

Primary care quality digest

Alison Price
Library Manager, Lincolnshire Knowledge and Resource Service, Lincoln, UK

> The probability that a disseminated document will arrive on someone's desk the moment it is needed is infinitesimally small. Secondly, the probability that the same document will be found three months later, when it is needed, is even smaller.
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> JA Muir Gray (Director of the NHS National Knowledge Service)[1]

The aim of this primary care quality digest is to bring to your attention recently published guidelines, reviews and papers related to issues of quality in primary care.

The resources included in the Primary care quality digest have been selected from those produced by the Primary Care Current Awareness Service (PCCAS).

The PCCAS gathers together the latest information on health news, National Service Frameworks (NSFs), health service management, public health, health promotion, legal and parliamentary information, statistics and social care. The resources are produced by librarians and knowledge managers in Trent and South Yorkshire, with support from the Trent Improvement Network and the National Library for Health.

The PCCAS provides a range of bulletins and newsfeeds on its website, including the daily news bulletin, www.tin.nhs.uk/welcome/keeping-up-to-date/daily-news-bulletin, and a range of subject-based newsfeeds, www.tin.nhs.uk/welcome/keeping-up-to-date/rss-newsfeed-menu

Papers and reports

Accelerating improvement

The author of this paper outlines the structured improvement process used in all work programmes by the NHS Institute for Innovation and Improvement, or the NHS Institute as it is more commonly known. The background to the development of the improvement process is described and the author reports that it is a process that would be of assistance in finding more timely solutions to specific challenges in improving health care.

Mugglestone M. Accelerating the improvement process. *Clinical Governance: an International Journal* 2008; 13:19–25.

Barriers to implementing hypertension guidelines

This American study examined the role of 'clinical inertia' in treating hypertension, by evaluating the knowledge, attitudes and practices of a group of family physicians. Through a series of interviews, the authors found that although 94% of physicians reported familiarity with the current Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure guidelines, many difficulties in applying the guidance in practice were identified, including a lack of time to discuss management with patients, lack of confidence in accurate blood pressure monitoring by staff, and difficulties in encouraging lifestyle modification and medication compliance amongst patients. The authors conclude that this study highlights contradictions between provider knowledge and the application of this knowledge, and call for improvement initiatives including competency training and continuing education.

Holland N, Segraves D, Nnadi VO *et al.* Identifying barriers to hypertension care: implications for quality improvement initiatives. *Disease Management* 2008; 11:71–7.

Healthcare quality assurance across Europe

This paper discusses the considerable variation within systems of quality assurance for health care across Europe and suggests a potential role for the European Union in tackling this issue, which is being highlighted by the increased mobility of both patients and professionals.

Legido Quigley H, McKee M, Walshe K *et al.* How can quality of health care be safeguarded across the European Union? *BMJ* 2008;336(7650):920–3.

Impact of the Quality and Outcomes Framework on general practice

This study, undertaken by researchers at the UK National Primary Care Research and Development Centre explored general practitioners' and nurses' thoughts about changes to general practice arising from the introduction of the Quality and Outcomes Framework (QOF). Twenty-two nationally representative practices were selected. The authors report that those interviewed believed the financial incentives of the QOF had been enough to change behaviour and to achieve targets, and that its aims in terms of disease-specific improvement of patient care had been met. However, unintended effects were also identified, focusing upon the relationship between doctors and nurses and also the nature of the patient consultation.
Campbell SM, McDonald R and Lester H. The experience of pay for performance in English family practice: a qualitative study. *Annals of Family Medicine* 2008; 6:228–34.

Industry influence upon quality measures

This paper looks at the impact of pay for performance on quality measures from a US perspective, specifically the need to ensure that clinical evidence and expert consensus alone underpin such measures.

The authors note that two types of organisation have influence over the content of quality measures – those that develop the measures, and professional medical societies. Both may have direct and indirect ties to industry, ties that may increase as organisational dependence upon industry revenue grows. The authors cite examples of inappropriate industry influence upon the drafting of clinical guidelines from professional societies, and discuss policy options for reducing the risk of such influences.
Rose J. Industry influence in the creation of pay-for-performance quality measures. *Quality Management in Health Care* 2008;17(1):27–34.

Making improvement happen

This paper explores the drivers for improvement in the NHS and further afield, by outlining these drivers and examining the underlying motivating factors for each one. The common attributes of successful healthcare improvement practice are discussed and the author identifies four fundamental skill and knowledge sets – leadership; performance and metrics; the right tools and processes; and relationships. How these can be used to build service improvement capacity and speed up the improvement process is explored.
Crump B. How can we make improvement happen? *Clinical Governance: an International Journal* 2008; 13:43–50.

Non-clinical quality of care criteria

The survey is a tool commonly used in quality-of-care research to explore issues of structure, process and outcome. Few surveys have focused upon patient priorities for quality. This paper uses over 100 000 records of survey interviews to describe the relative importance of eight areas of non-clinical quality of care, taken from the 'health systems responsiveness' concept developed by the World Health Organization (WHO). These include issues such as dignity, confidentiality, communication, quality of amenities and prompt attention. The authors explore the importance of such issues by geographic and population variables and report that their results provide a ranking of criteria of non-clinical quality of care which could be considered during health reform processes.
Valentine N, Darby C and Bonsel GJ. Which aspects of non-clinical quality of care are most important? Results from WHO's general population surveys of 'health systems responsiveness' in 41 countries. *Social Science and Medicine* 2008:66(9):1939–50.

Quality assurance for self-management of oral anticoagulation

This paper evaluated external quality-assessment methods used in patient self-management of oral anticoagulation within general practice in Sheffield. Practices involved in the study were randomly allocated to a formal external quality-assessment scheme of patients performing the test either independently at home, or under supervision at their practice. With reliability of results as the outcome measure, the proportion of tests in range was significantly higher for the patients performing the test independently, leading the authors to conclude that patients are able to undertake a formal external quality-assessment scheme reliably at home.
Murray ET, Jennings I, Kitchen D, Kitchen S and Fitzmaurice DA. Quality assurance for oral anticoagulation self management: a cluster randomized trial. *Journal of Thrombosis and Haemostasis* 2008;6:464–9.

Quest for quality in the NHS

On gaining power in 1997, the Labour government introduced an ambitious and wide-ranging series of reforms aimed at improving the quality of the NHS through modernisation and renewal. This report from

the Nuffield Trust combines comparative quantitative information with political analysis to present an overview of quality since 1997. The authors of this paper acknowledge that quality has improved overall, but report that it is not as clear whether this improvement reflects the resources invested. Three questions are asked – Are the improvements in quality over the past decade as good as could have reasonably been expected? How much of the improvement can be attributed to deliberate reforms? Has a reliable capacity for improvement been embedded in the NHS? The authors call for an English national quality programme, for which a blueprint is provided.
Leatherman S, Sutherland K and Dixon J. *The Quest for Quality; Refining the NHS Reforms; a Policy Analysis and Chartbook*. London: The Nuffield Trust, 2008. www.nuffieldtrust.org.uk/publications/detail.asp?id=0&PRid=389

Reducing inappropriate medication in the elderly

This US study assessed trends in the use of inappropriate medication by primary care patients aged 65 years or above. A four-year project was delivered to 99 practices, all members of a research network, using a common electronic medical record. Quarterly reports on inappropriate medication use were sent to each practice, with interventions such as on-site visits and network meetings to review performance put in place. The results showed that the use of inappropriate and rarely appropriate medication in the elderly population decreased over the time of the study.
Wessell AM, Nietert PJ, Jenkins RG, Nemeth LS and Ornstein SM. Inappropriate medication use in the elderly: results from a quality improvement project in 99 primary care practices. *American Journal of Geriatric Pharmacotherapy* 2008;6:21–7.

Universality, equity and quality of care in the NHS

As part of a series of analysis papers 'NHS at 60', the author of this paper examines the difficulties faced by the NHS in ensuring equity of access to quality health care. The author notes that little information about the quality of care was published before 1997, beyond statistical data. Developments in monitoring and reporting of the NHS quality agenda are outlined and commented upon.
Delamothe T. Universality, equity, and quality of care. *BMJ* 2008;336:1278–81.

Uptake of quality-improvement methods in Finnish primary care

This paper aimed to evaluate how widely quality-improvement methods are used in primary care in Finland, and how this use changed in a five-year period. A questionnaire sought information on 13 quality-improvement methods. The authors found that use of meetings, colleague consultation and continuing medical education were all high, and noted that the greatest improvement over the five years was in the use of clinical guidelines. Progress was also identified in the use of computer-assisted performance monitoring and quality-improvement manuals in the workplace.
Sumanen M, Virjo I, Hyppölä H *et al.* Use of quality improvement methods in Finnish health centres in 1998 and 2003. *Scandinavian Journal of Primary Health Care* 2008;26:12–16.

Workshops to increase knowledge of asthma management

This paper reports a randomised trial, conducted to assess the effectiveness of locally adapted practice guidelines about paediatric asthma management delivered to general practitioners (GPs) in interactive workshops. Twenty-nine practices took part, using the Australian asthma-management guidelines adapted to suit the local population. The authors found that the GPs taking part in the workshops felt more confident in the management of an acute attack of asthma, and in ongoing management, leading to the conclusion that the workshop method of disseminating guidance was linked with improved knowledge and confidence.
Liaw ST, Sulaiman ND, Barton CA *et al.* An interactive workshop plus locally adapted guidelines can improve general practitioners' asthma management and knowledge: a cluster randomised trial in the Australian setting. *BMC Family Practice* 2008;20(9):22.

REFERENCE

1 Muir Gray, JA. Where's the chief knowledge officer? *BMJ* 1998;317:832–40.

PEER REVIEW

Commissioned; not externally peer reviewed.

ADDRESS FOR CORRESPONDENCE

Alison Price, Library Manager, LKRS Beech House, Waterside South, Lincoln LN5 7JH, UK. Tel: +44 (0)1522 550658; fax: +44 (0)1522 516723; email: library_lkrs@lincolnshire.gov.uk

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