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Improving together: a new quality framework for GP clusters in Scotland

Citation for published version:

Smith, GI, Mercer, SW, Gillies, JCM & McDevitt, A 2017, 'Improving together: a new quality framework for GP clusters in Scotland' British Journal of General Practice, vol. 67, no. 660, pp. 294-295. DOI: 10.3399/bjgp17X691601

Digital Object Identifier (DOI):

[10.3399/bjgp17X691601](https://doi.org/10.3399/bjgp17X691601)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

British Journal of General Practice

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Smith, G. I., Mercer, S. W., Gillies, J. C.M. and McDevitt, A. (2017)
Improving together: a new quality framework for GP clusters in Scotland.
British Journal of General Practice, 67(660), pp. 294-295.
(doi:[10.3399/bjgp17X691601](https://doi.org/10.3399/bjgp17X691601))

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Deposited on: 30 June 2017

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2017

Dear Margaret,

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Manuscript No: BJGP-2016-0820

Title: Improving Together: A new quality framework for GP Clusters in Scotland

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The authors are very keen that the collaborative nature of the development of this framework is recognised and would be keen that this is reflected in the article by inserting "On behalf of the Scottish GP Cluster Advisory Group" as a qualifier at the

end of the article. In the published on-line version, where we recognise the flexibility for additional room, the authors are keen to include a list of the membership, if this is agreeable (or at least a list of the constituent organisations).

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With thanks to **Professor Frede Olesen**, University of Aarhus, Denmark for providing external advice and critical review.

Improving Together: A New Quality Framework for GP Clusters in Scotland

In her address to the Royal College of General Practice Annual Conference in Glasgow in October 2015, the Scottish Government's Cabinet Secretary for Health and Wellbeing, Ms Shona Robison, announced her intention to dismantle the Quality and Outcomes Framework (QOF) - the pay for performance scheme introduced into UK general practice contract in 2004 - and replace it within a Scottish GMS contract. This contract, of which elements will be introduced through 2017 and 2018, will contain an obligation for practices to participate, as part of a "GP cluster", in a new framework for quality improvement more suited to the emerging models of care in Scotland that will be required to meet the challenges facing modern healthcare ¹. This move away from a single UK contract for GPs denotes further divergence in the NHS across the four nations ^{2 3}.

A new contract for GPs in Scotland is a historic event. This route to a Scottish contract for GPs began in 2012, after UK negotiations stalled, allowing a separate agreement between the Scottish Government and the Scottish General Practitioners' Committee. This introduced the first discernible change in the approach to the GMS contract across the four UK nations. Further catalysts to the development of this contract have been the statutory introduction of health and social care integration in Scotland ⁴ and a commitment from both Scottish Government and the BMA in Scotland to work together to identify solutions to shared challenges.

The healthcare system is changing in response to the demands placed upon it and must continue to do so to preserve universal access and further improve health and

wellbeing within our communities. The National Clinical Strategy ⁵ signals the intent to transform the model of care across the whole health and social care system in Scotland, with primary care at the heart of the system, supported and enabled to fulfil its potential by additional investment of £500m by 2021. A component of this transformation, within the context of health and social care integration, is the formation of GP clusters. These clusters are professional groupings of GP practices, agreed locally, and though they may be of different sizes according to local need and geography, must be viable for small group work. Their purpose is to provide a mechanism through which GPs can engage in peer-led, values driven quality improvement and learning, within and across practices, and also contribute to the oversight and development of care within the wider healthcare system.

At a seminar in March 2016, hosted by the Scottish School of Primary Care, (<http://www.sspc.ac.uk/>) delegates from across the UK and Europe examined evidence for GP clusters, or “quality circles” as they are more commonly called in Europe, and began to develop the potential contribution of these clusters to the quality agenda⁶. With the introduction of these GP clusters, there is a need, and an opportunity, to wholly reconsider how we approach quality; key elements from UK and European evidence and experience of small group working around education and quality were elicited to help develop a fresh framework that would enable and support GPs to lead this agenda at a local level.

Scotland is not alone in this agenda. Wales began to introduce GP clusters with similar contribution to planning in 2014 but retains core elements of the QOF.⁷ In England, clusters of GPs are forming as local Federations in some regions, but not

nationally, and generally the QOF is being retained.^{8,9} Whilst the quality of care delivered in general practice has undoubtedly improved since the beginning of the century, it is contentious to what extent the QOF has contributed to this effect. There is some evidence to suggest that it initially accelerated the pre-existing trajectory of improvement in those chronic diseases that were included, and achieved greater equality in the standard of care across practices. However, over time, and for a variety of reasons, this effect became diluted and there were possibly unintended consequences of ‘crowding out’ other chronic conditions not included¹⁰.

In 2015, the Scottish Government and BMA undertook joint visits to each health board and local medical committee in Scotland to listen to views on the existing contractual approach, and test an alternative vision. These conversations evidenced concern about the volume of bureaucracy associated with QOF, and the effect that it was having on the consultation model. Many expressed regret that this was influencing the profession towards a disproportionate emphasis on a single-disease focussed biomedical model of care, which was less consistent with the values of general practice, and less fulfilling as a doctor to provide. This theme was consistent with knowledge distilled from Gillies *et al*’s learning journey¹¹ and commentary on the “industrialisation” of general practice by Gubb.¹²

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 with its national programme for patient safety. More recently, following the publication of Realistic Medicine ¹³, feedback has demonstrated that

doctors want to provide a more personalised approach to care with greater emphasis on shared decision making and to tackle unwarranted variation in care, harm and waste within our healthcare system. Scotland also has a vibrant academic primary care research community, supported by the Scottish School of Primary Care, and it will be important to provide high quality research and evaluation to support the new contract and the new models of care.

It has been suggested that it is now time for “Era 3” medicine; guided by reduced measurement, improvement science, transparency, and co-production with patients¹⁴. Achieving this requires a paradigm shift¹⁵ to an approach to medicine that has realistic and proportionate, high quality, high value care as its aim and collaboration at its core. Berwick defines this as ‘the moral era’.

This philosophy provides the context for “Improving Together”¹⁶, the framework developed to describe the future approach to leading quality in general practice in Scotland, and the infrastructure that will assist this. As it was developed, the advisory group felt it important to set out the common purpose and values that would underpin the work of GP Clusters throughout Scotland. These values were central to the conceptual approach and were agreed early in the process by the broad range of organisations represented, forming a compact upon which the infrastructure to support the framework could then be built. The framework sets out the contribution of NHS Health Boards, Health and Social Care Partnerships and professional organisations in supporting GP clusters to fulfil this role, allowing meaningful GP

participation in local planning that strengthens the delivery of health and social care integration.

The framework is based on the Juran Trilogy processes of quality planning, quality improvement and quality control. The key components that GP clusters may require support with were identified: data and health intelligence; tailored facilitation, improvement advice, learning and improvement tools, evaluation and research, and leadership and networking. These elements will be provided by a collaboration of national organisations working together in a network of support for clusters, and cluster quality leads. They include Healthcare Improvement Scotland, National Services Scotland, NHS Education Scotland, the Scottish School of Primary Care and the Royal College of General Practitioners (Scotland).

This collaborative approach is critical, and it offers an opportunity for practices, clusters and organisations to share support and learning. The vision for general practice and the GP contract in Scotland foresees an evolving role for GPs, with their time and skills being used at the more complex end of care, providing leadership to improve quality. To do so requires capacity, and so this framework must be viewed in the context of transforming Primary Care with evolving roles across an expanded workforce that will enable this style of working.

This recognition of the clinical environment to which this framework is being introduced is important, and all those who contributed to its production acknowledge the unprecedented challenges being faced in general practice just now. Patience to allow this framework to develop and fulfil its potential will be necessary, as will mutual trust, empathy and lenience in judgement by all parties involved. By staying

true to the purpose and values that are described within it, and remaining courageous that the aligned philosophies of Realistic Medicine and Era 3 Medicine describe the correct cultural approach, Improving Together offers a real opportunity for all involved to revitalise the approach to quality in general practice in Scotland.

¹ Health Secretary Shona Robison addresses RCGPAC, Oct 15 <http://news.gov.scot/news/major-change-to-bureaucratic-system-of-gp-payments>

² Bevan G. The Impacts of Asymmetric Devolution of healthcare in the four countries of the UK, Health Foundation, Nuffield Trust, September 2014; http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/revised_four_countries_summary.pdf

³ Bevan G, Karanikolos M et al; The four health systems of the UK; how do they compare?; Health Foundation, Nuffield Trust, September 2014; http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/revised_four_countries_summary.pdf

⁴ Integration of Health and Social Care, Scottish Government; <http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration>

⁵ A National Clinical Strategy for Scotland, Feb 2016; <http://www.gov.scot/Publications/2016/02/8699/downloads>

⁶ Mercer SW, Gillies JCM; Quality After QOF: Report on a workshop hosted by Scottish School of Primary Care, March 2016: http://sspc.ac.uk/media/media_480045_en.pdf

⁷ Our plan for a Primary Care Service up to March 2018; Welsh Government <http://gov.wales/docs/dhss/publications/150218primaryen.pdf>

⁸ Supporting Sustainable General Practice (2016) <https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/guide-netwrks-feds-gp.pdf>

⁹ Suffolk GP Federation; <http://suffolkfed.org.uk/>

¹⁰ 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

¹¹ Gillies JCM, Mercer SW, Lyon A et al (2009) Distilling the essence of general practice: a learning journey in progress. *Br J Gen Pract* 59: 562:e167-e176

¹² Gubb JD; Unintended Consequences: What of Quality outside the QOF?. *Br J Gen Pract* 59: 562; e173-e174

¹³ Realistic Medicine: The Chief Medical Officer's Annual Report 2014-15; <http://www.gov.scot/Publications/2016/01/3745/downloads>

¹⁴ Berwick DM. Era 3 for Medicine and Health Care. *JAMA*. 2016;315(13):1329-1330. doi:10.1001/jama.2016.1509

¹⁵ Kuhn, Thomas The Structure of Scientific Revolutions. University of Chicago Press, Chicago, 1962.

¹⁶ Improving Together: A Framework for Quality and GP Clusters; Scottish Government, January 2017 <http://www.gov.scot/Publications/2017/01/7911/downloads>