Quality in Primary Care 2010;18:357–8 © 2010 Radcliffe Publishing

Editorial

Improving primary care quality now and into the next decade

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I began work as a newly qualified general practitioner 20 years ago. This was 1990, the year of the New Contract. My predecessor was a respected general practitioner who had worked in the National Health Service (NHS) since its inception in 1948 and indeed for several years before this. He consulted at five-minute intervals using paper (Lloyd George style) records, saw 20–30 patients at each surgery and on most days visited about ten patients and their families. He typed his own referral letters on a typewriter during surgery with the patient sitting in front of him; he would even hand the patient their newly crafted referral letter and ask them to post it, thus minimising postage costs for the practice. He responded to the Family Doctors' Charter of 1965 and the General Medical Services contract of 1966, the first significant change in general practice before 1990, by forming a group practice with his partner and other colleagues, moving premises and employing nurses and reception staff. I learned all this because I was fortunate enough to spend a day speaking with him and observing him at work.

In some respects a great deal in general practice has changed irrevocably and utterly; for example the drive to computerisation, marketisation, widening access (through NHS Direct, walk-in centres, out-of-hours services) and regulation of general practice and the NHS. Other elements, such as the core features of primary care, have remained relatively intact. Much of my day-to-day work as a general practitioner still involves face-to-face consultations with patients and families but with longer consultations, greater therapeutic possibilities and more involvement of nurses and other professionals. Some processes have almost reverted back to those of two decades ago. I now type my own referral letters during surgery with the patient in front of me; however, now the letter is word processed into the electronic patient record and sent electronically to a receptionist who actions the referral; so even this seeming return to a bygone era is in fact an innovation.

There have been many innovations that have been slower to diffuse into general practice thinking – included in this are the innovations which encompass systematic methods for improving quality of care; methods which have been met with responses ranging from apathy to outright resistance.[1] Clinical audit and significant event audit may have found a reasonably secure footing in general practice but rather than engage with the vast range of quality improvement methods primary care has left them hardly touched.[2] The reasons for this are diverse and complex. They include interprofessional differences or conflict; legitimate concerns about lack of effects, waste of resources, harms or unintended consequences of improvement initiatives; poor knowledge of newer improvement techniques; negative attitudes towards guidelines, evidence based practice, indicators and measurement; resistance to external control, judgement and accountability; and professionals' self-perceived barriers such as lack of resources, time or any of the reasons stated above.[3] In light of these barriers there remain important questions about the quality of general practice now and what can be done to improve this in future.

To mark the beginning of the new decade the King's Fund is due to report soon on an 18-month 'Inquiry into the quality of general practice in England' launched in April 2009 (www.kingsfund.org.uk/current_projects/gp_inquiry/index.html). The stated remit of the inquiry is to make a 'judgement about the quality of primary care', to 'examine how data and information in general practice can be better utilised: to measure good practice; to enable quality improvement; to suggest important areas where new measures of quality should be used and developed' and 'to make recommendations for a system of quality improvement that can be embedded into the work of general practice'.

This review is intended to move beyond the Next Stage Review[4] and the Quality and Outcomes Framework[5] and is even more relevant and timely because of the impending move to general practice (GP) consortia. As part of this review a discussion paper by Dawda and colleagues explores why quality improvement is not embedded in general practice and what needs to happen for it to be so.[6] The review focuses correctly on why many GPs do not espouse quality improvement tools and techniques and why a culture of innovation

and leadership for improvement needs to be nurtured and harnessed. Many of their conclusions are based on the authors' experience rather than research but what evidence does exist lends support to some of their recommendations.

Leadership for improvement and a culture of innovation and training in quality improvement methods are rightly seen as a prerequisite for effective implementation of quality improvement and innovation. However, these attributes are not well developed in many practices and may be slow to develop because of the context in which general practice has evolved.[2] The past two decades have seen two key policy drivers which may have shaped the behaviour and attitudes of general practice away from innovation and towards conservatism.

The first policy driver, shaped in the eighties, implemented in the nineties and established in the noughties, is that of marketisation: the purchaser–provider split, commissioning, budgets, targets and pay-for-performance are all part of the organisational essence of primary care. The second policy driver, which began in the nineties and has become more prominent in the past decade following Shipman, is that of regulation: the Care Quality Commission, the National Institute for Health and Clinical Excellence, the General Medical Council and revalidation are at the forefront of clinicians' thinking. Both of these key quality drivers can be seen, to various degrees, as encouraging conformity and consistency rather than innovation and change. Practices focusing on achievement within the Quality and Outcomes Framework (QOF) or on maintaining strong governance could have a tendency to avoid taking risks, providing resources for driving change or rewarding innovation. Indeed there is increasing evidence that initial gains from the QOF reached a plateau once targets were achieved.[7] These are system barriers which will need system-level solutions.

The move to GP commissioning consortia could have a positive effect if this were to embrace new opportunities and resources for improvement and innovation. However, it could stifle creativity and development if leaders are tied up with additional bureaucracy or weighed down by the effort needed to make the new organisations function effectively. Since few general practices or consortia will be either familiar with or using many of the available quality improvement tools and techniques, Dawda and colleagues acknowledge that this will be an educational need for them.[6] They suggest developing central support and educational teams to work with consortia and practices to nurture their improvement skills. Based on previous experience from Medical Audit Advisory Groups they recognise that a collaborative approach, balancing local ownership and external expertise,[8] might overcome the anticipated problems which have been faced by similar initiatives elsewhere.[9]

Measures for quality improvement will need to be more sophisticated than those currently being utilised in the QOF; they might be based on composite care bundles,[6] quality of decision making[10] or, as suggested by Starfield and Mangin in this issue, health outcomes.[11] These are just some of the challenges for quality improvement in the next decade.

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