Quality in Primary Care 2011;19:143–4

Editorial

Improving the quality of general practice: from cottage industry to consortia

A Niroshan Siriwardena MMedSci PhD FRCGP
Professor of Primary and Prehospital Health Care, School of Health and Social Care, University of Lincoln, Lincoln, UK

'The Brain – is wider than the Sky –
For – put them side by side –
The one the other will contain
With ease – and You – beside –'

Emily Dickinson, 1830–1886

The King's Fund recently reported on its long awaited inquiry,[1] 'Improving the quality of care in general practice'.[2] The inquiry was launched in April 2009 and its aims were ambitious and wide ranging: to examine the quality of care in general practice as it is now, to explore the data available for measuring quality and how this was being used, to set out the challenges for improving quality and to make practical recommendations for supporting improvement.

The inquiry took the form of a number of commissioned research and review papers, followed by a process of validation of the findings from these using focus groups, seminars and discussions online with subsequent work to synthesise and integrate the findings and recommendations. The inquiry took a multidimensional view of quality including factors such as patient experience, effectiveness, efficiency, equity and safety. The main findings were summarised in the final report but the main messages were also communicated in a number of digests, blogs and slides that were helpful for disseminating the findings to a wider audience.

The report authors concluded that quality of care in general practice was generally good. This was based on evidence from patient surveys and national data from a variety of sources. However, they also found variations in care with some wide variations which they presumed were unacceptable and worrying evidence of worsening quality in important aspects of care such as continuity, coordination and some elements of patient experience.

It was felt that general practitioners were often largely unaware of gaps in the care; this was because data were not provided or because they were poorly presented; information on variation was often presented with practices arranged along a continuum which meant they did not know whether they were true outliers or whether the deviation from the norm or average was acceptable ('common cause variation') or not ('special cause variation'). The authors also found gaps in measurement, i.e. current measures such as the Quality and Outcomes Framework covered only a minority (10%) of general practice activity the sheer number of different databases being used and quality indicators which were developed led to confusion; some rich sources of data, for example available from practice systems was underutilised and there was a lack of transparency of information, i.e. more data needed to be made publicly available.[3]

The report covers specific areas for improvement such as long-term conditions, acute illness, preventive health, end-of-life and maternity care, but also addresses generic aspects for development which I will consider using the model of relationships, diagnostics, management and professionalism (RDM-P).[4] Firstly referring to relationships, the report identifies communication and the quality of joint working between different professionals, agencies and sectors within and outside general practice. Secondly, diagnostics refers to problem solving at an individual and population level including improving decision making, the accuracy and timeliness of diagnosis of serious illness and needs analysis for populations. Thirdly, management concerns the organisation of primary care including speed of access, continuity and the processes for referral, communication with and coordination between the parts of the health system. Finally professionalism focuses on leadership for quality improvement and where this might come from.

The recommendations from the report focus on where efforts need to be made and what issues need to be addressed. Information gathering involving national data needs to be coordinated to prevent confusion between the different sources and databases from which quality data are derived, but data from practice systems which are currently underused should also be exploited. Quality indicators and measurements should be standardised to reduce duplication. Information

on variation should account for differences in case mix and be made more widely and transparently available to general practitioners, commissioners and other stakeholders to increase awareness of gaps in care. Finally there should be training, support, rewards and incentives for quality improvement rather than just quality or performance assessment.

The report describes the current state of quality in general practice, explaining what is known and setting out what yet needs to be done. The authors attempt to explain how this can be achieved and what needs to be done for this to succeed. There is a hope that the emerging general practice consortia together with regulators and professional bodies will take on this challenge by developing a culture of quality improvement through professional leadership, training and investment in systems for better measurement, information and improvement.

As with any inquiry of this size and scope the evidence was incomplete and unfortunately there are a number of reasons why the recommendations may be slow to lead to change. General practice and the health service more generally is at best ambivalent to the planned restructuring of the NHS, which is to some extent reflected in the current 'pause' in the process of reorganisation. The energy of the leaders involved will be focused on forming and establishing the new organisations which will inevitably reduce the headroom for work on service development and quality improvement.[5] There will be natural constraints to change include the lack of capacity, unpredictability of patient care workload, and the sheer complexity of the work of general practice.[6] Finally, for a number of reasons[1] and despite notable exceptions in some localities, the uptake of quality improvement methods as well as leadership and culture for innovation have yet to become embedded in general practice.[7]

The King's Fund report is to be welcomed. How its findings will be taken up and translated into demonstrable improvements in care will be a challenge for general practice. The scope of the endeavour is indeed 'wider than the sky' and will need vision, energy and the harnessing of many minds to provide the solutions that are required.

REFERENCES

1 Siriwardena AN. Improving primary care quality now and into the next decade. *Quality in Primary Care* 2010: 18:357–8.

2 The King's Fund. *Improving the Quality of Care in General Practice*. London: The King's Fund, 2011.

3 Gillam S and Siriwardena AN. *The Quality and Outcomes Framework: QOF transforming general practice*. Oxford: Radcliffe Publishing, 2010.

4 Norfolk T and Siriwardena AN. A unifying theory of clinical practice: Relationship, Diagnostics, Management and professionalism (RDM-p). *Quality in Primary Care* 2009:17:37–47.

5 Fulop N, Protopsaltis G, King A, Allen P, Hutchings A and Normand C. Changing organisations: a study of the context and processes of mergers of health care providers in England. *Social Science and Medicine* 2005: 60:119–30.

6 Cohen RL. Time, space and touch at work: body work and labour process (re)organisation. *Sociology of Health and Illness* 2011:33:189–205.

7 Apekey TA, McSorley G, Tilling M and Siriwardena AN. Room for improvement? Leadership, innovation culture and uptake of quality improvement methods in general practice. *Journal of Evaluation in Clinical Practice* 2011: 17:311–18.

ADDRESS FOR CORRESPONDENCE

A Niroshan Siriwardena, Professor of Primary and Pre-hospital Health Care, School of Health and Social Care, University of Lincoln, Lincoln LN6 7TS, UK. Tel: +44 (0)1522 886939; fax: +44 (0)1522 837058; email: nsiriwardena@lincoln.ac.uk