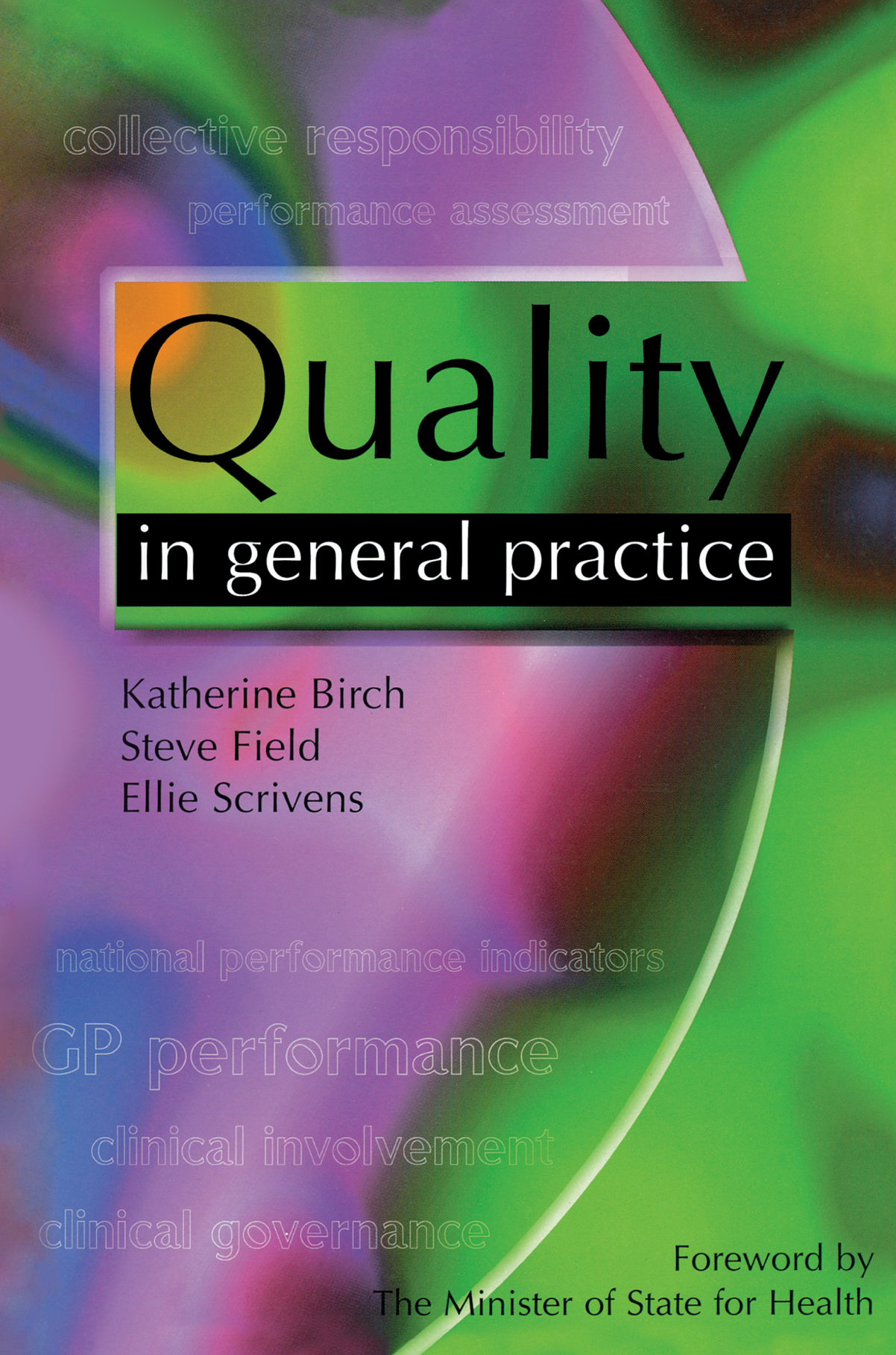
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Foreword by
The Minister of State for Health

Quality in General Practice

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Foreword

I believe that quality should be at the heart of primary healthcare. All patients who use the National Health Service are entitled to the highest quality of care regardless of where they live. Since being elected, the Government has put a great deal of effort and resources into ending the unacceptable variations in healthcare provision and into improving the quality of healthcare provided overall. The initiatives laid down in the *First Class Service* document are beginning to make an impact and the culture of clinical governance is pervading primary care.

Revalidation is on the horizon but it is important that all professionals and organisations within the NHS continue to critically examine how they provide care and develop systematic and comprehensive approaches to quality assurance now.

This book is intended to complement and reinforce the Department of Health's drive to improve quality. It discusses the key issues of quality review and performance assessment. It draws on a comprehensive national survey of all health authorities in England and Wales and provides practical examples of the breadth of quality and performance management programmes currently in use in primary care. It will provide an invaluable source of knowledge and experience to help professionals and their organisations reflect on their practice and develop a framework to improve the quality of healthcare that they provide.

John Denham MP
Minister of State for Health
June 2000

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Introduction

> *I will prescribe regimen for the good of my patients according to my ability and my judgement and never do harm to anyone.* (Hippocratic Oath)

In the constantly changing environment of healthcare and consumerism, one thing is constant – the prevailing desire to protect the patient from harm. All medical practice should, as the Hippocratic Oath states, be for the benefit of patients and, at a broader level, the fundamental *raison d'être* of the NHS is to improve the physical and mental health of the population. But how do we know if the NHS is doing a good job? How can the public be assured that those practising medicine do so to a high standard and how can those providing healthcare demonstrate that they are delivering a quality service?

Within the healthcare arena, achieving a balance between the many related components which together assure the provision of a quality service is not always easy. Indeed, owing to the demands of modern medicine and the context within which it is delivered, one can argue that it is extremely difficult for the NHS to provide a high-quality, comprehensive service – particularly at an individual practitioner level. Whilst there is a general perception that 'all [professionals] want to practice well and seek to base their decisions and care on the best possible knowledge' (Roberts 1999), there are many practical difficulties associated with this. 'It has been estimated [for example] . . . that a doctor . . .

would need to read 19 articles every single day in a year just to keep abreast with the publications' (op. cit.). However, this is only one of many pressures felt by those working within the NHS.

With the rapid technological advances that have been made within medicine there is now the prospect of delivering healthcare in new ways, transcending both institutional and geographical boundaries (Rigby 2000). The limits of medicine are continually being challenged and we have seen major advances in knowledge, expertise and in the ways in which the NHS provides care. At the same time, the general public have become much more aware of, and knowledgeable about, health issues. Information about health – whether related to lifestyle, illness or the provision of NHS services (at a national, local or individual practitioner level) – now forms a part of everyday life. Furthermore, with recent developments in telecommunications technology, people's ability to obtain global information about health issues (via the Internet, for example) has become almost limitless. This presents considerable challenges to those who deliver healthcare, since patients may use data from such sources to question decisions about their own care, without necessarily considering either the reliability of the information or its transferability to a UK context (Rigby 2000). Moreover, not only are practitioners having to respond to the opportunities and challenges brought about by new technologies, advancing knowledge and greater consumerism, but following media coverage of events such as the Bristol heart surgery cases in 1999, of the trial of Manchester GP, Dr Harold Shipman, in 2000 and of the pressures faced by an increasingly stretched NHS, there have been widespread calls for greater regulation of professional practice and improved performance of NHS services.

Reflective of the growing concerns about the provision of NHS services (Department of Health 1998a,b) and in order to demonstrate that the NHS is continuously striving to provide high-quality, accessible and effective healthcare, a range of new policies and procedures has been introduced. The Department of Health's

consultation paper *Supporting Doctors, Protecting Patients* (DoH 1999c) has put the quality of patient care and the procedures for detecting and dealing with poor clinical performance at the very heart of the health agenda. Equally, all NHS organisations have been charged with continuously monitoring and developing the quality of the care that they provide. Recent service reorganisations have created new opportunities for all those involved in primary care to deliver care focused more specifically on the needs of local populations.

How then can those involved in primary care respond to such challenges? How can providers and commissioners demonstrate that the NHS is providing a high-quality service? How can the quality of organisational and individual performance be assessed and what are the main issues surrounding performance management in healthcare?

It is important that all those within the NHS critically examine how they provide care and develop a framework for assessing and monitoring both organisational and individual performance. Whilst clinical audit and critical event analysis have been increasingly used within general practice, there is a need to develop a more systematic and comprehensive approach to quality assurance – whether at a health authority, primary care trust, primary care group or individual practitioner level.

This book outlines the key issues connected with quality review and performance assessment, and is designed to be of benefit to all those concerned with the development of primary care. Based on the results of a national study of all health authorities (HAs) in England and Wales, it provides practical examples of the range of quality and performance management programmes currently in use within general practice and identifies the key questions which need to be addressed when developing such schemes. Whilst the principal focus is that of primary or practice-based care, many of the issues relating to quality and the assessment of individual and organisational performance are applicable across the whole of the NHS.

There are two main sections to the book:

Section I: A focus on quality reviews the emerging policy themes and considers the major issues involved when assessing quality or performance within any organisation. Specifically, different perspectives concerning 'quality' are outlined and contrasting systems of review and standards for assessment discussed.

Section II: Health authority performance review systems presents the results from the national survey of HAs and has three principal elements. Chapter 4 looks at the measures which have been introduced by HAs to support poorly performing general practitioners. Chapter 5 reviews the wide variety of schemes developed to assess the quality of general practice based care and draws together the major challenges facing those involved in performance management. Following the introduction of clinical governance, Chapter 6 outlines one approach which may be used to locate quality or performance management initiatives within a wider framework.

KB, SF and ES
June 2000

SECTION I

A focus on quality

Chapter 1

The NHS

More than 50 years after its inception, the NHS is experiencing a period of unparalleled pressure. This chapter outlines the factors which together have caused many to conclude that the NHS is in 'crisis' (BBC News, 6 January 1999), and briefly reviews some of the recent policy initiatives which have been introduced in an attempt to address these.

The 'new' NHS

Within modern societies, good health and a sense of well-being have generally come to be expected attributes of modern life. The rapid advancement of medical knowledge, technological developments and the position of the medical profession within our society have led to a common belief that most health problems can be treated through medical or surgical intervention (Morgan *et al.* 1985). Public knowledge about health matters has increased and expectations about what the NHS can and should provide have risen (DoH 1998a).

Set alongside such increased demands for service provision is the ever present problem of resourcing health services. A number of co-terminous 'external' socio-demographic and economic factors and 'internal' service-orientated developments have resulted in the NHS coming under increasing pressure (*see* Box 1.1). In the light of such factors, it became increasingly evident throughout the 1980s and 1990s that a substantial re-evaluation of healthcare policy and

provision would be required (DoH 1989, 1997, 1998a,b). In response to calls for greater efficiency and improved effectiveness in the NHS, a range of service re-organisations has taken place

Box 1.1: Sources of pressure on the NHS

- Changes in population demography, whereby the average life expectancy has increased steadily throughout this century and now stands at 74.8 years for men and 80.1 years for women (1998). As a result 'elderly people (those aged 65 years and over) and, in particular, very elderly people (those aged 85 years and over) . . . continue to increase in number' (Annual Report, Chief Medical Officer, 1997).
- An increase in the prevalence of chronic diseases, disability and dependency which accompany such demographic changes.
- A reduction in the birth rate, which means that there are fewer people to look after the elderly and fewer workers to support them financially.
- Developments in clinical practice and advances in medical and information technology have led to changes in service provision (both in terms of the services provided and the mode of their delivery) and in both professional and public expectations about what the NHS can and should provide.
- Changing patterns of mortality and morbidity across all population groups.
- The persistence of inequalities in health between population groups (DHSS 1980, Acheson Report 1998) and criticisms concerning the effectiveness of NHS care.
- Increased awareness of health and healthcare issues which in turn has placed greater demands on those providing care to meet public expectations.
- Increased geographical mobility of the population and the decline of the extended family.
- Problems concerning the recruitment and retention of staff.
- A cash-limited service.

(e.g. DoH 1989, 1991, 1997, 1998a). However, it has been widely noted that 'as health care systems around the world undergo major reforms and [at the same time] resources remain limited, the quality of health care is threatened' (TPN 1998). Within the UK, for example, the development of the NHS 'internal market' and the ensuing emphasis that was placed by both purchasers and providers on aspects of contracting, such as costs and related activity, led to concerns about service quality being relegated to a poor third in terms of priorities (DoH 1998a,b, Paton *et al.* 1998).

Towards a primary care-led NHS

Throughout the 1990s there was a strategic shift in policy away from secondary care towards primary care and new ways of delivering and organising healthcare were sought. As a result, primary care – that is care predominantly provided by general practice, community nursing and psychiatric services, and the professions allied to medicine – has witnessed substantial changes to the ways in which services are organised, managed and delivered. These have included the relocation of some services away from the acute environment, the development of general practitioner fund-holding (GPFH) and the more recent introduction of primary care groups (PCGs) and primary care trusts (PCTs). Such changes have been brought about through a combination of factors. The value of supporting patients at home and providing care in a community setting has been identified as one way of alleviating the pressures on and costs of acute care, whilst from a commissioning perspective it has been argued that healthcare planning can best be achieved by those providers who are closest to patients. As a result, primary care providers have been given a much greater role in the planning and delivery of local healthcare.

Within the 'new' NHS, for example, PCGs have been established, bringing together groups of GP practices, and have been given a broad remit covering three salient areas.

- To improve the health of local population groups.
- To commission a range of services.
- To develop primary and community services.

However, as the DoH itself has previously acknowledged, giving primary care such a pivotal role is not without its problems.

> *On the one hand, advances in medical knowledge backed up by new technologies and larger teams of dedicated staff have brought new skills to primary care and increasing investment has raised both the quality and the range of services provided. Additionally, through GP fundholding and GP-led commissioning many primary healthcare teams have taken on a wider role in the provision, planning and management of services. However, such changes and opportunities have also brought pressures on the service.*
>
> *Whilst services have generally improved, the effect has been patchy and what we now see is a situation whereby some parts of the country and some groups of people continue to be less well served by the NHS than others.*

Equally, inequalities in health remain, and this holds true between different population groups (according to social class, gender and race) and between different locations (inner city and rural, north and south). Despite a range of policies which have sought to address the prevalence of health inequalities, these trends show no sign of abating (Acheson 1998).

Such disparity in the health status of the population and in the nature of service provision is problematic to a government committed to promoting good health and to ensuring equity of standards and access to healthcare services.

Focusing on quality

The Labour government has sought to place quality firmly at the heart of healthcare policy and practice. Moving away from a

competitive, 'market-driven' model, with its overriding concern with costs and activity, a spirit of greater collaboration, openness and fairness has been encouraged.

Underlying and informing all relationships must be a fundamental shift in culture and behaviour away from the adversarial approach of the internal market.

(NACGP 1997)

The Department of Health has reaffirmed the need for uniformity of standards throughout the *whole* of primary care, stating that 'services should not vary widely in range or quality in different parts of the country' (DoH 1997). The new emphasis:

> *shifts the focus onto quality of care so that excellence is guaranteed to all patients, and quality becomes the driving force for decision making at every level of the service . . . the new approach aims to improve standards of performance across the NHS.* (DoH 1998a)

It is envisaged that the way to achieving improved standards of service delivery is that of:

> *comparing performance and sharing best practice – not by financial competition between different parts of the service . . . the pursuit of quality and efficiency must go together if the NHS is to deliver the best for patients.* (DoH 1998a)

Such a reorientation of policy reflects a number of factors. Not only is the NHS having to respond to ever-increasing demographic and resource pressures, but within a wider context greater accountability and performance management have been called for throughout the whole of the public sector. PCGs, for example, are expected to have:

> *a rolling annual programme of action covering its three main functions (improving health and cutting*

> *health inequalities, commissioning services and developing primary and community services), so that by 2002 all PCGs and primary care trusts are delivering* ***measurable*** *improvements against their locally agreed milestones and targets.* (DoH 1998a)

For those working within primary or practice-based care, this extended role and the emphasis which has been placed on monitoring the quality of NHS care, brings with it the prospect of significant changes to their pattern and orientation of work. For example:

- there will be greater accountability and increased assessment of performance
- performance will be assessed, in part, in terms of quantifiable health gain across population/disease groups
- professionals will be required to demonstrate that they have undertaken programmes which ensure continuing professional development
- there will be a greater emphasis placed on evidence-based practice
- assessment of local health needs will play a major role in shaping local services, which in turn may lead to a development in the range and type of services provided within the practice
- there will be a greater focus on patient evaluation
- good communication across the whole of the practice team will be of paramount importance
- changing service configurations and the introduction of new technology into the healthcare environment may lead to shifting patterns of work.

In promoting and developing the quality of care provided, particularly within a controlled budget, certain measures of monitoring quality are required. Historically, both those responsible for

purchasing or commissioning services and those responsible for providing healthcare have sought to define what is meant by 'quality' and have introduced ways to monitor and assess the standards of care provided and have developed strategies to improve service quality. Whilst the desire to promote the quality or performance of services is commendable, the emergence of a plethora of locally derived schemes with varying definitions of 'quality', foci, methodologies and outcome measures is problematic to a government committed to ensuring uniformity of standards throughout the NHS.

> *Considerable resources are being directed at the process of monitoring, and as each authority undertakes this activity independently, each is finding different solutions. Not only does this consume . . . resources, it also defects the quest for equity in quality which might be expected within a national health service.* (Scrivens 1995)

In striving to develop a more standardised approach to monitoring and developing the quality of care, a range of measures has been introduced. At a national level, legislation has been passed concerning standards of GP performance (the Medical Performance Act 1997) and several polices have been introduced which specifically relate to the performance management and quality assessment processes within the whole of the NHS. At a local level, HAs (together with representatives from other relevant bodies) are having to develop policies and procedures which address poor GP performance and PCGs also have a responsibility to review and develop the quality of primary care.

New legislation and new methods of assessing performance

Under the 1997 Medical (Professional Performance) Act, HAs are now able to refer cases of sub-standard medical performance to the