

Guest editorial

'Doing' quality: an agenda for GP leadership to improve patient care

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Anyone who knows the *Lord of the Rings* trilogy¹ will recognise that when the eye of Sauron turns upon you the only protection is a strong sense of mission, knowing that you are doing your best and surrounding yourself with others who have different strengths and skills but fight on your side. Primary care practitioners, and particularly general practitioners (GPs) in England, certainly feel in the firing line at the moment: a diversifying and ageing population whose health and clinical needs and expectations are increasing,² many investigative and therapeutic options to choose from, austerity measures in public spending^{3,4} and the unforeseen 'gift' of commissioning health services.⁵ Understandable anxiety about workforce capacity and capability has had challenge added by critical reports of unacceptable variation in general practice,⁶ and by a plethora of 'shoulds and musts' about new roles.⁷ Finally, the role of primary care has been expanded—not only within the patient's care pathway towards integration with social and secondary care services,⁸ but also outwards towards diffuse and shared responsibility for population and public health actions.⁹ In the midst of this considerable agenda, this editorial suggests some practical priorities for GPs to lead the quality agenda in primary care into this new era.

A brief analysis of the challenges to primary care quality

The King's Fund report⁶ found opportunities to improve quality in multiple and long-term conditions, continuity and coordination of care, patient

involvement and engagement and specifically in prescribing. The message was that although most care in general practice was good, we need to accept that better care with less variation is possible, and lead the move to get there. The report made a number of suggestions for how this should be taken forward, which included regular measures of practice performance. Most public health practitioners and GPs would accept that measuring performance, aiming to improve care standards and transparent reporting are a legitimate minimum set of activities to underpin quality assurance by a healthcare organisation or team.¹⁰ However, quality is a complex issue, and it is essential that data which reflect healthcare organisations performance are meaningful, accepted and acted on.

Quality in practice

The Health Foundation recently sponsored a report which included useful 'ten tips' for quality improvement which have been synthesised from their last 10 years of work.¹¹ Many of these are well-established principles, such as the need to convince people that there is a problem, and ensure ownership and engagement with achievable solutions. Others fit well with the King's Fund recommendations, including the challenging idea that 'penalties' should be imposed locally for poor performance. The report highlights the importance of the following:

- getting data collection and monitoring systems right
- identifying and giving leadership

- balancing carrots and sticks—harness commitment through rewards, but also
- be clear about potential sanctions, and
- securing sustainability—normalise the activity into routine practice.

To this, we would add that excessive workload and a culture of negativity are real risks to quality; so staff need adequate ‘back of desk’ time for reflection, analysis and development of solutions—and recognition and encouragement for their efforts.

The King’s Fund report also highlighted the importance of providing clinicians with not only the necessary information for quality improvement, but also the training, support and time to use it. While all team members need to collaborate in quality initiatives, lead expertise can be developed by different people, e.g. in the idea that each practice should have a named child safeguarding lead trained to a specific level.¹² In addition, the pool of expertise can be increased by networking across practices—emerging research shows that ‘networks that unite people around shared interests, goals or challenges have a fundamental role to play in implementing change and in improving the quality of healthcare’.¹³ Increasing capacity while improving GP leadership needs ‘smart’ working—hence the RCGP recommendations to form practice ‘Federations’. These are based on the added value of cross-practice working, and were being promoted before consortia and commissioning were even on the political agenda.¹⁴ The RCGP is continuing to promote this approach, recognising that not only is there a great deal of achievement of quality at the practice level already,¹⁵ but also that peer comparison is an important driver towards accurate analysis of the causes of, and greater impetus for, reduction of interpractice variability.

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A short trip to the future may help us to agree what could work better, and help us to see what needs to be done to get there. If a commissioning consortium in 2020 has ‘taken on board’ the literature on quality in primary care, and managed to create the appropriate conditions, it will have fulfilled all of its criteria for authorisation, including QIPP¹⁶ and CQC registration.¹⁷ It will have excellent data coming in from both contracted providers of commissioned services, and from practices across the consortium, and will be using these data to monitor the delivery of common standards across the consortium and drive continual quality improvement. This is likely to mean close working with public health leads and data analysts—both to ensure accurate interpretation of data and to

align quality initiatives with major areas of potential patient gain.

It will have a specific unit or team dedicated to monitoring quality and to investigating areas where underperformance may be an issue—this includes exploration of unusual variation, but also significant event analyses (SEAs), complaints and concerns, so that all data that may indicate problems are held in one team. Finally, it will make links with local educational and academic partners—so that GP and public health registrars in training, or Masters students, can contribute to service development projects, fulfil their ‘quality improvement project’ training¹⁸ and contribute to the programme of work on quality.

So, what might all this mean for us as individual GPs? Clearly, if such changes are to be progressed, we need to become fully aware of the extent of the variation in the quality of our care to patients and the ‘quality gaps’ which still need to be addressed—although not all variation is bad variation. As busy clinicians, we all still need systematic and regular feedback on our performance—whether in commissioning groups, federations or as ‘communities of practice’; cross-practice collaboration seems likely to assist uplift of quality at individual as well as practice level.

Quality improvement is a key component of our ‘core business’ and is central to what it means to be a good GP in the 21st century. All of us are already engaged in clinical audit as part of our annual appraisals and in our preparations for revalidation, but we need to be confident that our audits are focused primarily on ensuring that *all* of the people registered with our practices receive care to the recommended standards. However, it is also important to remember that some key aspects of our care which are highly valued by both ourselves and our patients alike cannot easily be captured—e.g. continuity and the therapeutic doctor and patient relationship.

Conclusion

Not all stories end happily. The *Lord of the Rings* trilogy involves the heroic leads making some hard decisions, dumping sentiment, taking risks and renouncing wrongdoing in action to achieve their desired outcome.¹ So how shall we reach this happy and productive situation safely? The RCGP has recently undertaken a number of policy reviews¹⁹ to look at the overall quality of general practice and primary care, and believes that there is great potential for GPs to improve quality if better informed about quality shortfalls and systems failures. Often the problem is that we do not know where things are going wrong, we do not know what to do about it if we are

aware of problems, and we apply our individual energies in isolation where shared organisational action could be more effective and less onerous. The authors believe that, as consortia form and as primary health care organisations develop, GPs need to make improved quality of care their main mission, and to develop and maintain skills and systems that will make it work for all patients.

Ultimately, quality of care is about making sure patients can access and receive what they need, both when well and ill.²⁰ The basic organisational approaches that underpin quality of care are not that difficult, but some of them could easily be missed if financial constraints and regulatory obligations dominate the way consortia develop and what staff do within them. Primary care professionals have always been motivated by achieving what their patients need—quality is the same goal.

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PEER REVIEW

Commissioned; not externally peer reviewed.

CONFLICTS OF INTEREST

The three authors have written it as independent academics, with no input from others, and no funding or other incentives being given. We acknowledge that Amanda Howe and Nigel Mathers are both currently officers of the Royal College of GPs, but have written this in our personal capacity: and that Nick Steel is a member of the editorial board for this journal.

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