Quality in Primary Care 2007;15:327–9

Guest editorial

General practice: a heritage industry or the future?

Martin McShane BSc MBBS FRCS MS MRCGP MA
Director of Strategic Planning and Health Outcomes

John McIvor OBE
Chief Executive

Lincolnshire Teaching Primary Care Trust, UK

Improving the quality of health care within available resources is an ongoing challenge in the 21st century for all health systems. What role do general practitioners (GPs) and their practices have in this?

Analysis of the UK data from the Commonwealth Fund 2006 International Health Policy Survey of Primary Care Physicians in Seven Countries revealed a high level of satisfaction with medical practice among GPs but a belief that the healthcare system required fundamental change.[1] There will continue to be increasing tensions within healthcare systems across the world, driven by changes in demographics, the emergence of chronic diseases dominating resource usage (rather than acute episodic care) and advances in treatments and technologies which mean that more complex, continuing care can and should be delivered outside of the traditional hospital model. These challenges and proposals to address them are discussed extensively in *Crossing the Quality Chasm*,[2] and many of the proposed solutions have shaped policy in the NHS.

The professionals delivering care are central to improving quality within the resources available to the system.[3] However, the majority of healthcare professionals are trained to focus on the individual patient and to be an advisor and advocate for that person within the health system. Behind each individual, however, is a population. The limitation of finite resources necessitates a health system which supports professionals in addressing the needs of the individual patient while also acting responsibly for the remainder of the health needs of the whole population. This paradox is recognised and was summarised in a recent Royal College of Physicians report which said:

> Professionalism therefore implies multiple commitments, to the patient, to fellow professionals, and to the institution or system within which health is provided, to the extent that the system supports the patients collectively.[4]

Learning in other industries has created a body of evidence which demonstrates that the design and implementation of systems and processes is critical to quality improvement.[5] Practice-based commissioning creates a real opportunity for professionals to become involved in the design and implementation of systems and processes which will support them in delivering health care, in continuous quality improvement and in managing the paradox of their responsibility to both individuals and the population which they serve.[6]

Making this a reality raises serious challenges for practices (and the primary care trusts who are accountable for supporting practice-based commissioning).

The first challenge is information. Despite major efforts to improve the quality of information, the NHS still lags behind most major industries. Critically most of the data that are analysed are set in an organisational context and focus on activity. In order to really be able to commission properly, information is required about outcomes, processes and patient experience, and this should be used to drive quality improvement.

The NHS has huge potential to establish information systems which track outcomes for conditions. This is due to the strong foundations inherent in the registered list, the use of the NHS number and the almost universal computerisation of general practice.[1] Another of the paradoxes in the NHS is that despite the strong primary care infrastructure, which is acknowledged internationally to deliver more effective and efficient health care,[7] it is difficult to demonstrate the impact it has on outcomes. If data held within general practice could be linked and integrated with that from secondary care, the effectiveness and efficiency of changes to systems and processes in health care could be demonstrated. This would also centralise the commissioning process around the patient, as it would be

increasingly focused on conditions rather than on discrete episodes of care. Such *condition-based* commissioning would also reflect the fact that the major challenge facing health systems in developed countries is chronic disease. It should and could be used to demonstrate the effectiveness of upstream interventions in improving health and reducing health costs.[8]

The implementation of the Quality and Outcomes Framework (QOF) in the new general practice contract is a major success for the NHS in terms of capturing such information (although not seen as such by some critics because of the incentives aligned to it). It implements one of the priorities from *Crossing the Quality Chasm*,[2] by identifying '... priority conditions taking into account frequency of occurrence, health burden and resource use ...'. The QOF provides data for the registered population on processes that are evidence based and linked to improving outcomes. The way in which such data are presented and used is important. Appropriate benchmarking, together with an understanding of variation and its causes, is critical in order that data are set in context and become valued and useful to professionals.[9,10] However, the QOF data are only really relevant if they are linked to other information about outcomes and processes that support quality improvement. This will require access to data for the whole pathway of care, and improvements in coding to capture both processes and outcomes (Box 1). There are two ways to do this. The first is through continuing to reform the national data systems. The second is for practice-based commissioners to identify for themselves how to capture and analyse information in a systematic way with practice-based systems, and secure support in analysis and presentation of the data.

Such an approach requires a fundamental change in attitude and behaviour within practices. They need to make appropriate use of the information, to continually question the systems and processes which they are using internally and externally for patient care, and to use practice-based commissioning as a vehicle for improvement.

The demands of health care are becoming more complex, and developments mean that more can be done for patients. This, coupled with society's changing expectations, raises a second, critical question, of whether the traditional model of UK general practice is able and equipped to meet the needs and expectations of a modern health system. There is evidence that general practice is evolving.[11] There are exemplars of good practice utilising multidisciplinary approaches to delivering proactive care management,[12,13] which also demonstrate that lack of resources may be less of an issue than their effective and efficient use in improving the quality of care. Such an approach, however, requires team work, a commitment from professionals to be involved in and value management, and an understanding of how systems and processes (standard operating procedures) actually underpin quality improvement.[14]

Box 1 Outcomes and processes

Stroke is a major cause of disability yet there is a strong evidence base for interventions to prevent or reduce the impact.

Practice-based commissioners should be able to track how better management of hypertension (QOF), rapid access to transient ischaemic attack clinics (NHS number and unique booking reference number), 24-hour computed tomography (CT) scanning and thrombolysis (emergency admission data) and community rehabilitation (community services data) improve outcomes and patient experience (quality of life survey data).

However, most of the NHS data are not collected on this basis. For instance outpatient referrals, until recently, have been coded by specialty not the cause of referral (symptoms or condition) and community services data are poor or non-existent. The central repository for all of this information is predominantly the GP computerised record. Practice-based commissioners need to unlock this information and use it to shape health services.

How will the patients know who to register with to get such good care?

Unfortunately, for most patients the provision of good-quality care in the health system remains a lottery due to limited information available on outcomes, the standard of care and the experience users have of services.[15] This is likely to change significantly in the near future, with sites such as NHS Choices (www.nhs.uk), www.patientopinion.org.uk and www.yourgpguide.org.uk emerging to inform the public.

Marketing and exposing clearly all the services that can be offered by the NHS are part and parcel of meeting people's new expectations of the health service. Allegedly, Bevan did not want to nationalise general practice precisely in order that patients could retain choice of GP. Both the resources received by a practice and the resources used for treatment now follow the patient. The use of those resources is being benchmarked through better use of information, e.g. the survey on GP access,[16] and the NHS Institute Better

Care Better Value indicators.[17] Now is the time for professionals who aspire to delivering a quality service to use the tools available, evidence their effective use of resources, make their services more widely available and grow their practice across a wider geography using both the new GP contract and practice-based commissioning. It is time to offer people informed choice where it really matters – a choice of GP practice – competing on value across whole pathways of care.[18]

The challenge for practices is to understand this context and to seek ways of using the NHS reforms to develop new models of general practice that become the driving force for continuous quality improvement throughout the whole system.[19] The alternative is to become a much-loved heritage industry bypassed by the needs and expectations of modern society.[20]

REFERENCES

1 Hann M, Whalley D and Sibbald B. *The Commonwealth Fund 2006 International Health Policy Survey of Primary Care Physicians in Seven Countries. Analysis of the UK data.* Manchester: University of Manchester, 2007. www.health.org.uk/publications/research_reports/commonwealth_2006.html (accessed 14 September 2007).

2 Committee on Quality Health Care in America, Institute of Medicine. *Crossing the Quality Chasm: a new health system for the 21st century.* Washington DC: National Academy Press, 2001.

3 Ham C. Improving the performance of health services: the role of clinical leadership. *The Lancet* 2003;361: 1978–80.

4 Royal College of Physicians. *Doctors in Society. Medical professionalism in a changing world.* Report of a Working Party of the Royal College of Physicians of London. London: Royal College of Physicians, 2005.

5 Scholtes P. *The Leader's Handbook: making things happen, getting things done.* London: McGraw-Hill, 1998.

6 Department of Health. *Practice Based Commissioning: engaging practices in commissioning.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090357 (accessed 14 September 2007).

7 Jamison DT. Investing in health. In: Jamison DT and Mosley WH (eds) *Disease Control Priorities in Developing Countries* (2e). New York: Oxford University Press, 2006, pp. 3–36.

8 Department of Health. *On the State of Public Health: annual report of the Chief Medical Officer 2006.* London: Department of Health, 2007, p. 64. www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_076817 (accessed 14 September 2007).

9 Balestracci D. Data 'sanity': statistics and reality. *Quality in Primary Care* 2006;14:49–53.

10 Balestracci D. Statistics and reality: part 2. *Quality in Primary Care* 2006;14:111–19.

11 The Information Centre. *GP Workload Survey 2006/07.* www.ic.nhs.uk/pubs/gpworkload (accessed 14 September 2007).

12 Improvement Foundation. *Unique Care.* www.improvementfoundation.org/View.aspx?page=/topics/health/long term_conditions/unique_care/default.html (accessed 14 September 2007).

13 D'Aunno T. *Leadership and Change: Martin McShane at Moss Valley Medical Practice.* www.ccmp.fr/ccmp-publishing/en_insead/abstracts.asp?ref=H0508 (accessed 14 September 2007).

14 Frauenfelder C. Standard procedures are needed to improve patients' safety, says England's Chief Medical Officer. *BMJ* 2006; 333:990.

15 Coulter A. Can patients assess the quality of health care? *BMJ* 2006;333:1–2.

16 Department of Health. *Patient Surveys: your doctor, your experience, your say.* www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/index.htm (accessed 14 September 2007).

17 NHS Institute for Innovation and Improvement. *NHS Better Care, Better Value Indicators.* www.productivity.nhs.uk (accessed 14 September 2007).

18 Porter ME and Teisberg E. *Redefining Health Care.* Boston: Harvard Business School Press, 2006.

19 Corrigan P. *Size Matters: making GP services fit for future.* www.newhealthnetwork.co.uk/Content.asp?id=216 (accessed 14 September 2007).

20 Hodgkin P. Honey, we shrank the kids' health service. *British Journal of General Practice* 2007;57:505–6.

ADDRESS FOR CORRESPONDENCE

Martin McShane, Director of Strategic Planning and Health Outcomes, Lincolnshire Teaching Primary Care Trust, Cross O'Cliff Court, Bracebridge Heath, Lincoln LN4 2HN, UK. Tel: +44 (0)1522 513355; fax: +44 (0)1522 515337; email: martin.mcshane@lpct.nhs.uk