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Guest editorial

Measuring quality in the new era of team-based primary care

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We are living in a complex, changing world, and within health care, primary care is undergoing perhaps the greatest degree of change. Not so long ago, primary care was largely defined by the services provided by general medical practitioners, who were broadly trained to provide a wide range of services. The primary focus was on the care of individual patients, who would access the healthcare system via an initial consultation and have most of their problems sorted out individually. Only a small proportion would need to be referred to more specialised services, generally hospital-based services, for more expensive, extensive or specific investigations. Other health professionals played support roles that freed up the time of general practitioners (GPs), who could focus on patients with more serious conditions. The service was more reactive than proactive, as diagnosis, investigation and management would commence once patients presented with their symptoms.

The continuing and rapid trend in primary care is in the direction of providing teams of highly trained, more specialised services that keep patients within the community for longer, defer or delay admission to hospitals, and accelerate discharge back to the community. A more proactive approach to maintaining health and preventing illness sees patients being investigated increasingly within general practices, and increasingly managed by practice nurses with expanded roles.[1] Pharmacists and nurses may prescribe a range of medications without reference to medical practitioners, although following medically supported protocols.[2] Many GPs have moved along the medical spectrum to offer services once provided by general physicians, and many subspecialise in 'special interests' to become GPs with special interests (GPwSIs).[3] Referral to hospital-based specialists is more likely to be directed to a narrower subspecialty, with patients either partially or completely investigated. Investigations and procedures can more easily be instigated, and their results managed, within primary care. A substantial proportion of inpatient activity, within the range of 60–80%, is now taking place in 'same-day' centres, often attached to facilities for overnight accommodation of those patients too ill to go home.

These changes have clear implications for the measurement of the quality of care. Quality is a construct that should include the perspectives of all stakeholders – patients, commissioners, professional regulators and individual health professional groups.[4,5] These perspectives differ: patients are known to be more concerned with accessibility issues, commissioners with costs and cost efficiency, professional regulators with standards of care, and individual professional groups with training standards.[6,7] Whereas once the perspective of the individual practitioner was an important part of the complexity, a focus on outcomes of primary health care replaces individual performance perspectives with that of the whole primary care team, and individual knowledge and skills with those of the team role played by individual practitioners. Increasingly, primary care teams need not just *any* practitioner to fill specific roles, but *specific* practitioners with specific knowledge and skills that make the team function better. Individuals will need to be trained to meet specific roles, and these roles will change as healthcare provision models change. In some cases the role changes may be evolutionary, building on prior knowledge and skills, whereas in others the changes may be revolutionary, as certain roles become unnecessary and new roles emerge. Therefore all team members may require periodic retraining for a new role, as well as the usual continuing professional development that maintains currency of existing and evolving professional roles.

This view may be a challenge to the traditional view of clinical practice as the results of the endeavours of only one or two individuals within the group. However such development should not be seen as a threat, so long as the focus is maintained on what primary care is supposed to deliver. This also requires a shift from consideration of *structures* and *processes* of primary care practice, towards the *outcomes* of primary care service delivery,[8] adopting a more systems-based approach to health care.[9] Most of the clinical

indicators in the Quality and Outcomes Framework used in the UK reflect baseline structure and process measures,[10] although many can be achieved only through effective teamwork. It is not yet clear how well such intermediate measures predict longer-term health outcomes, and each clinical condition may have a unique set of predictive factors for outcomes, for example low back pain.[11]

The future of health care requires health professionals to be effective team members. Effective teams are not created easily or quickly, but instead require effective guidance, leadership, collaborative working and joint ownership of outcomes. The ability to work in teams may be something that health professional students can learn,[12] although true teamwork can probably be developed only within genuine teams.[13] The importance of stability of personnel to team function is not fully understood, but teams in primary care are likely to be more stable than those that will emerge in hospitals, where restrictions on working hours already require new models of teamwork to provide effective continuity of care over 24 hours a day, 7 days a week. In primary care almost all clinical care is provided within relatively normal working hours, minimising the necessity for complex handover and continuity procedures, although regional after-hours co-operative services will have to transmit information to and from their network of primary care practices. Most team members will work together most of the time.

While discussions about improving quality will generally attract universal support, improvement may not happen unless it is looked for. A list of potential outcome measures for the quality of primary care that address these changes, grouped by stakeholder perspective, is provided in Box 1. Some are not new, and the list is by no means exhaustive, but it demonstrates a shift to measures of outcomes of at least individual healthcare episodes, rather than processes, and to team rather than individual effort. Just as teamwork is increasingly the process by which health care is provided, outcome measurement methods will have to focus on team performance, although ideally they will be sensitive to the roles and functions of individual team members.

This shift in measurement may require methodological development. The best way to measure team performance is to focus on achievement of team goals,

Box 1 Outcome measures of the quality of primary care

Patient perspectives

- Availability of appointments
- Accessibility of practice facilities
- Attendance and pain relief in post-operative home-based care
- Communication and behaviour of practice staff
- Direct cost of care episodes

Commissioner perspectives

- Time from first encounter to appointment with more specialised services
- Estimated time delay for diagnosis of serious conditions (e.g. cancer)
- Cost-effectiveness of practice screening and surveillance activities
- Appropriateness and cost of investigations ordered
- Appropriateness and cost of referrals to more specialised services
- Proportion of patients managed appropriately within primary care
- Rates of patient pathway errors
- Total cost of managing specified conditions
- Adaptability of teams to new roles
- The degree of integration of multiple health and social care services in patient care episodes
- Professional regulator perspectives
- Performance of both individual practitioners and the practice team
- Effectiveness of teamwork within the practice
- Effectiveness of teamwork involving community-based staff
- Incidence and outcomes of complaints

Health professional group perspectives

- Acquisition and maintenance of knowledge and skills of individual practitioners
- Role evolution and transformation
- Leadership and management practices

rather than individual performance, but this is counter to the thus-far different cultures and hierarchical nature of the healthcare professions. The culture will need to change and adopt the continuing quality improvement principles of *no fault* reporting, which may require careful attention to whistleblowing and data-protection procedures. However, the price of not changing may be high.

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