EQuiP

European Association for Quality and Safety in General Practice/Family Medicine

March 2018

Final Announcement: 53rd EQuiP Assembly Meeting

22-24 March 2018 in Bratislava, Slovakia

"*Come and share your experiences - come and listen to stories of colleagues from other countries. You will see how things are similar and different at the same time. We really look forward to another inspiring meeting with you all.*"
Dr. Piet Vanden Bussche, EQuiP President

It is my privilege and pleasure to invite you to #1 European Congress of General Practitioners ever. The theme of the conference is: **General Practice: *Cornerstone for Health Care of Highest Quality***.

We will have an opportunity to share ideas, insights, and to discuss the 3 topics of the Congress, chosen as they are the areas with the greatest potential for improvement in Slovakia at the moment:

1. The Quality of Medical Education affects the quality, safety, efficiency and effectiveness of Health Care: How to improve Teaching in Quality and Safety?

2. Does eHealth improve the Quality and Safety of Care in General Practice?

3. Can GPs reduce or prevent overdiagnosis and overtreatment?

6 Keynotes
We are very happy to be able to welcoming cutting edge colleagues and keynotes - such as Zalika Klemenc Ketiš, Jaime Correia de Sousa, Ilkka Kunnamo, Harris Lygidakis, John Brodersen, and Adrian Rohrbasser - who have long been focusing on quality, safety, and efficiency of healthcare in different European countries.

Call to Action
Please do what 75 of your European colleagues have already done: Register for the 53rd EQuiP Assembly Meeting 22-24 March 2018 in Bratislava.

Hopefully, you will also be willing to share this Final Announcement within your professional network... just imagine what would and could happen, if every each one of you recruited 1 more participant!

How to register
The registration fee includes scientific program, conference materials and refreshment.

Simply fill in the online form to register:
http://equip2018.sk/registration.php

Hosted by
Slovak Society of
General Practice

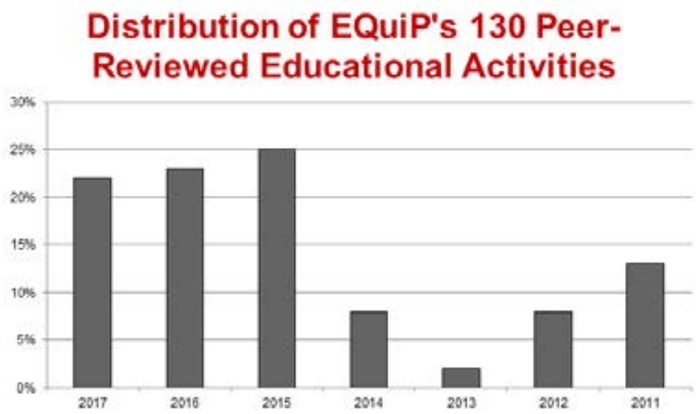
EQuiP working groups

Historical overview and outputs

The 8 EQuiP Working Groups: *Sessions*
We have produced an overview of all peer-reviewed EQuiP educational activities during the Seven Years from 2011 to 2017, including links to slides and videos. **Read much more here**.

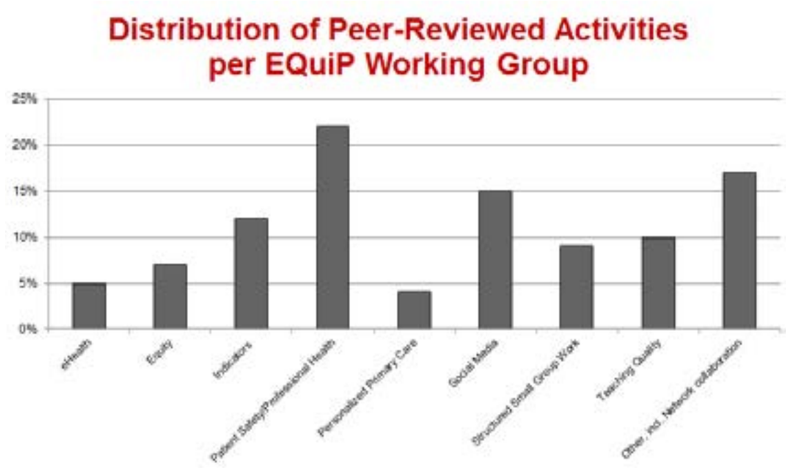
The 8 EQuiP Working Groups: *Outputs*
Also, we have pooled the 8 EQuiP Working Groups' Outputs: **Get the complete overview here**.

Finally, It turned out that EQuiP has carried out at least 130 peer-reviewed educational activities - key-notes, workshops, posters, oral presentations, panel debates, grand sessions, and more at Wonca & EQuiP Conferences - since 2011. What an impressive effort! Thank you all for that.



Distribution of Peer-Reviewed Activities

2017 (22%, n=28)
2016 (23%, n=30)
2015 (25%, n=33)
2014 (8%, n=10)
2013 (2%, n=2)
2012 (8%, n=10)
2011 (13%, n=17)



Distribution of Peer-Reviewed Activities per EQuiP Working Group

#1 eHealth (*5%, n=7*)
#2 Equity (*7%, n=9*)
#3 Indicators (*12%, n=15*)
#4 Patient Safety/Professional Health (*22%, n=28*)
#5 Personalized Primary Care (*4%, n=5*)
#6 Social Media (*15%, n=19*)
#7 Structured Small Group Work in Primary Care (*9%, n=12*)
#8 Teaching Quality (*10%, n=13*)
...Other, including Network collaboration (*17%, n=22*)

Practice Accreditation: The European Perspective (2011)

By Tina Eriksson, Immediate Past President of EQuiP

The EQuiP meeting 3-5 November 2011 in Zagreb, Croatia, focused on one theme – and one theme only, namely **Practice Accreditation in GP/FM**, which was chosen in close collabora- tion with the hosting country.

The meeting was arranged by Croatian EQuiP members Zlata Ozvacic and Venija Cerovecki and supported by the A. Stampar School of Social Medicine.

Data collection prior to the meeting

Prior to the meeting a web survey on the state of Practice Ac- creditation (PA) in the active EQuiP member countries was per- formed. We got answers from 25 delegates from 21 countries.

We learned that GP Colleges in the Netherlands, Estonia, Czech Republic and the UK were organizing PA systems in their countries. In Poland, Portugal, Switzerland, and Turkey and soon in Croatia and Denmark, various central health authori- ties were taking the lead in PA systems.

The European Practice Assessment (EPA) was used in Austria, Belgium and Germany - and as a part of the College initiated systems in the Netherlands, the UK and the Czech Republic.

In several countries, ISO certification wasin use; among those Finland and Sweden. The European Foundation of Quality Management (EFQM) was also used in more countries, such as Spain and Finland.

In conclusion, there was a wide variety of PA systems in use, in several countries more systems were in use at the same time, and there seemed to be a great need of more knowledge on the pros and cons of the different systems.

Opening the meeting to local GPs and administrators of Quality and Safety

The meeting had yet another new feature: An open part of the meeting, where EQuiP delegates offered their expertise and experience to the hosting country on the chosen aspect of quality. Croatia is planning to launch a national accreditation system organized by the Croatian Ministry of Health.
The open part of the meeting was a success with a range of interesting presentations of European PA systems:

- Prof. Helen Lester presented the newly developed systemin the UK
  PP slides (PDF)
- Rob Dijkstra presented the system developed by the Dutch College that after several years have accredited a large proportion of the GPs in the Netherlands
  PP slides (PDF)
- Sara Willems presented the latest developments and research results of the European Practice Assessment (EPA) that was initiated in EQuiP from 2001-2004 and later spread by the TOPAS collaboration
  PP slides (PDF)
- Katrin Martinson from Estonia presented yet another accreditation system
  PP slides (PDF)
- Venija Cerovecki presented the Croatian accreditation system initiated and organized by the Croatian Ministry of health (she had to step in at the last moment as Dr. Rena- to Mittermayer, director of the Croatian Agency for Quality and Accreditation in Health Care, excused himself as late as 3 November).
  PP slides (PDF)

Later, a panel discussion highlighted variation in PA structures. Helen Lester gave examples of top down systems like the one in Croatia and practice level up through college (UK); emphasis on the importance of achieving buy-in at GP and practice level.
Rob Dijkstra made a SWOT analysis (strengths, weaknesses, opportunities and threats) of the systems presented.

Sara Willms was impressed with levels of development and highlighted importance of paying attention to data manage- ment, and to focus more on quality of the system rather on the quantity of data collected.

"*This analysis provides useful information for practitioners and policy makers hoping to develop practice accreditation sys- tems in primary care. There is no one ideal European practice accreditation scheme, and a rather mixed picture of established schemes which share a number of common features emerges.*
Barriers to implementation, particularly concerns over costs, en- vironmental factors such as the political climate, and the limited evidence base, also echo previous work on critical success fac- tors for spread and sustainability of innovations in health care.
Finally, we found a reassuring balance of quality improvement versus assurance in most countries15,16 and no strong evi- dence that former Eastern Bloc countries are more likely to use accreditation as a regulatory activity in a primary care con- text.17 Indeed, Estonia in particular has not only created an ac- creditation scheme that is largely developmental in nature but has also broken free of traditional systems ways of thinking"

Source: "Practice accreditation: the European perspective," in: Br J Gen Pract. 2012 May; 62(598): e390–e392.
Published online 2012 Apr 30.
doi: **https://doi.org/10.3399/bjgp12X641627**

Videos (links):

- **Practice Accreditation in Croatia, Spain and Estonia**
- **Dr. Piet Vanden Bussche - The patient perspective on practice accreditation**
- **Dr. Zlata Ozvacic Adzic and Dr. Le Vallikivi - Why practice accreditation is important and useful**
- **Venija Cerovecki Nekic - Plan and structure of accredita- tion process in FM in Croatia**
- **Hrvoje Tiljak - Accreditation in Croatian family medicine - ideas and lessons from past experience**
- **Katrin Martinson - Building the QS in FM, Estonian experience**
- **Helen Lester - European accreditation schemes – the UK**
- **Rob Dijkstra - European accreditation schemes – the Netherlands**

The key points

- Keep PA systems simple, especially at the start
- Make broad measurements
- Involve patients and staff
- Implement change on the basis of measurement, best done within practice meetings, practice visit or some social context rather than online
- Good PA needs internal and external motivators

The introduction of inspections and public ratings in general practice in England:

What impact will it have on quality of care?

The Care Quality Commission

The **Care Quality Commission** (CQC) is an 'arms length' agency of the Department of Health and Social Care, which acts as the independent regulator of quality in health and adult social care in England. In 2014 it introduced the use of compulsory, regulatory inspections in general practice organisations. Between 2014 and 2017, all 7356 general practices in England were inspected, with a report and rating being made publicly available on every practice. This process aims to assess quality of care, help people choose care, and encourage services to improve the quality of care they provide. Compulsory inspections of all general practice organisations are not currently used in rest of the United Kingdom.

The Inspection

CQC inspections examine whether general practices are; **safe, effective, caring, responsive, and well-led**, across **six population groups**. The CQC tracks changes to leadership and organisational size through the registration process for GP practices. It monitors routinely collected metrics, referred to by the CQC as '**GP Insights**' (previously 'Intelligent Monitoring'). It also receives complaints and otherinformation from the public and commissioners of services.

During inspections general practice policies, processes and records are reviewed, and staff and patients are interviewed. Inspection teams are made up of clinicians and non-clinicians.

Reports are made public, with ratings which can be 'outstanding', 'good', 'requires improvement' or 'inadequate'. The CQC can take action to close a general practice if it deems it necessary.

Practices rated 'outstanding' or 'good' are expected to be re-inspected within a five-year cycle.

Practices rated 'requires improvement' are re-inspected within one year. Those rated 'inadequate' are re-inspected within six months. Re-inspections may focus principally on areas of concern. Inspections may also be triggered if there are concerns identified during routine monitoring processes by the CQC. During the **first round of inspections**, 4% of GP practices received an initial 'inadequate' rating, 13% were rated as 'requires improvement', 79% of practices were rated 'good', and 4% were rated 'outstanding'.

The Cost

The introduction of regulatory inspections with public reporting to general practice represents a major policy intervention in England. It has utilised significant resources since the inspection process began in 2014. The cost of the first round of inspections was absorbed by the CQC (which in 2016/17 had an **annual budget** of £236 million for the regulation of all health and social care in England). The next round of **CQC inspection fees** will be paid for by GP practices, although for now this will be reimbursed by **NHS England**. For an average practice of 5,001 – 10,000 patients this will be £4,526/ annum. Any additional time and resources needed by the practice to prepare for or respond to the inspection will be borne by the practice.

The Controversy

Externally led inspections of general practice organisations exist in many countries. They can be used for mandatory regulation, as the CQC does in England, with or without other tools such as data tracking. They can also be used in voluntary, often profession-led, accreditation processes. Public reporting and ratings may or may not form part of the inspection processes. The assumption underpinning inspections is that they serve to provide quality assurance to the public and commissioners of care, and that they should help lead to quality improvement in the practice.
The introduction of general practice inspections has been controversial in England. Critics of the CQC inspection process state that; they are inconsistent; do not measure what matters; provide little guidance on how to improve; can stifle quality improvement; burden all practices in order to address problems in a minority of poor performers; can lead to complacency; can provide false reassurance; can negatively affecting staff morale; can distract from patient care; and can worsen inequities of access.

Those supportive of the inspection process argue that; CQC inspections have permitted more comprehensive quality assurance and feedback on areas for improvement to all GP practices in England than was possible before; it has given power to the CQC to deal with practices which were unsafe, but commissioners of care had previously lacked the power to close; it is providing a mechanism through which to increase GP's accountability to their patients; and it is a way hrough which to increase the likelihood of patients making an informed choice about what GP practice they register with, and therefore drive competition between practices and encourage better quality of care.

Research needed

However, it is not yet clear what impact the inspections will actually have on patient choice or on the quality of care in England. In order to inform policy on the role of inspections in general practice and their implementation, it is therefore important to understand the contexts within which inspections have their desired effect or otherwise, and why this is the case. In view of this as part of a National Institute of Health Research funded Doctoral Research Fellowship, I will be studying the role and impact of inspections in general practice on the quality of care in England over the next five years. The subject of inspections/accreditation (terms which are often used interchangeably but mean different things to different people) of general practice organisations has been a **topic of interest** for EQuiP in the past. If you are working on a similar topic and/or have interest in this area, please **contact me**. This will inform the research project, and help develop a better understanding of the role of inspections in other countries.

February 2018

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Increase in Residency Scholarly Activity as a Result of Resident-led Initiative

By Kyle Hoedebecke,
Polaris – North America region Young Doctors' Movement

Background & Objectives

Scholarly activity (SA) is a fundamental component of family medicine residency training. Despite the variety of SA options, the output of resident presentations and publications remains disappointingly low, and many residents voice frustration with fulfilling the research requirements.

A resident-driven process improvement project was undertaken with the goal of achieving a 100% increase of peer-reviewed publications and scholarly presentations by residents with secondary goals of doubling the involvement of staff, residents, and visiting medical or physician assistant students.

This paper was presented at the 2013 Society of Teachers of Family Medicine (STFM) Medical Student Education Conference, San Antonio, TX; the 2013 USAFP Online Research Competition; the 2013 STFM Annual Spring Conference, Baltimore, MD; and the 2013 Wonca World Conference, Prague, Czech Republic.

Methods

1. increasing awareness of conferences for scholarly submission,
2. assignment of residents in a resident research team to lead efforts,
3. pairing of interns/students with senior mentors with similar interests,
4. faculty to include one resident on all projects, and
5. monthly SA meetings to track research progress, share ideas, and troubleshoot areas of difficulty.

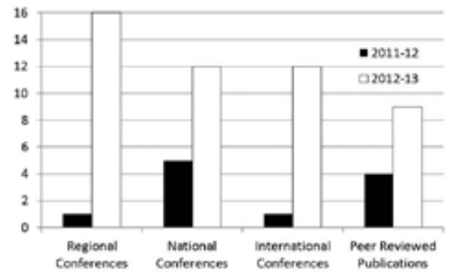
Scholarly totals were compared between the 2011-2012 and 2012-2013 academic years.

Results

The SA goals were achieved on all fronts. The number of resident presentations increased from three to 28 (seven regional, 10 national, and 11 international presentations), and resident peer-reviewed publications increased from two to six when compared to the previous year.

Scholarly participation doubled at all levels.

Figure 1: Resident Scholarly Submission Totals



Conclusions

The authors recommend that other residencies consider promoting increased resident-to-resident scholarly mentorship, early planning with scheduled timeline, and increasing awareness of SA opportunities yearly.

Read full article here.