

## Guest editorial

# Improving quality in general practice: what does it really require?

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The bewildering pace of organisational change within the NHS that was referred to in an earlier issue of *Quality in Primary Care* by Gillam and Siriwardena<sup>1</sup> has continued unabated with a change in government and a new White Paper on the NHS.<sup>2</sup> Gillam and Siriwardena also make the point that despite all the changes ‘the rituals and routines of day-to-day general practice have seemed to endure without significant alteration’.<sup>1</sup>

As reported in the same issue of *Quality in Primary Care*, the introduction of the Quality and Outcomes Framework (QOF) using financial targets to influence care has had a rather patchy impact,<sup>3</sup> perhaps due to weaknesses found in pay for performance schemes in general. It has been suggested that whilst it incentivises new processes such as blood pressure measurement and statin prescribing it does not adequately address health outcomes and aspects of patient perceived quality.<sup>4</sup> The question has been raised as to whether the improvements found might have happened anyway since achievement of standards was already high and trends were in the right direction.<sup>3</sup> Finally, concern has been expressed that it could encourage a ‘pay for reporting’ rather than ‘pay for performance’ approach, leading to limited applicability as a health improvement initiative.<sup>5</sup> It is important to understand that such criticisms relate to the systems being used rather than the professionals using them, since it is also reported that doctors are more enthusiastic about targets that are aligned to professional priorities.<sup>3</sup>

Whether the current White Paper will have an impact at patient care level remains to be seen, although its stated intention is to create an NHS that is more responsive to patients and achieves better outcomes. Its strapline, ‘Liberating the NHS’, suggests a move away from a centrally dominated, externally driven culture of practice to one where there are more degrees of freedom to plan local services tailored to local patients.

Darzi’s definition of high-quality health care as that which focuses on clinical effectiveness, safety and patient experience<sup>6</sup> can serve as a touchstone to keep

in mind as we respond to the White Paper’s shift from targets to outcomes and particularly to the current financial challenges. The Department of Health’s recently established Quality, Innovation, Productivity and Prevention (QIPP) programme focuses on its four core components and identifies the need to improve the quality of care whilst making funding go further.<sup>7</sup>

If we are to address these challenges we need to gain rather deeper insights into factors that nurture the continuous improvement of quality. Whatever changes go on around us the quality of care that patients receive is largely a function of what happens at the front line. It is how care is delivered here that really matters since this is where value is added for patients,<sup>8</sup> which suggests that a different lens for looking at improving quality is needed.

The essence of promoting best practice for improving quality has been summed up as:

- validating practice teams’ desires to provide the best possible care for their patients
- recognising that team members are already active agents of change in their daily lives, where they are in control of it
- nurturing each individual team member’s innate enjoyment of learning.<sup>9</sup>

With regard to the first bullet point, providing the best possible care for patients has to be at the core of any approach to quality improvement and requires that it goes beyond merely providing them with good experiences. We need to recognise that our underlying aim must be more profoundly to improve the way we meet their needs. Putting patients at the heart of health care is an often expressed desire and the NHS has a long history of attempting to measure patient satisfaction using surveys and other methods such as focus groups. However, a quote from a non-healthcare setting sets the context for a truly patient-centred dynamic.

The trick is to engage customers in a different kind of conversation, to ask them how they are doing ... to say, we don’t want to talk about us. In fact try to forget that we’re

even here. We want to talk about you. We want to understand what your wants and needs are, what makes you tick. Because if we understand those things more, we think we'll be able to apply our skills and expertise in ways that will better meet the needs you express, as well as some needs you may not even know you have.<sup>10</sup>

This translates especially well into primary care, whose essence is a personalised approach that recognises individual patients' needs, wants and preferences.<sup>11</sup> At this level of care concerns have been expressed that QOF targets may divert attention away from what is important to a practice's individual patients.<sup>11</sup>

More broadly when considering improving the way care is provided different ways of listening to patients are needed. For example, listening to patient stories has been shown to offer opportunities for clinical teams to use their own clinical and professional knowledge to identify better or new ways of meeting patients' and carers' needs, including needs they did not know they had.<sup>12</sup> Recent work focusing on back pain has highlighted the value of involving patients in quality improvement activities with a plea to 'listen to us rather than try to cure us'<sup>13</sup> whilst the emerging field of 'experience based design' illustrates the power of involving them as co-designers of improved care.<sup>14</sup>

As bewildering as the pace of change is the number of different 'brands' of quality improvement on offer (e.g. clinical audit, continuous quality improvement, lean, six sigma etc).<sup>15</sup> However, as such labels come and go there are a number of underlying principles that remain constant. First and foremost is the unceasing attention to patients' needs described above. Second is the requirement for patients, carers, front-line teams and managers habitually to all work together in pursuit of improvement. This interprofessional approach is very different from the centrally driven approaches to improving quality referred to above, which may unwittingly engender mistrust due to patients, managers and professionals not having a shared understanding of quality.<sup>16</sup>

As well as being an overarching aim, quality improvement can nowadays be considered an academic discipline. It has a conceptual framework, a developing body of knowledge, particular skills and methods and a growing volume of published evidence that confirms its potential for improving care in practice settings.<sup>17,18</sup> Much attention has been paid to teaching its principles and methods but systematic reviews of the impact of such teaching suggest that evidence for its impact on quality and outcomes is limited.<sup>19,20</sup> This leads to the third underlying principle, which is to reach the point where improving care is no longer seen as separate from providing care but as action learning within care.

It is not simply about providing bigger and better courses to teach methodologies that are then 'applied' to health care.<sup>21</sup> It has been claimed that learning how

to do quality improvement and actually carrying it out are essentially the same thing and are both forms of experiential learning.<sup>22</sup> Stories of successful improvement are inevitably stories of people learning together.

Understanding improvement as 'learning' rather than just 'doing' offers a framework that can strengthen mutual trust in practice-based teams and can serve as both a driver and integrator for those involved. The value of improvement principles and methods is that they are fundamentally patient centred, belong to no one professional group and provide a common language that crosses professional and organisational boundaries.<sup>23</sup> Learning and working together on improvement that is focused around patients' needs reconnects professionals with the deep feelings that brought them into health care. It benefits from team members' personal experience of making change and taps into an innate enjoyment of learning that is a core human characteristic.<sup>24</sup>

A fourth key principle embedded within the 'improvement as learning' paradigm is the idea of teams using an improvement model to continuously test small cycles of improvement in their care processes.<sup>25</sup> Feedback measures that are important to both patients and team members are built in. This trial and learning approach generates energy and enthusiasm in a way that collecting data against externally set targets simply cannot.

In summary, the golden strand that runs throughout continuous improvement is establishing continuous learning as a practice habit. This includes teams:

- learning about their patients' needs and about outcomes that need to be improved
- learning about the processes by which they provide care
- using this learning to identify, plan and test improvements
- using meaningful measures to learn from these tests and plan the next cycle of improvement.

Rooting such a learning model within practice and applying it to the improvement of quality appears to have the potential to provide insights and fresh perspectives to the organisational culture and leadership needed to sustain improvement into the future.<sup>16</sup> Creating these conditions is recognised as another constant across all brands of improvement and is a fifth underlying principle.<sup>15</sup>

The challenge is to seize the moment so that in the future we can say that the rituals and routines of day-to-day general practice truly have changed; that they have been unlocked by practice teams themselves habitually seeking to learn with their patients and improve care. By doing this they will move beyond any targets that externally driven frameworks may set and achieve improvements in health outcomes that are meaningful to both patients and themselves.

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## PEER REVIEW

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## CONFLICTS OF INTEREST

None.

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