Outcomes of the implementation of the Cornerstone General Practice Accreditation Programme

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John Wellingham and Maureen Gillon

Correspondence to: John.Wellingham@waitemataDHB.govt.nz

Introduction

Cornerstone is now firmly established as the most frequently used New Zealand general practice accreditation programme. The establishment phase from 2003 to 2006 has been a major investment by the College and its stakeholders.*

The assessment process, reporting structures and operational requirements of the programme have been tested and refined to establish a robust general practice accreditation process that is able to handle a high volume of practice assessments and include a robust and well supported assessor workforce. The online version of the *Aiming for Excellence* set of standards now exists to enable digital data collection and process management. It has been developed and tested during implementation of the process to support practices preparing for a Cornerstone assessment visit. This has been an added bonus for practices, assessors, PHOs, and IPAs involved in the process. External validation of the Cornerstone programme, and a process to validate findings of individual practice reports, has also been established in conjunction with HDANZ.

Its 'for general practice by general practice teams' approach has helped form a sense of joint professional and policy ownership that has been maintained by the RNZCGP. Early practices have developed a sense of excitement around their achievements.

The Cornerstone programme was chosen as a finalist in the June 2006 NZ Health Innovations Awards (HIA) process improvement section. Preparation for this included identifying results and lessons about the Cornerstone process and the performance of the criteria in *Aiming for Excellence* set of standards. At the time of the awards a total of 67 practices had been visited, with 36 accredited. At the time of writing this report, a year later, in May 2007, there are over 500 practices actively engaged in the programme, with 262 completed visits and 245 practices accredited. Considering Cornerstone is a voluntary activity for RNZCGP members, this is an outstanding achievement by general practices. This paper de-

John Wellingham *is a general practitioner, a member of the College Executive of the Royal New Zealand College of General Practitioners and Chair of their Board of Quality. He is also part-time Primary Health Advisor and Clinical Director in the Waitemata District Health Board Funding and Integration Team, where he is responsible for developing quality, through the use of integrated information systems and information pictures of the success of the District in achieving its strategic goals. He has a strong interest in defining, measuring and improving quality in general practice especially at a team level since he was inaugural Director of the RNZCGP endorsed QA unit in the Goodfellow Unit, Auckland University in the 1990s. He has played a significant role in the development and marketing of Cornerstone, which has obtained international recognition as a joint QA and CQI process for GP teams.*

Maureen Gillon *is National Director, Quality and Safety for the RNZCGP. She has managed all stages of the research, development and implementation of 'Aiming for Excellence' and the Cornerstone General Practice Accreditation Programme.*

* GPs, practice nurses, practice managers, Maori, consumers, NZMA, PHOs, IPAs, ACC, MOH.

scribes the information gathered and analysed for these HIA awards.

Method

Implementation of Cornerstone was carried out by volunteer practices with partial funding from several sources. The Ministry of Health (MoH) supported 85 practices, ACC supported 100 practices, and Pinnacle sponsored a further 100 practices. The process for practices involved a self-assessment, gap analysis, improvements to meet gaps, an assessment visit by College assessors, post assessment improvements and final accreditation. Practices and assessors entered results of their assessment against *Aiming for Excellence* onto GDSL software, an online application used by the Cornerstone programme to record current performance against the measures defined by the criteria in the indicators.

On completion of the process, practices were asked to complete a full evaluation of each stage of the process toward accreditation. The College also interviewed individuals in a number of practice teams to obtain qualitative data about their experience of preparing for an assessment visit and the value they attributed to the process. To obtain more in-depth information about performance achievement in practices, an analysis of the quantitative data in the GDSL software was undertaken on the measures from the first 41 accredited practices and included an analysis of qualitative evaluations from practices and assessors.

Early findings from the implementation phase

Findings from the first 41 practices accredited show that a large part of the benefit of the process is derived from the preparation, where practices compare themselves against the three levels of standards in *Aiming for Excellence*:

1. **'Legal and safety'** being those required by legislation or posing a significant risk if not met
2. **'Essential'**, being those considered essential by the RNZCGP
3. **'Desirable criteria'**, also known as aspirational criteria; criteria which are regarded as gold standard and are unlikely to be obtained at a first assessment.

A number of key improvements were apparent.

a. Teamwork

Practices report culture change that occurred as a result of learning to work together as teams to design and implement quality improvement processes. They reported discovering new ways of working as an important outcome. Active involvement in teamwork was reported as being responsible for improved communication, improved working relationships, discovering better ways to produce more effective patient care processes, and establishing better quality and risk management systems.

b. PHO/IPA support

The preparation phase of accreditation is reported as being the locus of many of the greatest gains. Practices that are members of Primary Health Organisations (PHOs) and Independent Practitioner Associations (IPAs) found the impact of preparation for the assessment visit considerably reduced. In spite of the support offered by the College, both ACC practices and MoH funded practices, which did not have dedicated support associated with the Pinnacle Management Services Organisation, struggled to complete the process within the times allocated in the contracts.

By comparison, Pinnacle practices had the advantage of one-on-one support and assistance. Each practice had been engaged in the Pinnacle Quality Plan since its inception and was aware that practice accreditation was an expected activity. Most practices bought into the process long before the contract was signed and were already committed to CQI. These practices progressed more quickly than others and with the least problems.

c. Quality assurance and risk management

All practices met legislative and safety requirements, and essential College standards for good general practice before achieving accreditation status.

d. Quality improvement

Practices acknowledged the guidance provided by the three levels of indicators provided in the *Aiming for Excellence* set of standards. By comparing themselves to the measures specified by the criteria in the indicators, they were able to identify areas for improvement from seeing the gaps between their current practice and these standards. They were then able to agree on proposed actions to close the gaps and incorporate these into their CQI plans for the future. A large number of quality improvement cycles were reported as occurring during the preparation phase. At the time of the practice visit, practices had reached a remarkable level of performance by being able to meet 95% of the hard to achieve, voluntary, aspirational criteria.

Action plans for further improvement, with scheduled completion dates, or completed actions that were signed off as part of the Post-Assessment Dialogue process for achieving accreditation, were achieved by all practices prior to achieving accreditation status. The first 41 practices to be accredited made 87 significant and critical system changes, affecting 300 000 patients.[1]

e. Acceptability

Practices report the process as being acceptable. Practices also noted that if Cornerstone were used as a compliance tool rather than a CQI process, the result would be a culture of meeting standards rather than a process to improve performance.

Discussion

Although there were a small number of practices included in this early analysis, these findings are important

indicators of the success of Cornerstone as a valued quality improvement process for general practice, and further proof that Cornerstone is making a positive contribution to quality general practice. It might have been anticipated that early volunteer practices would be early adopters who had already achieved high levels of performance and in which little extra improvement could be made.

If the amount of change seen in these early practices is small in relation to what might be seen in the practices that follow, then Cornerstone has considerable potential for assisting New Zealand general practices to make a quantum leap in quality. It was particularly exciting to see the exceptionally high achievement against the gold star aspirational criteria.

An important finding was the significant amount of quality improvement occurring in the preparation phase, and how this phase was made more successful by the support role of PHOs, Management Services Organisations and IPAs. Supporting the development of the support processes in these organisations so they can in turn support all general practice teams to enhance their quality improvement processes would be a powerful lever to enhance quality of health delivery by general practice teams.

The largest areas of improvement reported are identified as teamwork, communication and relationships. These are important enablers for organisations to develop capability and capacity to undertake further quality improvement activities and to meet the challenges of health policy on improving outcomes for people with long-term conditions and to engage with communities to establish ways to reduce inequalities. This process has moved Cornerstone accredited general practices into a very strong position to deliver on the Primary Health Care Strategy.

There is a growing public and media interest in safety in our health system. The public can now have confidence that general practice teams that have completed the Cornerstone process provide safe systems and have developed the capability to ensure they are doing the right thing well. Cornerstone accredited practices are able to use systematically acquired data for developing a quality plan, undertake an annual review, and implement practice improvement activities. Funders and other health system organisations which purchase services from general practices can also have confidence that Cornerstone accredited general practices are providing safe, effective, high quality care.

While a Cornerstone accredited practice can produce evidence of good clinical processes, it does not currently measure health outcomes or their associated disparities. An evaluation[2] of the UK NHS Quality Outcomes Framework, their use for setting targets and the provision of incentives for improving outcomes of care in clinical management and performance, suggests that there is scope to use outcome measures in New Zealand. Measuring outcomes will provide even greater benefits for an accreditation process as it will enable internal and external evaluation, research and development to understand the relationship between process and outcome indicators, and thence to better identify the critical process indicators associated with outcome success.

Conclusions

A robust, professionally-led practice accreditation system supporting clinical leadership and quality improvement now exists, through Cornerstone, for general practice teams. Together with *Aiming for Excellence*, which is firmly established as the expected standard for New Zealand general practice, they provide a robust framework to guide general practice teams to develop a safe environment for staff and patients.

Results show that a culture change of using teamwork to implement CQI action learning is also improving communication, relationships and establishing a platform for the delivery of health policy as described in the Primary Health Care Strategy.

The Cornerstone programme could be usefully enhanced by the inclusion of clinical outcome indicators, as these would better measure desired levels of performance whilst also providing information to assist in identifying the most important process indicators.

Practices that achieve quality improvements fastest and most effectively through Cornerstone, are characterised by receiving ongoing one on one support from PHOs, Management Services Organisations and/or IPAs. Incentivisation and development of these organisations to provide this support would be a significant step in levering further value from the Cornerstone process.

Cornerstone is providing an improvement process and a set of standards which give consumers, and organisational purchasers of general practice services, confidence that these practices are safe and effective.

The enhancement of the Cornerstone process and continued support to practice teams to undertake this challenging programme provide important opportunities for capability development in New Zealand's primary health care. Will anyone accept this accountability?

Competing interests

None declared.

References

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