
- Standards & Benchmarking
- Self assessment

\textsuperscript{2} [www.dti.gov.uk/quality-evolution](http://www.dti.gov.uk/quality-evolution)
1.3 QIPP

QIPP stands for Quality, Innovation, Productivity and Prevention and is seen as an essential initiative in driving Quality within the NHS and in securing cost savings over the coming years. Despite the recent good funding settlement for health, the NHS needs to make savings because of growing demand. With factors such as an ageing population putting the NHS under increasing pressure, it is not possible to go on as before. Now, more than ever before, the NHS has to achieve value for money and the best possible quality so that patients get the greatest benefit.

The Quality, Innovation, Productivity and Prevention (QIPP) programme is all about ensuring that each pound spent is used to bring maximum benefit and quality of care to patients. The NHS needs to achieve more than £15 billion in efficiency savings by 2015 through a focus on quality, innovation, productivity and prevention. Every saving made will be reinvested in patient care by supporting frontline staff, funding innovative treatments and giving patients more choice.

The “QIPP challenge” as David Nickolson referred to it in 2010 demands action at regional, and national level to drive up quality while meeting the financial demands of the next few years – making the best use of scarce resources. There is one central DH-led work-stream reviewing central budgets and international comparisons, while there are eight further work-streams within the service and a tenth looking at the system changes needed to support delivery. The NHS work-streams include:

- primary care productivity
- appropriate care, decommissioning and demand management
- new models of care, self care and prevention.
- secondary care productivity.

Proposals for new ways of working or service redesign should demonstrate how they meet the QIPP challenge if they are to be successful. The philosophy underpins the NHS Plan for 2010-15, ‘From Good to Great’ and the latest operating framework.

The concept is linked to research by the charity “The Health Foundation”. Their Quest for Quality and Improved Performance initiative developed a comprehensive picture of quality and highlighted differences in performance across the UK.

**QIPP Example in practice: Looking at clinical area of cytology:**

In addition to better patient pathways/ shorter time on receiving results, teams have also been trained to understand the cost of poor quality (defects) and reduce and eliminate the causes in a way that supports the interests of women and the cytology service. Improvements made are aligned to the Quality, Innovation, Productivity and Prevention (QIPP) strategy.

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3. For more detail, see [www.health.org.uk](http://www.health.org.uk) – go to publications/briefings and leaflets/QQUIP
Quality
- A ‘right first time’ approach
- Guaranteed and predictable results

Innovation
- Robust problem solving,
- Visual management

Productivity
- Removal of duplication
- Reduction and elimination of waste
- Reductions in overtime and outsourcing
- Appropriate use of skill mix

Prevention
- Timely referral to colposcopy and treatment,
- This programme of work has demonstrated benefits to over one million women.  

The table below shows a list of national QIPP workstream categories (2013).

<table>
<thead>
<tr>
<th>Workstream category</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Long Term Conditions</strong></td>
<td>To provide patients and their carers with access to higher quality, local, comprehensive community and primary care services to improve clinical outcomes and experiences.</td>
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<tr>
<td><strong>Right care</strong></td>
<td>To ensure consistency, best value, shared decision making and continuous improvement in patient care.</td>
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<tr>
<td><strong>Right care for patients - shared decision making</strong></td>
<td>To embed Shared Decision Making in routine NHS care, for example through the use of Patient Decision Aids, to help personalisation and patient empowerment in health care.</td>
</tr>
<tr>
<td><strong>Safe care</strong></td>
<td>To develop safer systems in which everyone understands their role in delivering safer care and works towards achieving that goal every day to reduce harm and associated expenditure.</td>
</tr>
<tr>
<td><strong>Urgent and emergency care</strong></td>
<td>To ensure that patients requiring urgent and/or emergency care get the right care by the right person in the right place at the right time.</td>
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4 Improvements in service areas are published by NHS Evidence [www.evidence.nhs.uk](http://www.evidence.nhs.uk)
<table>
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<tr>
<th>Workstream category</th>
<th>Description</th>
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<tr>
<td><strong>End of Life Care</strong></td>
<td>To ensure the provision of end of life care is in the most appropriate setting for the patient to allow for dignity and respect at the end of life. To ensure that patients feel safe and well cared for in the most appropriate ‘productive' environment where quality is maximised, processes are efficient and variation is minimal.</td>
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<tr>
<td><strong>Medicines use and procurement</strong></td>
<td>To ensure the efficient use of medicines used in primary and secondary care to reduce waste, improve patient safety and support patients get the maximum benefit from their medicines. To ensure that procurement is coordinated and optimised to get the best value for money in the NHS without compromising quality of patient treatment and care.</td>
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<tr>
<td><strong>Productive Care</strong></td>
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<tr>
<td><strong>Back office Efficiency</strong></td>
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<tr>
<td><strong>Procurement</strong></td>
<td>To ensure staff, patients and the voluntary sector are actively engaged and working to deliver quality and cost improvements.</td>
</tr>
<tr>
<td><strong>Mobilisation</strong></td>
<td>To improve the service quality and productivity of pathology services.</td>
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<tr>
<td><strong>Clinical Support Rationalisation (Pathology)</strong></td>
<td>To improve commissioning and contracting for primary medical care services to reduce unwarranted variation, deliver more consistently high quality services and contribute to the efficiency needs of the NHS.</td>
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<tr>
<td><strong>Primary Care Commissioning and Contracting</strong></td>
<td>To plan for and ensure a flexible, mobile, well supported NHS workforce based on local needs both now and in the future.</td>
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<tr>
<td><strong>Workforce Qipp</strong></td>
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For more details visit: [http://www.evidence.nhs.uk/qipp/case-studies-by-workstream](http://www.evidence.nhs.uk/qipp/case-studies-by-workstream)
2. STANDARD SETTING AND BENCHMARKING

2.1 Benchmarking

Benchmarking is the continuous activity of identifying, understanding and adapting best practice and processes that will lead to superior performance.

Benchmarking measures an organisation’s products, services and processes, to establish targets, priorities and improvements, against known external companies or databases. The objective is to measure the company’s current performance level, measure it against known standards and/or internal prior standards with a view to identifying areas for improvement. This in turn should lead to competitive advantage, cost reductions, greater efficiencies and/or better quality. The data and information collected and analysed as part of a self-assessment can be used in a benchmarking exercise.

There is a clear distinction to be made between internal and external benchmarking – to be most meaningful, one would measure against an external “benchmark”.

The benefits of conducting a benchmarking exercise include:
- Greater clarity on its current position,
- Identifies whether an organisation has improved or not over the prior period,
- Focuses on current customer needs,
- Encourages innovation and identifies inefficiencies,
- Supports the development of realistic, stretch goals,
- Establishes realistic action plans,
- Positions an organisation relative to its peers and other relevant comparable “benchmarks”,
- Allows the company to set standards,

2.2 Quality outcomes Framework

Introduced in 2004 as part of the General Medical Services Contract, the QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. The QOF gives an indication of the overall achievement of a practice through a points system. Practices aim to deliver high quality care across a range of areas, for which they score points. Put simply, the higher the score, the higher the financial reward for the practice. The final payment is adjusted to take account of the practice list size and prevalence. The results are published annually. Whilst voluntary, QOF revenue has become an important component of practice income accounting for between 15 to 20% of total income annually.

**Proposed Changes to QOF 2013/2014**

Introduced in 2004 as part of the General Medical Services Contract, QOF (Quality Outcomes Framework) has seen many changes during its 9 year period. In its 10th year, 2013/14, the whole framework stands to change again.
Proposed changes to QOF are out to consultation and as part of the QOF process; stakeholders have the opportunity and are encouraged to comment on these. The consultation period is open until February 2013.

**Main changes outlined for QOF 2013/14 are:**

**Threshold Changes:**
Thresholds in QOF are planned to increase in line with upper quartile of current achievements. These will be phased over a two year period with the increase being applied to 20 clinical indicators in 2013/2014 and to all remaining indicators from 2014/15.

**Removal of Organisational Domain:**
This Domain will be removed however the Quality and Productivity Indicators will remain. The current QP (quality and productivity) indicators will remain until 31 March 2014 but with some slight amendments to reflect the new NHS Commissioning Board (NHS CB) structure - they mainly involve removing deadlines and reporting requirements. Indicators not retained in QP or moved into the public health domain will be removed. The funding released will be used partly to fund the NICE recommendations and partly invested in new directed enhanced services (DES) – see below.

**Introduction of a Public Health Domain:**
The following indicators from the current QOF will be grouped in a new public health domain: CVD-PP1, CVD-PP2, OB1, smoking 5, 6, 7 and 8, records 11 and 17, information 5 and all the additional services domain indicators.

**Implementation of NICE recommendations, these include14 potential new indicators across the following six domains:**

- Hypertension
- Dementia
- Coronary heart disease (CHD)
- Diabetes (including tightly linked measures)
- Peripheral arterial disease (PAD)
- Stroke and TIA

**New disease areas such as the inclusion of Rheumatoid Arthritis.**
The four new targets in this disease area include annual reviews and cardiovascular and fracture risk assessments.

**Directed enhanced service:**
A new directed enhanced service will be developed by the NHS CB and will be offered to practices on a preferred basis. This will be funded from £120m of resources released from ending QOF organisational indicators. The NHS CB will ultimately have the decision on the operational detail for the scheme, but they are likely to include:

- Risk profiling and care management
- Case finding for patients with dementia
- Remote care monitoring
- Improving online patient access

**QMAS Closure:**
QMAS will still be in place for payments for QOF 2012/13 for GP practices; however will be replaced by a new service called the Calculating Quality Reporting Service (CQRS). This new system will be used to calculate payments for GP practices across England for 2013/14 financial year.

To review the proposed new indicators refer to [http://www.nice.org.uk/newsroom/pressreleases/NICEAnnouncesNew2013-14QOFMenu.jsp](http://www.nice.org.uk/newsroom/pressreleases/NICEAnnouncesNew2013-14QOFMenu.jsp)

3. **CARE QUALITY COMMISSION**

3.1 **Introduction**

The Care Quality Commission is the independent health and social care regulator for England. It regulates health and adult social care services in England, whether they're provided by the NHS, local authorities, private companies or voluntary organisations.

CQC makes sure that essential common quality standards are being met where care is provided and work towards the improvement of care services. It promotes the rights and interests of people who use services and have a wide range of enforcement powers to take action on their behalf if services are unacceptably poor.

Its work brings together independent regulation of health, mental health and adult social care. Before 1 April 2009, this work was carried out by the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection. These organisations no longer exist.

The Commission’s functions are in assuring safety and quality, performance assessment of commissioners and providers, monitoring the operation of the Mental Health Act and ensuring that regulation and inspection activity across health and adult social care is co-ordinated and managed.

3.2 **CQC’s Main Activities**

The CQC’s main activities are:

- Registration of health and social care providers to ensure they are meeting essential common quality standards
- Monitoring and inspection of all health and adult social care
- Using enforcement powers, such as fines and public warnings or closures, if standards are not being met
- Improving health and social care services by undertaking regular reviews of how well those who arrange and provide services locally are performing and special reviews on particular care services, pathways of care or themes where there are particular concerns about quality
• Reporting the outcomes of our work so that people who use services have information about the quality of their local health and adult social care services. It helps those who arrange and provide services to see where improvement is needed and learn from each other about what works best.

CQC’s vision is of high quality health and social care which:

• Supports people to live healthy and independent lives
• Helps people and their carers make informed choices about care; and
• Responds to individual needs.

By high quality care, it means care that:

• is safe
• has the right outcomes, including clinical outcomes (for example do people get the right treatment and are they well cared for?)
• is a good experience for the people who use it, their carers and their families
• helps to prevent illness, and promotes healthy, independent living.
• is available to those who need it when they need it; and
• provides good value for money

CQC’s values are to:

• put the people who use services first, be informed by what they tell us and stand up for their rights and dignity
• be independent
• be expert and authoritative, basing our actions on high quality evidence
• be a champion for joined up care across services
• work with service providers and the professions to agree definitions of quality
• be visible, open, transparent and accountable.

### 3.3 Registration System

In 2010, the Care Quality Commission introduced a new registration system. The regulation of health and adult social care is changing. Subject to legislation, all health and adult social care providers who provide regulated activities will be required by law to be registered with the Care Quality Commission (registration under the Care Standards Act 2000).

The new system will make sure that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights. The new system is focused on outcomes, rather than systems and processes, and places the views and experience of people who use services at the centre. The new system will enable a joined up regulation for health and social care, helping to ensure better outcomes for the people who use services.

The Act gives the Commission a wider range of enforcement powers along with flexibility on how, and when to use them. This will allow the regulator greater powers to achieve compliance with registration requirements - including requirements relating to infection control. The Commission will be able to apply specific conditions to respond to specific risks
such as requiring a ward or service to be closed until safety requirements are met, as well as being able to suspend or de-register services where absolutely necessary.

From 1st April 2013, all GP practices must be registered with the Care Quality Commission.

Completing the CQC application process practices must review the following 16 essential quality and safety standards and highlight whether they are compliant or non compliant and offer a **SMART action plan** to remedy any non-compliance. (i.e. description of non compliances – no staff training on records, however holding training course on xx date. Future plans will incorporate an audit of records every year)

### CQC's ESSENTIAL QUALITY AND SAFETY STANDARDS

Practices must meet these 16 standards:

1. Care and welfare of people who use services.
2. Assessing and monitoring the quality of service provision.
3. Safeguarding from abuse people who use services.
4. Cleanliness and infection control.
6. Meeting nutritional needs.
7. Safety and suitability of premises.
8. Safety, availability and suitability of equipment.
9. Respecting and involving people who use services.
11. Complaints.
12. Records.
13. Requirements relating to workers.
15. Supporting workers.
16. Co-operating with other providers.

During 2013 CQC will continue to update practices with what they need to know once they are registered. This will include information about what will appear on their website and their inspection programme.

#### 3.4 Inspections

There will be three types of inspections:

- Scheduled – CQC will carry out these regularly – inspectors will talk to members of staff, observe patient staff interaction (for example, observe reception areas), they will also speak to patient groups and patients about the practice. In addition to this information available from external bodies will also be referred to. CQC state that a practice having a scheduled visit will normally be given 48 hours notice and such inspections will take place every two years.
responsive – these are carried out if concerns are raised over whether the practice meets the essential standards and where non compliances were identified during a previous inspection.

- Themed – CQC carry out these when they review a particular type of service or set of standards.

CQC will publish more information later this year about what to expect from an inspection.

4. Developing a Quality Culture at your Practice

The introduction of this chapter gives a brief historical perspective on the development and introduction of quality thinking, quality systems and quality standards to industry and how relatively recently the same thinking and philosophies are now being implemented into the NHS and healthcare system.

The introduction of quality standards to your practice is not a choice it’s a necessity to comply with CQC registration. However, it would be a missed opportunity to see this as an imposition of regulatory standards and a bureaucratic exercise which will take from the practice time and require a lot of input from the practice manager and team. Implementing and developing a quality culture can yield significant improvements in the practice performance as illustrated by the following case study summary:

4.1 Case Study:

Implementation of improvement program following Alpha Primary Care’s benchmarking of a practice and working with team to implement agreed changes led to significant improvements in practice rating:

![Graph 2: Improvement in Practice Performance as measured by KPI Index](image-url)
Benchmarking was used to measure the performance of each area against a set of key performance indicators. An action plan was developed to target areas for improvement where experience from other practices indicated a higher performance was easily achieved. The overall KPI practice index rating was improved by almost 20% in the first phase of the work as shown in Graph 2.

Graph 3: Improvements in a number of Practices as measured by KPI Index and over a number of different time periods during the implementation program.

The improvements seen in a number of different practices over four phases (P1, P2 etc in graph) of work are shown in Graph 3. The KPI index acts as an excellent benchmark (internally and externally) for measuring the current and ongoing state of each practice and quantifiable improvements can be seen in each