BMA Scotland

RCGP SCOTLAND

RCGP and SGPC – GP Quality Clusters

Background

The NHS Quality and Outcomes Framework (QOF) general practice financial incentive scheme was abolished in Scotland in 2016 to shift the focus to clinically led quality improvement, centred around the needs of local populations. The Scottish Government redirected QOF funding into core general practice, to enable GPs to focus their time on patient care rather than the pre-set quality improvement goals, which had come to be considered bureaucratic and onerous. A commitment was made to continue collecting data for the next three years on the QOF indicators, in areas such as cancer, diabetes, heart disease, mental health, and obesity.

The 2016/17 GMS Agreement between the Scottish GP Committee (SGPC) of BMA Scotland and the Scottish Government introduced GP clusters, professional groupings of GPs from practices to address local clinical care and services to improve outcomes. These decisions were based on examining the evidence base supporting such a professionally led approach. Within each GP practice, a GP would take on duties as a Practice Quality Lead (PQL) to engage in their local GP cluster, and each GP cluster would select a GP as the Cluster Quality Lead (CQL) in a coordinating role. Clusters have functions both intrinsic (in and between practices in the cluster) and extrinsic (between clusters and their wider local system).

Quality clusters had been set up to learn, develop and improve together for the benefit of local communities, and the Scottish Government described its intention to encourage clusters to develop at their own pace.[i] However, it was recognised that variation between cluster development emerged, due to the challenges in capacity, learning and development support, and administrative support.

In recognition of this variation, the National Cluster Guidance was launched in June 2019, developed jointly by the Scottish Government, the SGPC, RCGP Scotland, the Scottish Primary Care Clinical Leads, and informed by input from Healthcare Improvement Scotland (HIS).[ii] The guidance set:

- Definitions for Practice Quality Leads (PQLs) and Cluster Quality Leads (CQLs) to promote consistency
- Recommended minimum expectations for clusters
- Key relationships to influence wider system quality improvement
- What support clusters needed to best enable their growth

Five years on

In August 2022, representatives from RCGP, SGPC, Primary Care Leads, and Scottish Government met to consider where we had reached in respect to the quality landscape in Scottish general practice, five years on from the introduction of clusters. RCGP and SGPC drew up a document setting out some joint principles, which was shared with the Scottish Government. These areas of agreement provided a basis to consider potential next steps for developing a system to demonstrate general practice's service quality, starting with the principle that such a system has to be owned by the profession. A roundtable was proposed as a means of developing thinking around possible next steps for the quality agenda.

In March 2023, RCGP and SGPC hosted a roundtable discussion with attendees invited for their expertise in primary care and quality improvement and assurance, from a range of practitioner, leadership and academic perspectives.

There were consistent themes across the discussion, namely that this should be a wider quality system, shifting away from the term 'quality standards', instead encompassing both assurance and improvement in a dynamic learning system. The desired system would include: planning, support for quality improvement, dedicated resource, mechanisms to monitor improvements, trust and autonomy for GPs and their teams, building on the cluster role of quality improvement, and maintain good links to clinical care and governance frameworks. It was also agreed that to bring in this quality system was contingent upon the provision of appropriate resource and supporting infrastructure. Other themes that emerged included the recognition of the current pressures on general practice and that new processes should be meaningful, proportionate and supportive.

With those messages in mind, representatives from RCGP, SGPC, Primary Care Leads, and the Scottish Government met in June 2023. Constraints in resourcing and capacity were considered barriers to furthering the quality systems agenda at that time, although it was deemed possible to strengthen and enable the GP clusters further. After work paused on this issue in the latter part of 2023, RCGP and SGPC met in January 2024 and agreed to progress development of a quality system in general practice through a joint review document on the position of GP Quality Clusters with recommendations to support and further enable their quality improvement work. To inform that work, the organisations also agreed to conduct a joint survey of CQL and PQLs.

Survey findings and analysis

A survey was sent to Local Medical Committees (LMCs) requesting it be distributed to all practices in May, asking that the Practice Manager then forward this invitation to the PQL/CQL in their practice. Respondents to the survey were asked to identify themselves as a CQL, if they hold that role, or as a PQL. Response to this determined further questions. Questions were directed to understand time spent in the role, perceived support provided, barriers to further progress and to shed light on work undertaken by GP Quality Clusters. 159 completed surveys were received representing just under 18% of practices. Of these responses, 113 came from PQLs and 46 from CQLs.

Key findings

1. Time spent in role and funding for PQL and CQL role.
    - The average time spent in the PQL role is 2.1 hours. The time spent in the role did vary but the vast majority of PQLs reported average time in role as between 1 and 4 hours weekly.
    - PQLs are contractually required to spend 2 sessions and 2 hours per month on quality activities – to include preparation, attendance at cluster meetings and taking learning back to the practice.
    - The average time spent in the role was 4.2 hours. A significant number of CQLs reported spending 8 hours per week in this role and a number less than 4 hours.
    - CQLs are engaged directly by the Health and Social Care Partnership (HSCP) to act in the role of CQL on local contracts. CQLs were therefore asked whether their HSCP funding matched their time spent in this role. The response to this question was that 43.5% of CQLs reported that funding matched time in role, 34.8% said it did not and 21.7% said that they did not know.
    - Only 15.2% of CQLs reported that they had had any uplift in payments since they had taken up their post.

The survey allowed for free text comments at this point, and a review of these comments shows a general concern that the resourced time is inadequate to drive large scale change, and that additional funding and administrative support is required to drive the quality improvement within general practice. Multiple comments were made about the rise in backfill locum costs not being matched by any rise in payment for this work. Some CQLs reported working significant additional unfunded hours whereas others made the comment that they did the QI work which was possible in the funded time recognising that this meant that valuable work was left untackled. This difference in approach may explain why 43.5% of CQLs were able to respond that the funding matched the role and may not mean that that response should be read as the CQLs assessment that current resourced time allows all valuable and necessary QI work to be undertaken.

2. PQL and CQL attitude to undertaking more Quality Improvement (QI) work

    - 64.7% of CQLs and PQLs said that they would want to take on a greater time commitment for QI work if additional resources were available to support this.
    - 96% said they would be interested in doing more QI work relating to practices delivered services and care of registered patients.
    - 79% of those responding said they would be interested in more QI work relating to wider community-based health services and acute delivered services.

This response shows a strong desire in GP Clusters to undertake more QI work if suitably resourced and supported.

3. Resources required to enable GP Quality Cluster work which are not in place

Respondents were asked to comment on resources not in place which would help GP Quality Clusters fulfil their QI potential. There were many responses to this. Common themes were:

- Need for admin support
- More protected time for quality improvement work
- Impact of workload pressures in general practice impacting on protected time for qi work
- Perception of lack of valuing of external quality work by HSCPs/Health Boards
- Lack of Protected Learning Time (PLT) to embed change in practice
- Need for CQL networking to be facilitated to share good practice and for peer support
- Responses to this question indicate that factors outwith the control of CQLs and PQLs are limiting their potential to deliver qi to the system.

4. Role of Protected Learning Time in enabling identified change to be embedded in GP practices

A specific question was asked on whether the current level of provision of PLT is acting as a barrier to implementing change in practice as identified through GP quality cluster QI work.

- 61.7% of respondents said that the current level of provision of PLT is acting as a barrier to implementation of change.

This response indicates that the link between provision of PLT and Quality Cluster activity needs to be recognised, to see the learning implemented as change within GP practices

5. GP Quality Cluster work leading to change in GP practice service delivery

- 74% of respondents said that they believed that work undertaken in GP quality clusters has led to change within their practices which has benefitted patients or the practice team in the delivery of care.

This response demonstrates that the GP Quality Clusters are capable of delivering QI activity.

6. GP Quality Cluster work leading to wider system change

- 33% of respondents said that work undertaken in GP Quality Clusters had led to change in the wider system e.g. change in HSCP delivered services or improvements in interface working.

This response highlights the need for further work on the interface between GP Quality Clusters and HSCPs.

7. Provision of leadership training

- 27% of CQLs have been provided with leadership training.

This response shows that the system is not supporting CQLs as intended by providing leadership training, which has been recognised as necessary for GPs to perform in these roles.

8. Provision of QI and data training

- 35% of CQLs and PQLs have been provided with QI and data training
- This shows that around two thirds of GPs in these roles have not been provided with the training necessary to perform in these roles
- Access to a data facilitator
- 50% of CQLs and PQLs reported that they had access to a data analyst (Public Health Scotland LIST analyst)

The National Cluster Guidance is clear that all clusters require to have access to a Public Health Scotland (PHS) LIST analyst to support their work.

9. Administrative support to the GP Quality Cluster

- Only 22% of respondents reported that they had access to administrative support or additional support for practice staff to undertake this activity.

The National Cluster Guidance is clear that HSCPs should provide administrative support to facilitate the work of the GP Quality Cluster.

10. Awareness of and participation in the National CQL Network hosted by Healthcare Improvement Scotland (HIS).

- 57% of respondents are aware of the National CQL Network hosted by HIS.
- 97% of responding CQLs said they were a member of the network.

This suggests a high membership of the National CQL network amongst those that responded.

11. Use of the National GP Cluster Guidance

- 26% of respondents said that they were aware of this guidance and had made use of it in considering the terms of reference and remit of the GP Quality Cluster.

This shows lack of penetration of this guidance apparently even within membership of the National CQL network. This is significant given it details not only the role of GP Quality Clusters but importantly the support that the wider system is expected to provide to the cluster.

In addition to the above questions respondents were asked to highlight examples of work that the GP Quality Cluster had undertaken. The responses described over 200 individual pieces of QI work undertaken which had direct beneficial impact on clinical care and patient services. Areas of work included patient safety systems within practices such as monitoring and recall, safer prescribing of high-risk medicines, sharing good practice, looking at unwarranted variation, patient pathways, chronic disease management for conditions that were previously monitored under QOF and many conditions that were not. To give an indication of the scope of work undertaken a very small sample are captured here.

“We improved our KIS summaries for our frail elderly patients which anecdotally we feel has led to reduced admissions-work ongoing on this. We successfully implemented group consultations for menopause in our practice”

“Our Renal QI audit has improved management of patients with reduced eGFR. We have all worked hard on greener respiratory care also”

“We now have an annual audit calendar runs all year long ensuring quality and safety. We arranged an educational session on cancer care ensuring we identify new cancers as early as possible and utilise all available supports for patients diagnosed with cancer”

“We undertook QI work on Chronic Pain with a learning needs assessment and upskilling in holistic management of chronic pain which reduced opioid and gabapentinoid prescribing and resulted in improved holistic management of patients with chronic pain.”

“We have had several projects helping to improve patient safety and quality: simple medication audits on sodium valproate in women of childbearing age, anticoagulation monitoring and DOAC switching, and mirabegron BP monitoring are example of these.”

Case vignette: Example of GP Quality Cluster working actively supported by HSCP

Given the survey findings and clear reference to the essential enabling role that HSCP support can play in promoting the work of GP Quality Clusters, focussed interviews were undertaken with key stakeholders in Renfrewshire HSCP which has a strong history of actively supporting their GP Quality Clusters. This was an attempt to: add some detail to the survey findings; to identify key characteristics of such a relationship; and to shed light on what one HSCP has done. It was hoped that this work might enable other HSCPs to consider and develop their relationship with and support for their GP Clusters.

Brief, focussed interviews were undertaken with two of the experienced CQLs from the HSCP, with multiple relevant factors identified by them.

The CQLs regarded the HSCP as actively supportive of the GP Quality Clusters. They particularly valued a collaborative working relationship with the HSCP Clinical Director (a GP) and the Change and Development Officer. These two HSCP leads have been in post throughout and the continuity and organisational memory afforded by this was positively commented on. The visibility and accessibility of the individuals in these roles was said to be important to the CQLs.

The CQLs reflected that at the introduction of GP Quality Clusters the HSCP made funding available which supported significant Protected Learning Time and helped establish quality

projects. This meant that from the outset there was enthusiasm from GPs as the work was seen as being supported and valued by the system.

The HSCP has organised regular CQL meetings, supported by the CD, which can be either remote or in person meetings. These meetings are intended to promote sharing of good practice, allow for problem solving and provide an opportunity for networking and peer support which is viewed as very important by the CQLs. The CQLs also have a contact group which the CD is a member of.

The CQLs reported that the clusters have a strong sense of ownership over the QI work and that the work is driven by need identified by the PQLs. The sense of ownership of the work was identified as being important to motivation and buy in. The CQLs in this HSCP feel well supported by the LIST analysts from PHS.

Significantly in this HSCP CQLs reported that the HSCP valued the insights and views of its CQL including in regard to quality within HSCP delivered community services.

As an example of effective pieces of work undertaken in conjunction with the HSCP, the CQLs pointed to the Schools Interface Project, detailed below. In regard to the high level of motivation gained by the self-directed QI work, the CQLs pointed to develop of an “audit calendar” which has been adopted by practices.

Limiters to progress identified by the CQLs were the workload pressure upon GPs in practice, inadequate resourced CQL and PQL time, lack of PLT to embed learning in practices, and not enough specialised support to the clusters in the form of template production and excel spreadsheet development.

The HSCP Clinical Director and Change and Development Officer were interviewed to understand their perspective on what they have put in place to support GP Quality Clusters and the value of cluster working as they see it.

The HSCP is clear that cluster working has driven development of a positive relationship between practices, with formal groups sharing data and undertaking QI being a significant cultural change in general practice. The development of a body of GPs acting as leaders is also valued and the HSCP has developed clear lines of communication with a named HSCP Officer being the contact point for CQLs.

The HSCP is clear in regard to the GP Quality Clusters’ intrinsic work (that related to practice delivered services), that they are supportive but do not seek to direct activity.

The HSCP organises quarterly meetings of CQLs and the PCCD. The HSCP Officer attends and collates activity allowing a tracker of activity to be developed. These meetings allow CQLs to pick up ideas from each other and share progress they have made on QI activities, so that tools etc can be shared also.

With regard to extrinsic QI work (services delivered outwith the practice), the HSCP points to the local primary /secondary care interface group which has good involvement from CQLs. The HSCP also has a system in place to allow CQLs to raise issues of concern regarding other

community-based services with a clear contact point within HSCP, who is receptive to approaches from the CQLs.

In this HSCP national historic non-recurring cluster funding has allowed some meetings to share learning to take place but the absence of any ongoing funding, and the absence of centrally supported PLT, is identified as a significant risk to the ongoing ability to embed change in practices arising from the learning done in clusters.

Other barriers to realising the full potential of clusters were restricted data availability (since the demise of SPIRE) and the absence of funding to support QI expertise directly in practices where a need has been identified.

As an example of outcome from HSCP support for QI issues raised by the clusters the HSCP pointed to a school interface project which resulted in agreed expectations around CAMHS referrals and sharing of contact details between schools and GP Practices.

In conclusion, the CQLs highlighted well organised local support networks and retention of ownership of the QI agenda as the essential features to motivate GPs to participate in QI work and deliver the potential of GP Quality Clusters. The HSCP leads clearly value the output of the GP Quality Clusters and take steps to show that the output of the clusters is listened to. CQLs are provided with contact details for those senior HSCP leads that are able to take matters forward and the HSCP facilitates regular CQL networking events. These arrangements demonstrate respect and appreciation of the autonomy of GP Quality Clusters to determine the QI work of the clusters. The understanding and alignment of the aims and principles GP Quality Cluster working between CQLs and HSCP in this area is evident and likely to be driving a productive working relationship.

Discussion

Anecdotal reports have suggested significant variability in how well GP Quality Clusters have developed over the years and what further requires to be done to strengthen Quality Improvement work in General Practice. Different parts of the wider system seem to have a variety of expectations of GP Quality Clusters and organisational knowledge as to the purpose of GP Quality Clusters is variable outside of general practice. This is leading to the suggestion that GP Quality Clusters require greater external direction and perhaps new national guidance. The purpose of undertaking the survey was to cast greater light on the work that GP Quality Clusters are currently undertaking and to understand what factors are restricting their ability to contribute even more to QI work in general practice.

Before considering any change or introducing new guidance it is essential to learn for the experience of the last 6 years and listen closely to the CQLs and PQLs who have direct experience of what supports and what challenges their ability to be effective agents of change. It is crucial that changes are not made which reverse the significant cultural and organisational change that the development of GP Quality Clusters in Scotland has driven.

It seems clear from the survey responses that GPs in these leadership roles recognise the value of working in this way and have a strong appetite to do more Quality Improvement work if they are resourced to do so. However, the survey also shows that HSCP support for GP Quality

Clusters is in many cases inadequate and not consistent with the expectations of HSCPs in the National Cluster Guidance. CQLs and PQLs cannot deliver the important Quality Improvement work that they are tasked with without the necessary training, in QI activity and leadership skills, and without adequate administrative support. Data Intelligence is essential for QI work and it is a great concern that only half of respondents reported that they had support from a LIST analyst. Protected and resourced time for the GPs acting as PQLs and CQLs is fundamental and the clear message from the survey is that the current level of funding is acting directly to inhibit the amount of QI activity undertaken and preventing change being instigated in GP practices. However, despite these restrictions, the vast majority of respondents were of the view that QI work undertaken had resulted changes being made within their practices which would benefit patients and a smaller number reported having been able to contribute positively to wider patient service change.

The introduction of GP Quality Clusters in Scotland has brought about significant change in bringing GPs together to share their individual data and experiences and identify areas for further study and improvement. This is a significant cultural change, as is the close working relationship that many GP Clusters have developed with their HSCP. The National Cluster guidance makes clear that GP Quality Clusters are intended to be a bottom-up approach, with the GPs identifying areas for QI work supported by the HSCP and data analysts. Comments from those interviewed identified ownership over QI activity as a significant motivating factor, which is consistent with other GP surveys that have identified autonomy and the ability to direct activity as a highly valued feature of being a GP, and therefore caution is necessary before considering any change which might threaten that sense of ownership.

Conclusion and recommendations

This review of the current position of GP Quality Cluster activity in Scotland finds that QI activity can flourish in GP Quality Clusters where adequately supported by the system, and that there is potential for further benefit to both direct practice delivered services and wider community delivered services. However, the enabling support, in the form of directly resourced PQL and CQL time and wider training/admin/data resource, is inadequate in many cases and does not meet the expectations set out in the National Cluster Guidance. A consistent approach to the delivery of required support and a review of the funding available for these roles are both warranted. If the system wants to hear the collective insight available from GP Clusters on service delivery in the community and wants to see practices empowered to make change which benefits its patients, then it requires to support it as committed to when this system of GPs coming together to do QI work was introduced. At this time, it is not further national guidance which is required but consistent adherence to existing guidance and review of funding to keep pace with rising backfill costs and to allow for expansion of activity.

The necessary areas for action required to be taken forward by Scottish Government and Health and Social Care Partnerships are summarised as:

- Review of funding to keep pace with backfill costs
- Review of funding to allow for additional QI work
- Support for PLT to embed change in practice
- Access to leadership and QI training
- HSCP supplied administrative support
- HSCP level networking events for CQLs
- Board level and possibly national CQL networking events
- Focus on HSCP and CQL interface particularly in regard to the extrinsic role of clusters with HSCPs having a clear line of communication with CQLs to discuss quality in wider community services
- "Off the shelf" QI activity could be made available but should support and not threaten the sense of autonomy and ownership that the GP Quality Clusters currently value
- PHS LIST analyst support
- Public-facing information to promote better understanding of breadth and impact of GP cluster work, showcasing examples
- The existing national cluster guidance should be promoted to address the loss of organisational memory around the purpose of GP Quality Clusters.

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[i] Improving Together - National Framework for Quality GP Clusters, Scottish Government
[ii] National Cluster Guidance, Scottish Government