

# Implementing Primary Medical Care Provider Accreditation (PMCPA): What it means for your practice

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# PMCPA development

- Criteria and evidence based scheme
- Based on RCGP Quality Team Development award (QTD): 24 domains and ~240 original criteria
- Also developed from:
  - Other international Accreditation schemes such as EPA
  - Review of Standards for Better Health
  - RCGP Roadmap
  - Training criteria

Developed by Stephen Campbell, Helen Lester, Bill Taylor, Janet Hall



# PMCPA domains: version 1

1. Health Inequalities and Health Promotion
2. Provider Management
3. Premises, Records, Equipment and Medicines Management
4. Provider Teams
5. Learning Organisation
6. Patient Experience / Involvement



# Key objectives of PMCPA

- Enable teams to improve organisational quality of care
- Support continuous quality improvement : evidence of implementation and follow-up not just protocols
- Provide a vehicle for team development
- Support needs of the Care Quality Commission?
- Support revalidation through an accredited environment



# Summative and formative

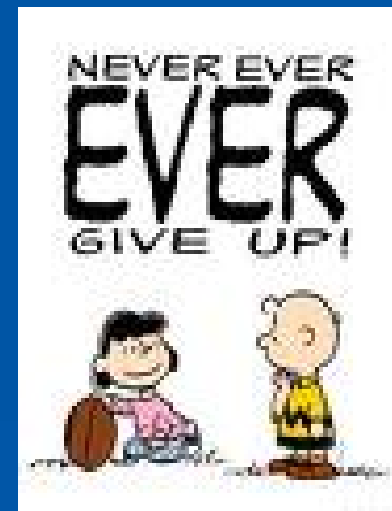
## Summative- assessment of learning:

judgmental test of whether minimal standards are achieved on a given day.  
Pass or fail a standard



## Formative – assessment for learning:

non-judgmental educational systems using optimum standards that foster quality improvement by focusing on education, self-development, improved performance



So not just pass or fail but also 'working towards'



# Summative and formative

Summative- assessment of learning:  
30 core criteria



Formative – assessment for learning:  
82 formative criteria



Data from core criteria



# PMCPA pilot

- Aimed for 40 practices in 4 PCTs (10 in each)
- Autumn 2008 for 16 weeks
- Recruited 36 practices in 4 PCTs: Oldham, Notts, Warwick, Haringay (Nationally representative sample)
- 34 practices engaged in the evaluation and 32 practices fully completed the pilot



# Internal evaluation objectives

1. To analyse the uptake and achievement of criteria in each of the domains in real time
2. To explore staff experiences of the scheme
3. To assess the workload involved in the scheme
4. To understand the barriers and facilitators to implementation
5. To understand how best to modify the scheme before national roll out



# Pilot findings

- Content made sense to general practice
- Reflected team views of quality in primary care
- Worthwhile use of practice time
- Works best when it's not a tick box exercise but an opportunity to reflect on and change practice as a team
- Sufficiently flexible to be valuable for all practices



# Quantitative evaluation: engagement

- 34 practices uploaded 1817 documents (mean 53.4, range 1-165)
- Most uploaded in the last week!

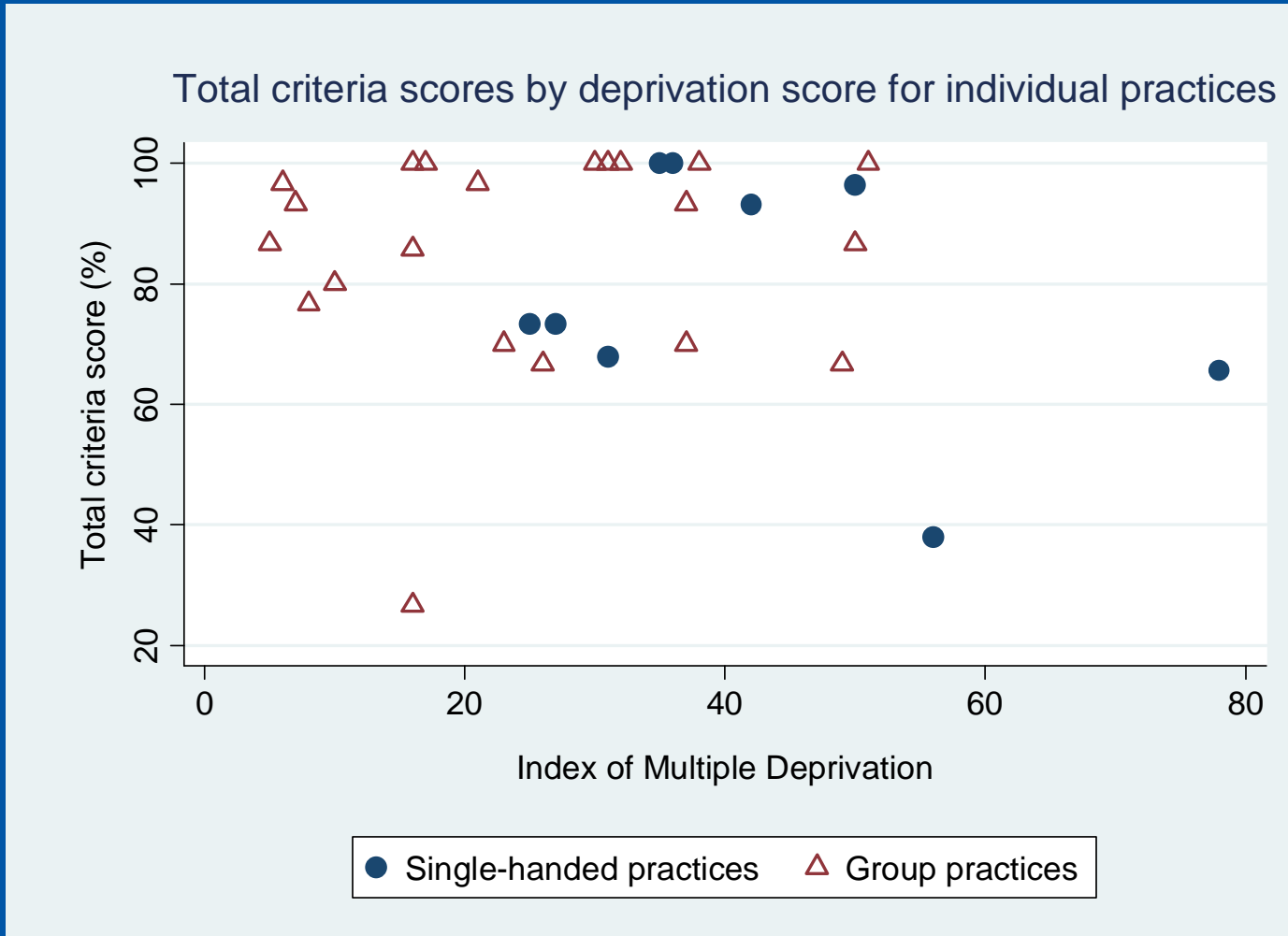


# Quantitative evaluation: core criteria scores preliminary analyses

- Using a rating by assessment teams of “good” or “satisfactory” as a pass, the range of scores for practices for the core criteria ranged from 8 to 30
- 1 practice (3%) scored between 0 -10
- 5 practices (17%) scored between 11- 20
- 24 practices (80%) scored between 21- 30
- Eight practices ( $8/30=27\%$ ) scored 30/30



# Practice scores



# Qualitative interviews

	Nottingham	Oldham	Haringay	Warks	Total
Number of Practices	7	9	9	9	31
GPs	7	8	8	8	33
Practice Managers	7	9	9	8	14
Practice Nurses/Nurse practitioner	5	4	3	2	6
Others (Admin)	3	-	3	0	31
Total	22	21	23	18	84



# Value of Accreditation

‘It is not necessarily that obvious to a patient who walks through the door, but with an accreditation scheme plaque they could look up and see that their local practitioners were moving forward and not stagnating or moving backwards.’

(PM affluent, medium sized practice)



# Motivations for participation

Different motivations but 4 recurring themes:

1. Dragging a 'poor' practice up
2. Demonstrating perceived excellence
3. Using it as a "team development" exercise
4. Prestige of involvement



# Motivations

'I am a single handed doctor working with locums and I wanted to do it because I thought well this would be a good way to do things you know **for the community** as well as to find out where I am wrong. It was a real eye opener and it really made me aware of the little things that I thought were not important you know in the running of the surgery but that in fact made me more aware of things really.'

(GP, SHP, deprived area)

'It gave me ammunition to fly the **quality agenda** within the practice.'

(PM, affluent area)



# Motivations

‘I think the doctors were keen that not only are we a **flagship** practice that we are seen as a flagship practice.’  
(PM, large practice, deprived area)

‘It is nice to try and raise the perception of the practice and the general community to say look we are still here and we are trying to be **innovative** we like to be part of new interesting and different things.’  
(SHP, deprived area)



# Motivations

“The **RCGP brand** definitely attracted us”.  
(GP, deprived area)

“It's better being done from the bottom up  
point of view as well, run by the college”  
(GP, urban practice).



# Workload

- 90% of the work was completed by the practice manager
- Team engagement was also crucial
- Majority as a flurry towards the end
- Some in a steady manner from the first day
- Competing priorities e.g. IMT DES
  
- All practices needed training and practice visit from NPCRDC



# Workload

“The main barrier I would see as a practice manager, **who's going to do the work?** And it often ends up on a certain group of people, and mostly practice managers I would say”

(PM, medium sized practice in affluent area).



# Facilitators to participation

- Teamwork
  - Designated responsibilities
  - Experienced PM
  - Stable practice
  - GP 'buy in' and support
  - Larger practices?
- 
- Training and support from external contractor



# Teamwork and leadership

“I think it is definitely a **teamwork project**. Individuals on their own, it’s not practical as well as possible to be able to do all that work and perhaps they may not have the necessary skill or knowledge.”

(GP, small practice in deprived area)



# Importance of teamwork

‘There were times when I involved the entire practice. I gave them updates from time to time. I had a major piece of training because there were a number of protocols and policies that were not written down in a formal way before and **I really had to train the whole team** about these issues.’

(PM, rural area)



# Value of policies

‘We knew that getting the evidence approved was far far easier said than done because when you look at it, it was, ‘we can do that’ and then you would go down to the ticks and go ‘yeah yeah yeah’ and then when you go and look for the evidence you go well actually we do it **but we haven’t got it recorded** in a formal presentable way.’

(PM, Rural area)



# Importance of developmental elements

‘It should be a living and working entity. If not it is worthless because all it does then is mark a point in time against standards which were the norm at the time that the standard was created. It has to be a fluid entity you know. It has to develop us as a practice.’

(GP, affluent, medium sized practice)



# Patient benefits

- Histology safety nets
- HCA training to understand abnormal results
- Bereavement visits
- Becoming a more reflective organisation
- Looking outwards into the community more

‘We have learnt many things and new ways of thinking and new ways of how to develop the practice to be **more clinically orientated and also safer for patients.**’

(GP, urban deprived area)



# Visits

- Generally positive feedback
- Local assessors lent a degree of familiarity
- Outside assessors could be more objective
- Perceived variability in quality of assessors



# Facilitators to implementation

- Most interviewees, though not all, felt it should not be part of QOF
- Tensions noted in rolling out externally set standards and the desire to implement a reflective developmental scheme that moves quality forward regardless where you start from
- Tension between comparing the practice with itself year on year, and with all practices against a national benchmark



# PMCPA v QOF

‘PMCPA is a step up from QOF and clinical governance. Everyone knows what to expect in QOF. PMCPA is harder.’

(PM, SHP, deprived area)



# Overall experience

‘Overall we found it to be a **good experience**. It highlighted a lot of areas we would like to develop as a practice. I think there were some great opportunities to come out of it as a practice team and I think that **we would be keen to go on and to do the real thing.**’

**(PM, medium practice size)**



# Overall experience

‘It’s a very holistic overall look at the way a practice runs and there was nothing in there which I felt was unfair or felt ‘why are you testing this’ it’s not relevant, or anything like that. It was a very good all round assessment. **You know we are all patients and these are the sort of things that you want your practice as a patient to provide.**’

**(Practice Manager, large practice)**



# Real primary care

*“[PMCPA] isn't asking you to do things that you didn't think made sense, they were all things that you could see, things to benefit patients. **It wasn't just an academic exercise, it was mostly quite real things that we actually do and you know, real general practice.** So that was a nice thing about it, that you could tell that people from day-to-day general practice had been involved with producing it.”*

(GP, medium sized practice in affluent area)



# PMCPA domains: revision

1. Health Inequalities and Health Promotion
2. Provider Management
3. Premises, Records, Equipment, Devices and Medicines Management
4. Provider Teams
5. Learning Organisation
6. Patient and Carer Experience / Involvement / Responsiveness



# Stakeholders consulted

- Care Quality Commission
- The Steering Group of the Practice Management Network
- General Practitioners Committee
- Department of Health
- NHS Alliance
- RCGP Patient Partnership Group
- RCGP EOLC Strategy Group
- National Patient Safety Agency
- Royal College of Nursing
- British Association of Medical Managers
- Quality Committee Northern Ireland



# Next steps

- Mapping against training criteria
- Working with revalidation group to reduce duplication and/or ensure positive overlaps
- Working with CQC around registration
- Stakeholder meetings across England 2009/10
- Negotiations with BMA and DH around funding



# Thank you for listening

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