

## Editorial

# A primer for quality improvement in primary care

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## The quality improvement challenge for health care

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Health care provides endless challenges for quality and infinite opportunities for improvement. Quality improvement begins with our own personal experiences as practitioners. In our patients', friends', relations' and our own experiences with health care, we encounter daily high-quality care contrasting with poor or downright dangerous care. In these situations, it is easy to understand why quality matters, and what we can learn about quality. Much of our personal experience and previous work in quality improvement has focused on how to overcome poor care we have encountered throughout our careers.

There are many examples with which we have been personally involved, for example, improving care for people with acute myocardial infarction or stroke, the challenge of improving influenza and pneumococcal vaccination rates in high-risk groups and care for those with long-term conditions. Patients need access to better care, practitioners want to provide this, organisations have to accommodate new ways of working and the health system should change to enable patients, clinicians and organisations to access better options for treatment.

Our aim is for a new series of articles which will develop into a primer for quality improvement, principally directed at doctors and nurses in general practice but relevant to all healthcare professionals. Health professionals learn throughout their career: continuous professional development is a lifelong commitment and today, perhaps more than ever, we recognise the compelling need to develop the knowledge and skills to improve the quality of the care provided.

## The historical context for quality improvement

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At every stage in its development, the practice of quality improvement (QI) has been heavily influenced by industries and activities outside the health sector. Early writers on the processes of industrial production included Ford and Fayol, but our story really starts with Deming<sup>1</sup> and Juran.<sup>2</sup> Their insights underpinned the development of total quality management. Over the past 50 years, Toyota's 'lean manufacturing' and Motorola's Six Sigma have found their place in health care. Current approaches to risk management and patient safety, for example in *An organisation with a memory*,<sup>3</sup> have borrowed heavily from the aviation industry. The idea of 'clinical governance' was derived from the private sector's concept of corporate governance.<sup>4</sup> The current emphasis on health systems – 'every system is designed to achieve the results it gets' – is an important development because it moves improvement from individuals to organisations and leaders.<sup>5</sup> Organisations like the Institute for Health Improvement in the USA and the NHS Institute for Innovation and Improvement have championed improvement science and these novel approaches in health care.<sup>6</sup>

## The changing context of health care

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The political dimension of health care and translation of the changing knowledge base into best practice are important contextual factors for increasing our knowledge of QI.

## The political dimension

Following the Kennedy report into the scandal of paediatric heart surgery at the Bristol Royal Infirmary and with the publication of *A First Class Service*, the New Labour government of the time placed QI at the centre of the health policy stage.<sup>7</sup> The term clinical governance was used to capture the range of activities required to improve the quality of health services together with accountability for their delivery. Central among these were the need for all NHS organisations to develop processes for continuously monitoring and improving quality and to develop systems of accountability to ensure that these were in place. Quality components of clinical governance include evidence-based practice, clinical audit, risk management, mechanisms to monitor the outcomes of care, lifelong learning and systems for managing poor performance. In addition, the term combines an emphasis on improving care for individual patients with QI targeted at whole populations. This wide ranging approach creates a challenge for those leading the implementation of clinical governance, particularly in the face of highly public failures in health services.

## The changing knowledge base

Medical scientific knowledge and the evidence for what works, its costs and safety are increasing at an exponential rate. Practitioners have to rely on the translation of evidence to systematic reviews and guidance rather than necessarily having time to access primary sources of research. Archie Cochrane who first extolled the importance of the randomised controlled trial is often regarded as the father of evidence-based health care and successors such as David Sackett and Iain Chalmers established his lasting legacy in the Cochrane Centre which coordinates the production and publication of high-quality systematic reviews.

The translation of guidance into routine practice is one of the greatest challenges for health care – the so-called ‘second translation gap’. QI provides a means to bridge this gap and so the science of quality improvement is now as essential to good practice as anatomy, biochemistry and physiology which doctors and other health workers learn in their undergraduate training – arguably, more so.

## What do we mean by quality?

There are three key models of quality in current use. In his classic work *Evaluating the Quality of Medical Care*, Avedis Donabedian first enunciated the quality triad of structure, process and outcome.<sup>8</sup> This formed the

basic structure for medical audit activity in the 1980s, symbolically redefined as clinical audit in acknowledgement of the multidisciplinary nature of all QI activities.

The Institute of Medicine report, *Crossing the Quality Chasm*, was a landmark publication on quality from the USA which identified effectiveness, efficiency, safety, timeliness and patient-centredness as key dimensions of quality,<sup>9</sup> and these have been refined in the UK into safety, effectiveness (which includes efficiency) and patient experience in the *Next Stage Review*.<sup>10</sup>

A number of other conceptual models have been proposed between these key frameworks and provide further ideas of what quality is. Toon’s conceptual examination of ‘good general practice’ distinguished three different approaches – a disease-focused, biomedical model; a patient-focused, humanist model; and a population-focused, public health model.<sup>11</sup> Toon’s argument that the meaning of good general practice differs between models goes some way to explaining the variety of approaches to assessing and improving quality which have been put forward.

Howie *et al* attempted to assess quality from the patient’s perspective by measuring the extent to which their consultation enables them to understand and cope with their illness.<sup>12</sup> McColl *et al* took a more biomedical approach, proposing that primary care teams can assess the potential impact of different clinical activities by applying evidence on clinical effectiveness as performance indicators to their own practice population.<sup>13</sup> Roland *et al* combined patient, population and organisational perspectives to identify 14 markers of quality in general practice.<sup>14</sup> These include measures of access and availability (e.g. waiting times and telephone access to doctors); clinical markers relating to the quality of acute, chronic, terminal and preventive care; and measures of prescribing and referrals.

Greenhalgh and Eversley explored several different perspectives from which to consider quality in general practice.<sup>15</sup> They distinguished patient, activity and performance, evidence-based, educational and managerial perspectives, each of which focuses on a different cluster of markers of quality. Greenhalgh and Eversley argued that no single perspective can be used to describe the quality of care in practice.<sup>15</sup> In a similar vein, Toon argued that it is impossible to define a single version of good quality general practice if there is no agreement on what it is aiming to do and the values pursued through it.<sup>11</sup> These points are relevant to clinical commissioning groups whose key tasks are developing primary care services, commissioning health care and improving the health of the local population. This combination of individual and population-based goals needs to be reflected in the range of clinical governance activities which underpins them.

## What drives quality improvement?

The main drivers of QI and health care are (at least) threefold and they are inter-related.

### Education

At one time, doctors were thought to emerge ‘fully formed’ from medical schools and, in our professional lifetimes, it was possible to go straight from pre-registration house jobs to take on all the responsibilities of general practice without any higher training. As training programmes have evolved in term of their breadth and sophistication, so too has the notion of time-bounded medical education faded. Medical education is a career-long, continuous process, central to the maintenance and the improvement of quality. We will examine how you need to approach later in this series of articles.

### Health service evaluation/audit

All doctors need to understand how to measure quality; they are all directly or indirectly involved in evaluating the quality of the services they provide. The motives for doing so are not simply altruistic. In our litigious age, practitioners need not only to understand how to deal with complaints, but also to pre-empt medico-legal consequences of health service failures. The main driver, however, is surely internal and linked to an ethos of professionalism. For most doctors, job satisfaction is largely derived from delivering services they perceive to be optimal. We wish to do as we would be done by.

### Market mechanisms, choice and regulation

The third set of drivers to improve quality relate to market (financial) incentives, choice and regulation. There is a long history of using payment to improve the quality of general practice in the UK. Evidence for their effectiveness is contested, but the elements of successful pay-for-performance scheme can be delineated. A closely related consideration is patient choice. In an unfettered market, consumer choice of healthcare provider is supposed to be based in large measure on perceptions about its quality. Central to this is the provision of meaningful information to users about quality of care and, of course, the ability to make real choices. These are not ‘givens’ in a state-run monolith like the NHS and successive government reforms have sought to strengthen consumer power, through greater involvement and choice, and also to ensure that regulation helps to safeguard the consumer. The recent

restructuring of the health service and legislative changes will see regulatory organisations such as the Care Quality Commission (CQC) and Monitor assuming increased powers in the coming years.

## Whose business is it anyway?

Health service commissioners, currently clinical commissioning groups in England, are the organisations through which clinical governance will be developed at a local level and local priorities identified. Yet the nitty-gritty work of clinical governance and QI is undertaken by the members of individual practices and primary care teams.

Over the last two decades consideration of the ‘primary care team’ has begun to replace narrower discussions about general practice, but there is no single definition of the scope or constituency of primary care. In the UK, the term is often used interchangeably with general practice. Most work on quality therefore focuses on general practice.

Underpinning contemporary theories of QI is the axiom that poor individual performance usually reflects wider ‘system failure’ or the absence of an organisation-wide system of quality assurance. In healthcare organisations, critical incidents can lead to death, disability or permanent discomfort. This, together with clinicians’ tendency to protect their individual autonomy and reputation, can promote a culture of blame and secrecy that inhibits the organisational learning necessary to prevent such incidents in future.

Introducing clinical governance to primary care, the government stated that it

must be seen as a systematic approach to quality assurance and improvement within a health organisation ... Above all clinical governance is about changing organisational culture ... away from a culture of blame to one of learning so that quality infuses all aspects of the organisation’s work.

Organisational development is therefore central to the effective establishment of clinical governance.<sup>16</sup>

## Structure of the series

We will begin by examining clinical governance and how primary care organisations are held accountable for quality and QI. As we have seen, the concept of clinical governance places a central responsibility for quality on the shoulders of those managing and leading within the health system. To one extent or another, that means all of us.

Second, we will examine market mechanisms, commissioning and the role of regulation which are an increasing part of many health systems and are increasingly being used as levers for change and improvement.

Third, leadership, management and organisational culture are prerequisites for improvement. How these can support QI will be examined in more detail. All doctors work within teams, organisations and the wider health system; how these are designed and managed greatly determines an individual's and team's effectiveness.

In the second part of the series, we look in more detail at the tools and techniques used for assessing and measuring quality of care. It is one thing to observe (or diagnose) and another thing to effect change (or cure). We explore how quality improvements are actually delivered. The concepts in each article will be illustrated with case examples.

In the final article in the series, we return to our own needs as individual practitioners. Nowadays, preparing for and acting on appraisal is a regular feature of medical working lives. How do we identify our own developmental needs and work with others to address them? This is not just about providing more satisfactory experiences for the people we serve. It is also about deepening the personal yields from what is already a rewarding occupation. What do you, the reader, want to provide and receive from your work?

## Conclusion

Our aim is to provide readers with a set of tools to convert the endless challenges for quality and infinite opportunities for improvement into meaningful and useful change. It will enable you as practitioners to use your personal experiences to transform the services you provide. We hope this series of articles will develop into a primer for quality improvement in primary care, relevant to every individual working and learning in primary health care and the wider health service that needs to understand what QI is and how QI should be carried out ... and that means all of us.

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## PEER REVIEW

Commissioned; not externally peer reviewed.

## CONFLICTS OF INTEREST

None declared.

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