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General Practice Locum Improvement Tool

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Abstract

An improvement culture is required in the NHS. Staff members who move from one place of work to another are often best placed to see alternative methods of working that at times are more efficient – locum general practitioners (GPs) tend to be in this category. A tool was developed specifically to obtain quality improvement suggestions to the general practice from the locum GP and vice versa in a time efficient manner. A pilot study was performed in one general practice in Tayside (Grove Health Centre) in December 2013 to assess if this was possible. During this month a general practice partner provided feedback to the locum GP by completing a drop down tick box survey while reviewing three cases dealt with by the locum. The locum GP was emailed after their session with a one question survey enquiring about improvement suggestions for that practice. Five different locum GPs provided clinical cover during the month studied – of these, one opted out from the study. The other four locums performed their clinical session and completed the survey. Feedback from the practice to locums included specific clinical guidance, suggestions for improving documentation, and ways to optimise referrals; of note, unique feedback was given to each locum and this was generated using this tool. Themes from the locum suggestions to the practice included more physical resources (such as cameras in each room), different ways of handling prescriptions, and a suggestion about identifying complex patients. As a direct result of this pilot a locum box has been implemented in this practice and plans are to rerun this tool periodically. The authors would recommend utilising this tool periodically in other general practices as it has the potential to identify improvement suggestions unique for that particular practice.

Problem

In primary care locum general practitioners (GPs) are used frequently and are commonly regarded as a necessary part of the service. There is a national drive for efficiency savings in the NHS and relatively junior staff are often left out of quality improvement discussions. Locum GPs have a wide range of experience and are frequently working across different general practices. However, they tend to receive minimal feedback on their performance and are unaware if they have performed suboptimal management in some cases. Potentially the locum could continue to provide suboptimal management unless suggestions of improvement are highlighted in a timely, non-threatening manner.

Currently, there is no standardised system in place for the locum GP to provide improvement suggestions to the general practice where they have been working. The quality of clinical care could potentially be improved if useful quality improvement suggestions are shared between the locum clinician and the general practice itself. This study examines whether this useful information can be exchanged between locum GPs and general practices to enhance the quality of care delivered to patients.

Background

Locum GPs are a key component of the primary care workforce. This quality improvement project seeks to improve their quality of work by providing feedback highlighting areas that they could improve in (if any identified) as well as providing the locum with a readily accessible tool that helps provide quality improvement suggestions to the general practice. This utilises the locum's knowledge of different practices and enables them to convey what works well elsewhere, as well as allowing them to receive ideas that they could improve, which may make them feel potentially more valued in their role. Previously not much has been published regarding general practice locum feedback; when searching PubMed for "general practice locum feedback" only one result was obtained. This was an article in the Canadian Family Physician journal in which one Canadian general practice provided an orientation process for locums to maximise their efficiency (1).

The authors felt that obtaining feedback from the locum to the practice and vice versa is a potentially useful idea which could be disseminated further across other practices to enhance patient care. This represents an example of culture shift in the NHS towards one of openness, sharing information, and being willing to change. This is the background of the Francis report (2), some of which stresses that a culture change in the NHS is important; by putting forward this quality improvement programme for peer review and disseminating this information we are hoping to improve the patient care delivered in primary care nationally and potentially internationally. The Faculty of Medical Leadership and Management interpreted the Francis report for trainee doctors (3) and highlighted that trainee doctors rotate through different hospitals, providing them with the ability to make comparisons and establish what is the best and worst care provided; hence they may play a potentially key role in improving patient care.

GP locums are in a position similar to trainee staff in hospitals, often going to numerous different places of work and seeing variations of care due to different systems. GP locums could provide solutions to problems or suggestions that could enhance the quality of care delivered in cases where a problem had not yet been identified.

Before this improvement, suggestions from GP locums to the practices were seldom shared; this is likely due to the time this would take and a possible fear that the GP locum would appear overly critical of the particular practice and may not be asked to return.

Baseline measurement

Baseline measurements took place in Grove Health Centre, a general practice situated in Dundee, Scotland, which used 10 different locums over the past year. At time of performing this study both the authors were working in this practice, one as a locum and the other as a partner. Before this study there was no established mechanism for sharing quality improvement suggestions to or from locum GPs in this practice.

Friendly discussions took place between the authors and informal verbal feedback from partners was obtained on their perceived performance of locums from past experience. These discussions highlighted that on some occasions partners perceived too frequent follow up had been suggested, resulting in unnecessary return visits; one example was that a patient had been told to return for an appointment solely to have a photograph taken of a skin lesion, even though the locum had already referred the same patient to dermatology. These discussions led to speculation that the GP locum did not know the location of the camera; therefore it was decided that the implementation of an improvement exchange mechanism would be useful to address issues such as this.

Design

It was decided that the best way to share the improvement suggestions was electronically, so that these could be completed opportunistically; this also reduced costs to a minimum. It was necessary to get all the GP partners on board so the idea was discussed at a practice meeting in November 2013 with view to commencing this as a pilot scheme for 1 month in December 2013. It was agreed to make clear that this scheme was voluntary and that the GP locums could perform their sessions even if they wished to opt out. A personalised email was sent from the practice manager to each locum who was due to provide clinical cover in December 2013, with view to recruiting them to participate in this project with relevant background (appendix 1 - participation invite email).

Specific surveys aimed at capturing improvement suggestions were designed and produced specifically for this project by the authors. One of the main priorities when designing these was to keep them as user friendly as possible so that they could be completed in minimal time. Therefore the survey providing suggestions to the locum GP consisted of categories of feedback that would be provided, with suggested responses organised in a drop down list; it was felt necessary to include an open text box for free comments so that suggestions generated would be more relevant to that individual. Appendix 2 (practice suggestions to locum) contains the survey designed, including the drop down list options. These were delivered using an established survey website that could be completed electronically at the clinicians' desired time.

Improvement suggestions to the practice were captured using a one question survey with an open text box allowing them to write their suggestion(s) down; this is shown in appendix 3 (locum suggestions to practice).

Strategy

During the month of December 2013, five GP locums performed clinical sessions, one of whom declined to participate in this project due to the fact they felt overwhelmed with emails. The other four locums completed their clinical sessions and provided feedback to the practice. Full details of feedback received can be seen in appendix 4 (suggestions from locums to practice); however, to summarise the authors agreed the following themes were prevalent: including more physical resources (such as cameras in each room and a specifically made locum box with useful items), a suggestion about different ways of handling prescriptions, and a suggestion about identifying complex patients. The feedback to the practice was discussed at a further partners meeting and agreement was reached that this was useful.

Feedback from the practice to the locums was generated by completing a survey and cut and pasting the results onto a standard letter; the feedback provided is shown in appendix 5 (suggestions to locums). Of note, different feedback was given to each clinician.

Post-measurement

To establish the locum GPs' views of the project, when quality improvement suggestions were distributed back to them, a further link was present to provide their thoughts. The feedback template on the project is shown in appendix 6 (feedback on project). Only two of the four GP locums completed this. Both said it took under 5 min to provide feedback to the practice; they felt that the improvement suggestions received were useful and that they would recommend using this method again.

Of note, after the pilot was completed further quality improvement suggestions were provided verbally to the practice (such as providing a direct dial number to the back office and an individual login for each locum so once logged in their name would be written automatically at the end of clinical entries - a further improvement suggestion resulting from feedback provided to the locum GPs). Also an email was received from a senior GP locum praising the idea and mentioning he had never been asked in the past for his views from other practices.

See supplementary file: ds3276.doc - “Appendix”

Lessons and limitations

The main limitations of this study are that it took place in one general practice, that both authors worked in this location during the month, and that they were closely involved in developing the project, implementing it as well as analysing its effectiveness. This

is one of the reasons why we have submitted this project to an open access journal so others can utilise this method in other practices. Using this tool in greater numbers of practices could start to build an evidence base for this intervention; for example, surveys relating to the perceived efficiency of the practice could be sent to patients and practice staff before and after this intervention. However, it is likely there are many external factors that would effect the perceived efficiency of each practice rather than purely this intervention.

One of the challenges involved was ensuring that consent was obtained from locum staff to participate in this study and that they understood the primary purpose; this was addressed by providing a detailed email to the locums at the start of the project. It must be appreciated that taking part in this quality improvement project was a risk for this practice – potentially the project could have frustrated locum staff, leading them to feeling undervalued, and if feedback was overly critical they may not return to the practice to perform future work. Therefore, before feedback was sent out to locums this was discussed again at a partners meeting to ensure all the GPs were happy to send out each individual's feedback. Once again this highlights that it was essential to obtain a buy-in from all partners before commencement of the project.

The main challenge here in terms of engaging with the project was that additional time was required from clinicians to participate in this project and there was no particular incentive other than aiming to improve performance. To address this the surveys were specifically designed to be as non-time consuming as possible, with drop down lists or solely one question; however, due to clinical commitments, these were completed in clinicians' own time. There was a lack of enthusiasm from one of the GP partners who, although agreeing to the project, did not feel he or she personally had the time to contribute.

Conclusion

This intervention was performed cost neutrally and has been specifically designed to allow improvement ideas to be shared openly between both the locum GP and the general practice in a user friendly way that is not arduous on time.

As a direct consequence of this study, in Grove Health Centre a locum box comprising useful items of equipment has been put in place to assist the locums with their clinical duties and to raise awareness of quality improvement by providing more suggestions.

The authors feel that this was a successful pilot and Grove Health Centre plan to rerun this process periodically when different locum staff are attending to obtain their views. The authors would recommend a similar process is implemented periodically in all general practices to see if useful improvement suggestions can be obtained that are relevant to that particular practice.

References

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Declaration of interests

Nothing to declare