One Dorset practice's experience of using a quality improvement approach to Practice Professional Development Planning

Charles Campion-Smith and Andrew Riddoch

C Campion-Smith, DCH, FRCGP, general practitioner and primary care educator, Cornwall Road Practice, Dorchester, and Institute of Health and Community Studies, Bournemouth University. A Riddoch, MRCGP, general practitioner, Cornwall Road Practice, Dorchester.

Address for correspondence

Dr Charles Campion-Smith, 38 Prince of Wales Road, Dorchester, Dorset DT1 1PW. E-mail: ccampions@aol.com

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SUMMARY

There has been considerable discussion on and recommendation of the idea that Practice Professional Development Plans (PPDPs) should develop the whole practice as a healthcare resource, integrating and improving the educational process. In this study, the PPDP concept was launched in a practice in Dorset, following the Bournemouth PPDP framework. The practice linked the educational activities of individuals, small working groups and the whole team, to meeting the needs of the patients using a continuous quality improvement approach. The learning needs of the practice team were identified and learning actions were planned, leading to a better response to patients' needs.

Keywords: *Practice Professional Development Plan; Personal Development Plan; learning needs; learning actions.*

Introduction

In 1998, Kenneth Calman, the then Chief Medical Officer, proposed a review 'of how general practice patient care might be better supported through better alignment of continuing education, audit, research and application of clinical effectiveness material — together known as continuing professional development (CPD)'.[1]

The principal recommendation of the report was that Practice Professional Development Plans (PPDPs) should develop the whole practice as a healthcare resource, integrating and improving the educational process. The team would respond to national and local priorities and identify the educational needs necessary to better respond to these.[2]

The paper *The New NHS — Modern, Dependable* had already introduced the ideas of clinical governance and primary care development with quality assurance, audit, peer review, and professional development being linked[3]; subsequently the paper *A First Class Service* gave details of the increasing emphasis on quality standards and the role of clinical governance in improving the quality of care, as well as managing risk. The latter also reinforced the role of CPD and lifelong learning in improving standards of care. It endorsed multi-professional, on-the-job and team learning, and emphasised that education must be driven by the need to respond to local service development needs.[4]

In our practice (five principals, three whole time equivalents, 5700 patients), situated in the market town of Dortchester in Dorset, we have been able to embrace the PPDP concept, leading to significant patient benefits.

Process

The PPDP concept was launched at a multidisciplinary meeting in March 2000. Ideas and information from this meeting were documented in tables of *Professional Development* — a published manual of primary care development.[5]

The practice committed two hours of protected meeting time each month; a schedule of dates is published annually.

The process is led by the practice clinical governance lead who is a GP partner. Simple worksheets are produced for each team member and distributed seven days before meetings. These sheets advertise meeting time and location, advise on group work, and have space for each person to log their notes from this working time. They are collated in Personal Development Plans (PDPs) and in a PPDP portfolio, providing an essential link between personal and group learning.

Meetings generally consist of small group work for the first hour, followed by lunch and feedback of work to the whole group. Significant event analysis or a short talk from a visiting speaker makes up the second part of the meeting.

The practice followed the Bournemouth PPDP framework[6] (Figure 1). This has been developed by local primary care educators through facilitated work in practices throughout the county and focuses on linking education to patients' needs. The entire process in the Bournemouth PPDP framework has been outlined below.

Agreeing on the purpose (Box [a] in Figure 1)

There was agreement across the team that the purpose was to provide a high quality primary care service that meets patients' needs, both for care when they are unwell and to enable people to do all they can to remain healthy. Secondary aims of remaining a financially secure organisation and providing a good workplace for all staff were also agreed upon.

Assessing the needs (Boxes [b], [c] and [d] in Figure 1)

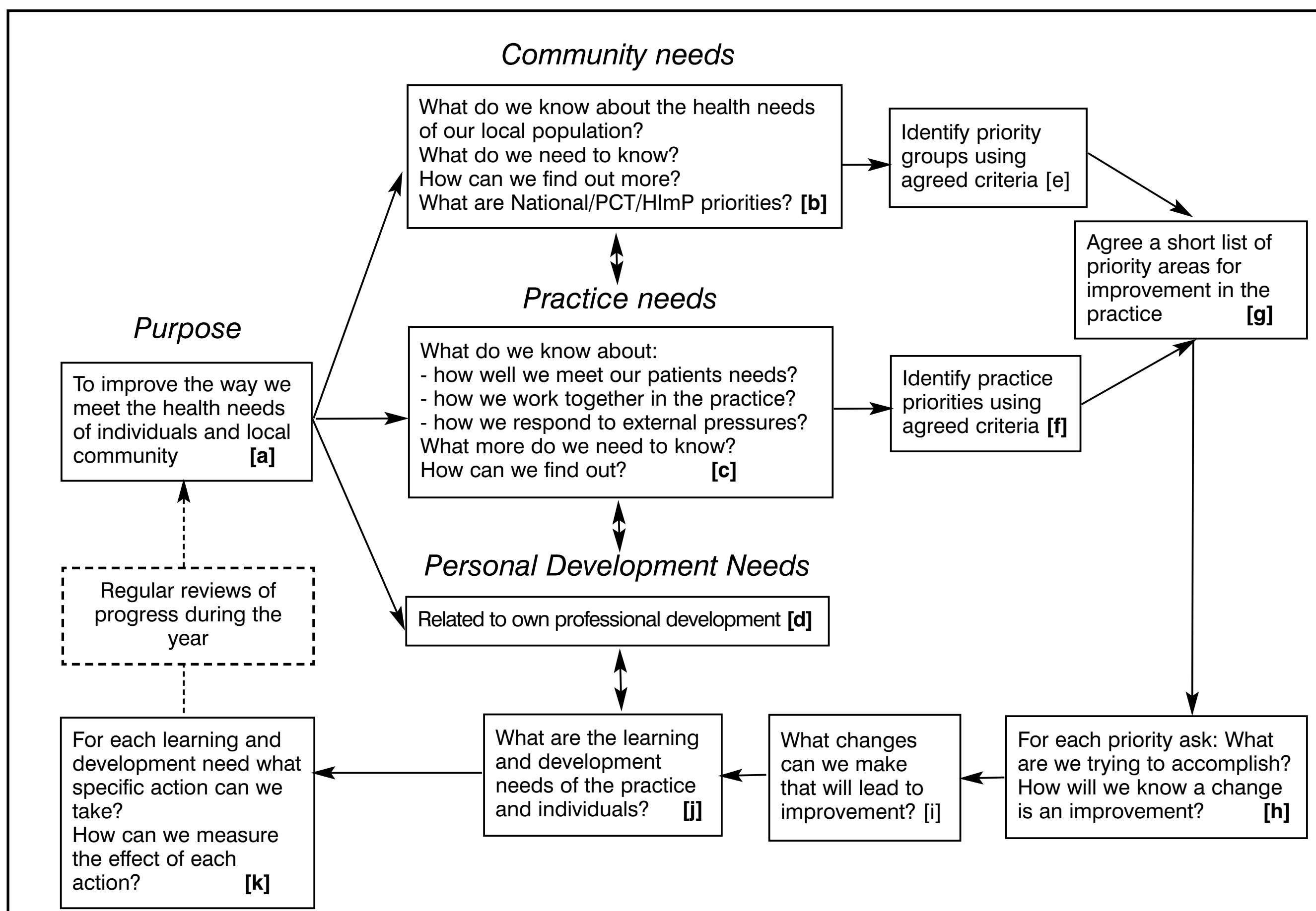

Figure 1. The Bournemouth PPDP Framework.

The staff at the initial meeting identified a number of needs. Other imperatives have either arisen from audits or significant events ('internal') or have come from government policy and Health Authority and PCG directives ('external'). It is also accepted that individuals within the team will have personal learning needs arising from questions in their own practice, reflection on their work or appraisal.

Negotiating the actions to take and sharing the work (Boxes [e], [f] and [g] in Figure 1)

The practice accepted that negotiation and choice was important — it would have been easy to take on too much and complete little. They looked for areas where there was a congruence between the practice's aims and those things that 'had to be done' to satisfy the external agenda. They were also able to ensure that the work was consistent with practice's membership of the National Primary Care Collaborative.

Planning the actions (Boxes [h] and [i] in Figure 1)

For each action planned, the practice team followed the continuous quality improvement model[7] and agreed on the following points:

- What is the high-level aim?
- What specifically are we trying to accomplish?
- Can we plan a change that we think will lead to improvement?
- Can we make measurements to see if the change has resulted in improvement?
- How can we plan to implement the change as a trial?

The practice team or subgroup then entered the 'plan-do-study-act' process.[8]

Identifying the learning needs (Box [j] in Figure 1)

For each change planned, the learning needs for the improvement to come about were determined. These included:

- the acquisition of specific skills or knowledge by one or two team members (e.g. a practice nurse learning how to carry out spirometry, and interpret the results);
- the need for more general knowledge for a greater number of the team (e.g. the entire clinical team needed to know which patients it is appropriate to refer to spirometry, what the patient should expect, and what the likely outcomes might be); and,
- the need for systems that the whole team was confident of (e.g. the use of a paperless internal communication and message system).

Planning learning actions (Box [k] Figure 1)

Once these learning needs were identified, the ways to meet

them were decided upon. These included attending external courses, bringing a resource to a practice education meeting, or just a learning activity within the team.

Some improvements planned, implemented and evaluated

- A protocol for the rapid management of simple urinary tract infection.
- The establishment of a palliative care register with fortnightly interprofessional meetings to review those patients on it.
- Establishing a spirometry service for patients with chronic lung disease.
- Changes to ensure that practice prescribing costs remained within budget without loss of quality.
- A programme of regular resuscitation training for all staff.
- A practice team approach to increasing influenza vaccine uptake.
- A whole-practice approach to meeting the National Service Framework targets for coronary heart disease.
- The introduction of a 'smokestop' clinic in the practice.
- Introduction of regular significant event analysis meetings to which any team member can propose a topic.
- Improved use of consistent, coded, computerised data for patient records and procedures to maintain the accuracy of these records.
- A number of initiatives to improve patient access, including:
  - — telephone surgeries;
  - — direct referrals of patients already assessed as needing specialist review by opticians;
  - — nurse consulting and triage;
  - — plans for self mea surement of blood pressure by selected patients;
  - — development of a practice website; and,
  - — a more flexible appointment system, creating slots for 'semi-urgent' problems.

Box 1 shows a specific example of benefits from the PPDP.

Aim: To work as an effective and supportive interprofessional clinical team.

What are we trying to achieve? The improvement of patient care, interprofessional communication, and teamworking, and support in a practice-based team delivering palliative care.

Can we plan a change that we think will lead to improvement? To establish a practice palliative care register and conduct a fortnightly interprofessional review of the patients on it.

Can we make measurements to see if the change has resulted in improvement? Review after four months. Check whether the meetings occurred, whether there were instances where care improved as a result, and whether staff members valued the meetings.

How can we plan to implement the change as a trial? Clinical team to meet regularly to review those on the register. Agreed criteria for entry to the register, agreed computer coding to record entry.

What are the learning needs and actions required? Review of different criteria defining 'palliative care'. Dissemination of understanding of special needs of patients receiving palliative care and their families to the whole team. Review of criteria for assessing care as a basis for regular review. Development of skills of membership and leadership of an interprofessional team. Review of procedures used to ensure continuity of care out of hours. Specific clinical and communication issues identified for future learning as they arise.

Results

Benefits to patients
- review of their care and needs;
- team members more aware of their situation;
- criteria-based review of their care should lead to less unmet need; and
- regular proactive review should lessen the chance of patients becoming 'lost'.

Benefits to team
- team members feel better supported in their work;
- there is a forum for discussing difficult clinical or interper sonal issues; and
- there is an opportunity for specific learning in response to clinical problems.

Box 1. Establishing a palliative care register and regular review meetings.

The links between the PPDP and PDPs

Individual learning needs arising from the practice PPDP

The PPDP generated learning needs and actions. These were met in different ways:

- by the whole team working together;
- by the team working individually on the same topic (e.g. everyone needing to update and maintain their resuscitation skills to the appropriate level); and
- by individuals seeking specific training.

Personal learning arising from practice problems and its relationship to the PPDP

One GP's encounter with a patient who gave a history of hepatitis C infection related to his previous intravenous drug use, made him aware of how little he knew about the condition and its implications.

Box 2 provides an excerpt from his PPDP that illustrates the process of identifying a learning need and the subsequent learning actions taken.

Practicalities of drafting and implementing the PPDP: difficulties, barriers and solutions

Introducing a new task to an already beleaguered primary care team was not easy. The difficulty of finding a time when all the key people could meet, and the concern about the work building up while they were away from there usual work was considerable. There was also a commonly held view that the PPDP meetings did not constitute 'real work' — only direct work with patients seems to fulfil this definition. There was a worry, arising from previous experiences, that the meeting would be a 'talking shop' and that nothing would be different for patients or staff as a result. There was some suspicion about the terminology or jargon used, and concerns that the team were being expected to respond to someone else's agenda.

However, the initial meetings were led in a way that ensured that the team felt a sense of ownership and control from the

Trigger
Event or area of uncertainty
Patient with history of hepatitis C infection feeling unwell

Learning need
What do I need to find out/learn?
Learn more about hepatitis C: clinical course, investigation, treatment, infectivity

Learning plan
How shall I do this? What will I do, with whom, when?
Internet search, journal reading, ask colleagues

The learning done
What did I do?
Web page of Canadian Association of Hepatology Nurses very useful, *Nursing Standard* review paper highlights high incidence of hepatitis B and C carriers who are unaware of this. Suggests all patients should be treated as potentially infectious rather than depending on making value judgements — which may often be incorrect. Discussion with local Public Health Laboratory Service consultant has clarified significance and role of different tests — liver function tests, core and surface antigen, polymerase chain reaction, etc. Discussion with recently appointed consultant gastroenterologist who informed me that he has a special interest in the topic, is introducing a hepatitis clinic locally with a nurse specialist, and that he would be happy to review this patient but does not envisage any need for liver biopsy at present. I learnt more about clinical features, including non-specific malaise, need for alcohol avoidance, risks of progressive disease, malignancy risk, and the role and limitations of b interferon and antiviral drugs.

Reflection
What have I learnt?
I now know the significance of the different tests (and have a written summary). I also have questioned my current policy and judgmental attitude to assessing infection risk. This has also highlighted the lack of practice-wide policy on wearing gloves for venepuncture.

Review
Did I do the learning I planned?
I did the learning.
Did I find what I wanted?
I found answers to the immediate question and now feel I know more about hepatitis B and C.
Has it altered my practice in any way?
I have reflected on the process and shared it with others as an example of informal 'just-in-time learning'. I have questioned some of my judgemental decision making and have asked my partners to consider a practice-wide policy on routinely wearing gloves for venepuncture.
Is there any evidence of this for my portfolio?
The written account of this learning journey is in my portfolio and has value for both process and content.
What next?
The initial patient has been referred to specialist clinic.

Box 2. Excerpt from a GP's PPDP, illustrating the process of identifying a learning need and subsequent learning action taken.

start. The initial issues chosen for action came from the internal agenda and some rapid improvement cycles with clear benefit for patients and the staff helped to overcome reservations. Once the staff had gained confidence in the process they felt happier to use it to respond to the external demands of the National Service Frameworks and the Primary Care Group's annual accountability agreement.

Time remains a problem, but it was emphasised that most of what the group dealt with was work that had to be done anyway, and that the PPDP meetings provided an appropriate and efficient forum for getting these 'must do' tasks dealt with. Time was saved by abandoning another regular meeting that had become protracted and of limited usefulness. Nevertheless, initial funding that allowed payment of a locum to ensure the presence of key people, which has been important in establishing and sustaining the process. The lunchtime setting on a day when the reception team already meet and provision of sandwiches has also helped.

However, we believe the most important thing is that team members have felt involved in the selection of areas for improvement and the planning and implementation of practical changes, which they believe have improved the services for patients of the practice.

Adult learners:

- are not beginners but are in a continuing process of growth;
- bring a wealth of experiences and values;
- come to education with intentions;
- already have set patterns of learning;
- need to know why they need to learn something;
- need to learn experientially;
- approach learning as problem solving;
- learn best when the topic is of immediate value; and
- have competing interests — the realities of their lives.

Box 3. Some characteristics of adult learners according to Knowles[11] and Brookfield.[12]

Discussion

The practice has linked the educational activities of individuals, small working groups, and the whole team, to meeting the needs of patients using a continuous quality improvement approach.

They have found that their experience of shared learning to improve patient services is an effective use of time in a hard-pressed practice team, as previously described by Jones.[9] Recognising the skills and potential of team members is consistent with the current NHS policy.[10] It also brings improvements in teamworking and relationships within the practice.

This approach viewed the practice team as adult learners who have a great depth of knowledge and understanding about the practice, the patients and families who use it, and the systems in place to meet their needs.

Box 3 gives some characteristics about adult learners as suggested by Knowles[11] and Brookfield.[12]

There is also a belief in the interprofessional learning that centred on meeting the needs of patients. However, there is an acceptance that, in effective interprofessional learning, different professional groups do not necessarily learn the same things while working and learning together to plan improvement.[13] However, working together to improve the way patients' needs are met is a fruitful activity that enhances the sense cohesive teamworking.[14]

Enthusiasm for the process remains. The practice has decided not to run on a rigid annual cycle, as different improvements and external imperatives to which the practice has to respond have differing timescales. Rather, they view the PPDP process as a continually running mill of improvement that can be used to help them respond to a number of demands for change, be they externally imposed or arising from within the practice.

Key factors for the success at the Cornwall Road Practice

These are:

1. wholehearted willingness of the entire team (including attached and reception staff) to be involved and give it a try;
3. a sense that this was helping us do something we want to do anyway — meet our patients needs better;
4. protected time;
5. an awareness of the need to manage the group process effectively;
6. Periodic review to make all aware of what has been achieved; and
7. A practice member (the lead GP) who showed great leadership and acted as a champion for the initiative, both in starting it off and in maintaining the momentum.

References

1. Calman K. *A review of continuing professional development in general practice.* London: Department of Health, 1998.
2. Department of Health. *The New NHS: Modern, Dependable.* London: DoH, 1997.
3. Department of Health. *A First Class Service: Quality in the new NHS.* London: 1998.
4. While R, Atwood M (ed). *Professional Development*. Oxford: Blackwell, 1997.
5. Campion-Smith C, Elston S, Wilcock P. *Practice Professional Development — a guide.* 2003 (in press).
6. Langley GJ, Nolan KM, Nolan TY, Provost L. *The improvement guide.* San Francisco, CA: Jossey-Bass, 1996.
7. Nelson GC, Batalden PB, Ryer JC. *Clinical improvement action guide.* Oakbrook Terrace, IL: Joint Commission, 1998.
8. Jones RVH. Getting better: education and the primary health care team. *BMJ* 1992; **305:** 506-508.
9. Department of Health. *A health service of all the talents: developing the NHS workforce — consultation document on the review of workforce planning*. London: DoH, 2000.
10. Knowles MS. *The Modern Practice of Adult Education: From Pedagogy to Andragogy*. 2nd edition. Wilton, CT: Association Press London, 1980.
11. Brookfield SD. *Understanding and Facilitating Adult Learning.* San Francisco, CA: Jossey-Bass, 1986.
12. NHS Executive South West. *Achieving health and social care improvements through interprofessional education, Report of the seventh meeting.* NHS Executive South West, 2000.
13. Campion-Smith C, Wilcock P. *Putting patients first will help interprofessional education.* [Letter.] *BMJ* 2001; **322(7287):** 676.

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