

# Editorials

## Improving together:

a new quality framework for GP clusters in Scotland

### A NEW CONTRACT FOR GPs IN SCOTLAND

In her address to the Royal College of General Practitioners (RCGP) 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 the UK general practice contract in 2004 — and replace it as part of a new Scottish General Medical Services (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 health care.<sup>1</sup> This move away from a single UK contract for GPs denotes further divergence in the NHS across the four nations.<sup>2,3</sup>

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<sup>4</sup> and a commitment from both the Scottish Government and the BMA in Scotland to work together to identify solutions to shared challenges.

### TRANSFORMING THE MODEL OF CARE

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*<sup>5</sup> 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 £500 million by 2021. A component of this transformation, within the context of health and social care integration, is the

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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 agenda.<sup>6</sup> 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.<sup>7</sup> In England, clusters of GPs are forming as local federations in some regions, but not nationally, and generally the QOF is being retained.<sup>8,9</sup> Although 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 included.<sup>10</sup>

### QUALITY IMPROVEMENT

In 2015, the Scottish Government and the 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-focused 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 journey<sup>11</sup> and commentary on the 'industrialisation' of general practice by Gubb.<sup>12</sup>

Over this same period, there has been an expansion of interest and understanding in the approaches to quality improvement in health care, and Scotland has been at the forefront of this with its national programme for patient safety. More recently, following the publication of *Realistic Medicine*,<sup>13</sup> 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

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science, transparency, and co-production with patients.<sup>14</sup> Achieving this requires a paradigm shift<sup>15</sup> 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’.<sup>14</sup>

This philosophy provides the context for ‘Improving Together’,<sup>16</sup> 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, NHS National Services Scotland, NHS Education Scotland, the Scottish School of Primary Care, and the RCGP (Scotland).

## DEVELOPING THE FRAMEWORK

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.

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## REFERENCES

1. Scottish Government. Major change to bureaucratic system of GP payments. 1 October 2015. <http://news.gov.scot/news/major-change-to-bureaucratic-system-of-gp-payments> [accessed 26 May 2017].
2. Bevan G. *The impacts of asymmetric devolution of health care in the four countries of the UK*. London: Health Foundation, 2014.
3. Bevan G, Karanikolos M, Exley J, et al. *The four health systems of the United Kingdom: how do they compare?* London: Health Foundation, 2014.
4. Scottish Government. Integration of health and social care. <http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration> [accessed 26 May 2017].
5. Scottish Government. *A national clinical strategy for Scotland*. 2016. <http://www.gov.scot/Publications/2016/02/8699/downloads> [accessed 26 May 2017].
6. Mercer SW, Gillies JCM. *Quality after QOF*. Glasgow: Scottish School of Primary Care, 2016. [http://sspc.ac.uk/media/media\\_480045\\_en.pdf](http://sspc.ac.uk/media/media_480045_en.pdf) [accessed 26 May 2017].
7. Welsh Government. *Our plan for a primary care service for Wales up to March 2018*. 2015. <http://gov.wales/docs/dhss/publications/150218primaryen.pdf> [accessed 26 May 2017].
8. Connor R. *Supporting sustainable general practice*. NHS England, 2016. <https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/guide-netwrks-feds-gp.pdf> [accessed 26 May 2017].
9. Suffolk GP Federation. <http://suffolkfed.org.uk/> [accessed 26 May 2017].
10. Guthrie B, Tang J. *What did we learn from 12 years of QOF?* Literature Review Series, Glasgow: Scottish School of Primary Care, 2016. [http://sspc.ac.uk/media/media\\_486342\\_en.pdf](http://sspc.ac.uk/media/media_486342_en.pdf) [accessed 26 May 2017].
11. Gillies JC, Mercer SW, Lyon A, et al. Distilling the essence of general practice: a learning journey in progress. *Br J Gen Pract* 2009; DOI: <https://doi.org/10.3399/bjgp09X420626>.
12. Gubb JD. Commentary. Unintended consequences: what of quality outside the QOF? *Br J Gen Pract* 2009; DOI: <https://doi.org/10.3399/bjgp09X420644>.
13. Calderwood C. *Realistic medicine: Chief Medical Officer's annual report 2014–15*. 2016. <http://www.gov.scot/Publications/2016/01/3745/downloads> [accessed 26 May 2017].
14. Berwick DM. Era 3 for medicine and health care. *JAMA* 2016; **315**(13):1329–1330.
15. Kuhn T. *The structure of scientific revolutions*. Chicago, IL: University of Chicago Press, 1962.
16. Scottish Government. *Improving together: a national framework for quality and GP clusters in Scotland*. 2017 <http://www.gov.scot/Publications/2017/01/7911/downloads> [accessed 26 May 2017].