

PCRTA serendipitous carrot masquerading as stick?

PARTY LINE: (Fenny Green & Nigel Mathers)

High quality primary care research is undertaken in the practice setting, and the RCGP's Research Group wishes to promote and encourage this. It evolved from the RCGP Research General Practice Awards. These were developed to demonstrate the need to make research infrastructure funding available to research-active practices to support the high quality research within practice settings. The funding was limited and demand high. Recognising the shortage of these awards a number of practices urged the Research Group to consider developing accreditation for research-active practices. With the support of the Department of Health and many other key primary care R&D stakeholders, Primary Care Research Team Assessment (PCRTA) was developed to meet this need.

PCRTA is a key activity for the RCGP Research Group and offers a rigorous assessment that gives recognition to best practice in the conduct of research in the practice setting. It also includes a formative component that encourages practice development. The implementation of Research Governance across the UK means that some aspects of research governance and management are now undertaken within primary care organisations. However, direct contact takes place with study participants at the practice level in many studies. PCRTA, being a practice-based assessment, provides a valuable means of ensuring that good practice cascades through the primary care research community.

FAQ'S (Mark Gabbay) SO WHAT REALLY HAPPENS?

Our practice has been part of the Mersey Primary Care R&D Consortium since its 1999 inception. The Consortium allocated resources to support practices undertaking PCRTA, recognising that within the context of impending contract change and associated quality

assessment agenda, the timing wasn't great. MG's trepidation in announcing the application to his colleagues was justified, but he hoped that his seniority (well, age anyway), and his deluded conviction that the respect attached to his academic status would see him through.

DID IT?

The offer of Consortium support enabled us to allocate time and effort despite competing priorities. A 'carrot' underpinning success required that inputs for PCRTA should mirror those to prepare the practice for other changes. Just as well, as the predicted stick of PCRTA being a basic requirement for research in general practice transpired to be more 'Pooh' than 'Harry Potter wand'. We were in it for the honour, challenge, and reflective learning developmental opportunities it offered.

The process started slowly. The application form seemed daunting initially, but preliminary internal practice plus RCGP/PCRTA supported consortium meetings reduced the initial application form back to molehill proportions. Furthermore, the fee was refundable if we proceeded to full application. However, the scope was considerable, requiring substantial review of practice policies, processes, protocols and professional roles, as well as patient participation, and thus, careful interpersonal negotiation and team politics to secure a result.

WHAT'S THE SECRET?

Once a team had been volunteered to see the process through by our enthusiastic practice manager, we apportioned the form's sections among ourselves. All parts of the practice were represented and we were tasked to ensure the sections were completed, with colleague support and involvement. We were to be the spokes attaching the team rim to the PCRTA form's hub. As the analogy suggests, we inevitably took most of the strain, while linking the PCRTA drive to the practice and attached staff. Our key discovery was the

commonality of PCRTA objectives with those already facing the practice. Much of what we did both identified and streamlined processes across the practice, preparing us for the quality agenda. This considerable bonus compensated for the PCRTA's challenge of increasing the profile of research activity and development during that fraught time among a raft of externally imposed priorities. In some senses this gave us some internal control of external chaos.

WHAT'S THE POINT?

Despite being a paperless practice with an interactive website (www.brownlowgrouppractice.org) we were not exploiting IT fully. PCRTA prompted us to develop an intranet facility that attracted the envy of our PCRTA assessors. This is now our electronic library, where all our clinical and process protocols, audits, guidelines, meetings minutes, etc., are available with a swish of a computer mouse's tail. We successfully publicised research across our practice community, enhancing interest and involvement. The process engaged the team in thinking about our research activity and its continuing development, and ensured we addressed the panoply of regulations and stipulations regarding research governance. It became increasingly clear why these were important and how they resonated with enhancing service quality and clinical governance. We reviewed, for example, team and individual staff training, audits, information updating and dissemination, staff induction, getting research into practice. This motivated us to explore ways to enhance patient involvement with research activity. The more routine processes to ensure we followed the recommendations of research governance seemed straightforward by comparison. As our PCRTA team gained confidence and a considerable sense of personal achievement, we were able to enthuse colleagues, and cajole them into accepting challenges we'd previously ducked (like

getting all those policy documents finished and establishing a formal patient group). We managed to complete the application within our deadline without breaking any spokes or losing the rim, although it looked a bit travel-weary at times. We also found the energy to come up with new research ideas stimulated by our discussions.

SO IT WASN'T ALL ROSY THEN?

It wouldn't have been worth the effort if it had been. Even as an RCGP apparatchik writing in the party organ I realise PCRTA can be onerous, seemingly irrelevant and a drudge at times. I used to hang my head in shame and avoid colleagues' gazes convinced I sensed accusing 'what are you making us do?' vibes. The guilt at looming deadlines when I was to present progress with my sections, knowing how much lay untouched on my hard drive, tested my anxiety management skills; and I was the one allegedly leading the process.

Surprisingly, we always seemed to achieve our meeting's objectives, and what seemed at times a pointless diversion turned out to have the benefits we'd hoped for. Sometimes the complexity and detail needed seemed daunting, and required considerable effort to complete. The key was to link as much as possible with other practice priorities and requirements to maintain support, and commitment of resources, among the host of competing priorities that characterise UK general practice.

WHAT ARE THE CORRECT ANSWERS?

We sought these for some time, asking our colleagues undertaking the same process in other consortium practices — who frankly were as much in the dark as we were — but the PCRTA office did join our consortium meetings and presented us with a very helpful bluffers guide. This, of course, doesn't give the answers, but does outline the purpose of each question, and the sorts of evidence that might be required. There are no shortcuts. The submission is a substantial document informing the practice visit, and ensures that all the evidence will be available to support the practice's submission. The PCRTA visitors team will thoroughly check the evidence, and ask penetrating

questions. The standards expected are rarely negotiable, and often demanding.

THE VISIT ...

Fantasies of police-type interrogations proved to be unfounded, most of the time. The visit was thorough, discerning and savvy. We successfully obtained our investigator-led award, and were left with a short but important 'to do' list as a parting gift.

WAS IT WORTH IT?

Ultimately this is a whole practice team-building process. It belongs to, is owned by, and deliberately centred within the practice. The PCRTA gives the team a common purpose, and enables members to develop at their own pace and choose their level of involvement (beyond their basic responsibilities). Our practice community remains more enthusiastic about research, with a shared commitment and understanding of why we want to do it. More staff are involved, and two new research projects have been generated by staff since completion.

The spin-off benefits for the quality framework and other contract preparations were considerable. Would we do it again? We'll have to, in 3 years!

SO, WHAT ABOUT THE POOR PEOPLE YOU DRAGGED INTO THIS? (Diane Exley, Tina Atkins, Monica Gallagher & Dawn Brayford)

Don't believe these ravings of a deluded RCGP apparatchik? In the following accounts MG's colleagues give their honest perspectives:

The PCRTA was a daunting, challenging and arduous project to take on, and even more so when we were in the middle of it. A key to our success was enlisting the core team, part volunteer, part volunteered (past experience had identified them as effective under pressure). Initially, it seemed like we were working towards the accreditation alone. It quickly became apparent that the process was helping us to look carefully at our existing procedures and protocols and we took the opportunity of improving and updating these. It facilitated a whole new way of sharing information within the practice with the development of the

practice intranet. We completed tasks that had been semi-completed or needed updating, and the effort met a range of other requirements. The practice developed a set of policies and procedures that met the requirements of the Information Governance Framework before it was rolled out by the PCT. It was certainly an aid to the new GMS contract and recently for our Quality and Outcomes Framework visit. The accreditation efforts have led to lasting changes in information management across the practice and the implementation of policies which are the envy of the PCT. It took up an enormous amount of time from these key individuals and we did wonder if it was worth it on a few occasions. However, not only did the process leave us with a stronger, more confident and very proud team, it has even widened research interest and participation. Three of us recently attended a workshop to assist non-clinical staff becoming involved in research.

THE FUTURE?

Well, PCRTA has proved less attractive as a carrot than as a stick, a victim of the change culture that continually challenges practices to meet new targets and provide evidence of progress and quality. If viewed in isolation it is onerous, resource hungry, and general practice-centred. Some of these perceived disadvantages are, however, the strengths for team development and ownership. Its practice centredness builds capability and sustainability and strengthens the team. A process led by primary care organisations would focus on their agenda, and be unlikely to energise the practice or provide the satisfaction and enthusiasm required to sustain research development. A short, research governance tickbox-type form might be easier to complete, but research needs commitment and energy, and more complex interwoven processes that involve the team are likelier to embed research within the practice and sustain it. What we need is to make sure that PCRTA is integrated with other RCGP quality frameworks, and that achievement in one fulfils aspects of others.

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