

Standards in general practice: the quality initiative revisited

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Introduction

IN 1983 the Council of the Royal College of General Practitioners launched its quality initiative¹ with the following aims: (1) each general practitioner should describe his or her work and should be able to say what services his or her practice provides for patients and; (2) each general practitioner should define specific objectives for the care of his or her patients and should monitor the extent to which these objectives are met.

In achieving the second aim, the Council said that performance review — here synonymous with clinical audit — should become part of everyday clinical practice. The initiative should be implemented in every general practice in the UK within 10 years.

Background

Five important reasons for the initiative were given in the Council debate and briefing paper:²

- There seemed to be a substantial tail of poor patient care in general practice. Previous attempts by the RCGP and the General Medical Services Committee, successive governments and the Royal Commission on the NHS³ to solve the problem had failed.

- To help solve this problem, and to promote and maintain high standards overall, Council believed that general practitioners must be willing and able to assess their own clinical performance. Self assessment was regarded as a fundamental attribute of a professional person and as the basis for personal professional development. Similarly, peer assessment was seen as the foundation of professional self regulation.

- Council sensed that the public was seeking greater accountability from people in all professions, industry and the public services. Medicine would be no exception to this societal change and would have to respond either voluntarily or under pressure from parliament, a view reflected by Professor Ian Kennedy in his 1980 Reith lectures.⁴

- General practitioners would also have to become more accountable in future. Given this, Council held that such accountability, especially clinical accountability, should be primarily to a doctor's peers and patients rather than to NHS management.

- In a health service in which competition for resources had long become a reality, it was essential that in future each general practice should be able to relate its services to the needs and expectations of people registered with it, to secure appropriate funding.

Recent events

How does the quality initiative, and the reasoning behind it, look today on the eve of the government's new contract for general practitioners?

On the positive side, successive Councils of the RCGP have described their vision of the way forward for general practice,^{5,6}

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emphasizing good quality patient care based on more clearly defined services, teamwork, effective practice management, and appropriate education and performance review for all team members. Various methods for assessing performance have evolved — of which more later — together with the standards described in the RCGP's clinical folders. A heartening number of RCGP members responded to the quality initiative by carrying out personal practice audits (RCGP Council, *Quality initiative 1984–86*, unpublished report, 1986) and some reported their results through the *Quality in practice* bulletins.

These constructive developments, and the positive attitude to clinical audit taken by the conference of representatives of local medical committees, have demonstrated a growing acceptance among general practitioners of the need for practice standards and performance review.^{7,8} However, they have to be set against the continuing difficulty that general practice as a specialty still seems to have in ensuring that all general practitioners subscribe to certain basic standards of care and that all practices hold themselves accountable for maintaining these.

It is likely that it was this perceived weakness that was the decisive factor in prompting the public, through government, to act. Successive green and white papers relating to general practice have had a common overall theme, that is to increase the accountability of general practitioners.^{9–11} This aim has commanded broad public and parliamentary support.¹² Political arguments have centred on the means of achieving it.

What can we learn from all this? The key question for the future is exactly how greater accountability is to be exercised. A balance has to be struck between measures operated by the profession — self regulation — and measures required by contract. If the profession provides effective self-regulation then only a loose enabling contractual framework would be necessary; conversely, the less effective self-regulation is, the tighter the controls, including some clinical controls, that would be operated through the contract. The 1990 contract, with its specific clinical directions on some aspects of prescribing and anticipatory care,¹³ has shown what happens when the profession appears to leave a vacuum.

The quality initiative and practice management

Given this background it has now become more clear why we should indeed be able to describe the work and services of our practices, the first aim of the quality initiative. Ideally, we should know the health status of our patients, what they need and want, and the extent to which our services meet these. It is from such a baseline of current experience that we can set our priorities for care, define our standards and assess our performance. We would also be better placed to identify the appropriate clinical knowledge and skills required for effective practice.

Good patient care is thus becoming increasingly dependent on our having the organization, management skills and data generating information technology in our practices which, in combination, can best ensure that the right care is given to the right people in the right place at the right time. Good care today means planned care, especially for patients with chronic illness and for promoting health and preventive medicine, but also for handling acute illness adequately. Planned care requires effective teamwork, especially when several carers in a practice — nurses as well as doctors — are looking after the same patient. It also requires good data for informed decision making, especially in determining objectives and priorities for care, in

setting standards and in assessing the performance of individual members of the practice team. This is why the modern general practice is inevitably evolving as a managed system of primary health care in which its functions and responsibilities in its local community are clearly defined and understood by all.

Let me illustrate from my own experience. My partners and I want to try and define, with our local community through the family practitioner committee, just what range and quality of service our patients need and want from us. We want to identify aspects of our patient care for which explicit standards can be set and to adopt implicit standards — based on judgement — where precise definition is not possible. We feel we should be prepared to justify our performance against such standards. This we could see as the basis of our contract in future, a contract subject to periodic review. We would expect to be judged by our results; and given this, we would not expect to be told in detail by government how we are to achieve them — as the 1990 contract tends to do.

The overall purpose of our practice described in our five year development plan (Lintonville Medical Group, unpublished report, 1989) is 'to provide services for patients which always reflect, and whenever possible are on the leading edge of, the latest clinical, technological, organizational, social and economic advances in primary health care.' We have reconstituted the partnership as a board of management and have brought in (and bought in) new management skills. We have the following aims: to set clear objectives and priorities for patient care based on explicitly identified health needs; to develop standards for patient care and to monitor performance against these; to use measures for assessing the effectiveness (or outcomes) of care where these are available and; to develop the means of determining unit costs.

The first three of these reflect the aims of the quality initiative. We have added the fourth aim, that is knowing what care costs, because we think that the responsible use of taxpayers' money — value for money within clearly defined standards for patient care — can be another important indicator of quality.

Standards and performance

Within the framework of quality assessment and practice management, we can now consider the main methods of standard setting and performance review in use today.

Practice visiting

In general practice the best developed system for setting standards and assessing performance is operated by the Joint Committee on Postgraduate Training for General Practice and the regional postgraduate organizations providing vocational training. In the early years the national and regional criteria (standards) for selecting trainers emphasized the structural features of a practice such as the standard of the practice premises and the adequacy of clinical and office equipment. The emphasis now is on the process of care and the teaching offered. There are, for example, explicit standards for record keeping; and there are implicit standards for prescribing. Compliance with such standards is monitored by the regional postgraduate organizations through practice visiting.

In the Northern region we have just taken the standard setting process a stage further by adopting a personalized agreement for teaching services.¹⁴ In this, individual teaching practices and the regional education committee for general practice agree certain standards for a given period of appointment, against which subsequent performance is assessed. At the time of the review, trainers are asked to submit appropriate data on performance which is then considered on the practice visit which follows. The visits, which usually last for half a day, are carried out by a team comprising one nominee each from the ap-

propriate local medical committee and RCGP faculty led by a regional associate adviser. Subsequently, the practice profile and visitor's report are made available to the trainer appointments committee.

The visiting method has been refined. For example, the 'What sort of doctor?' approach¹⁵ comprises peer group inspection by a visiting team using a structured grid to assess four areas considered to be indicative of performance: professional values, accessibility, clinical competence, and ability to communicate. The latest refinement, offering a very testing appraisal indeed, was introduced by the College in 1989 for assessing potential fellows (RCGP, June 1989 Council meeting, unpublished minutes).

Experience with teaching practices has shown that performance review has to be both internal — by practitioners and their local peers — and external — by doctors from outside the immediate area. Before a visit takes place, it is important to distinguish whether the purpose is essentially educational or whether it is official, in this instance to do with the doctor's appointment as a trainer. In the first situation practices can let their hair down, and show all; in the second, the visit should be conducted with more circumspection because it is about the trainer's contract. Another helpful finding is that experienced visiting practitioners can and do make judgements about those aspects of general practice which cannot be quantified or measured numerically. This is important; we could be in danger otherwise of concentrating only on those aspects of patient care which are measurable, at the expense of qualities which are not.

Practice activity analysis

Practice activity analysis is a descriptive appraisal of what happens in a practice between doctors, practice team and patients. Practitioners have undertaken audits of practice activity on many clinical and operational aspects of care. These mini studies may be retrospective or prospective examinations of care given, and they form a basis for comparison with other practices.

In the mid 1970s the RCGP offered its members a service in which practices recorded routine data on such variables as home visiting¹⁶ and hospital referrals.¹⁷ These data were collected, collated and analysed by the RCGP Birmingham Research Unit, which then gave the doctor personal feedback, relating the individual's performance to the range of performance demonstrated by colleagues. Although this service has now lapsed, the principle of feedback is still as relevant as ever, and will need to be taken up again by the new medical audit advisory groups.

The NHS provides a similar service to all practitioners by giving feedback data on prescribing patterns and costs via 'PACT'. The question now is how these data should be integrated into clinical audit.

Confidential case analysis

Random case analysis, using patient records and videotapes, is an established and popular part of teaching and learning in general practice and an accepted way of reviewing standards.

On the other hand, it is unusual for practices to enquire routinely into cases where there has been an obvious failure in clinical care. Yet here is a method which, if used within the privacy of a practice, could yield substantial benefits for patients by improving practice procedures. We can all think of cases. For example, there may have been a delay in diagnosis or an important diagnosis may have been missed, with potentially damaging consequences for the patient. Or there may have been complaints from patients about waiting times, missed calls or perhaps a breakdown in communication between one or more team members. We can all learn from the uncomfortable lessons which emerge from a careful review of a situation in which we have been personally involved. The method is worth exploring, and

the exploration would need to consider the impact of this form of performance review on the doctor-patient relationship, on the ways in which confidentiality should be handled, and on the medicolegal and contractual implications. Practices which feel confident enough to review their performance in this way may also consider allowing their results to be collected and collated in an anonymous form, rather as the surgeons and anaesthetists are doing for perioperative deaths.¹⁸

Clinical standard setting

Some groups of general practitioners are producing clinical standards for use within their own practices.^{19,20} In the Northern region, for example, general practitioners, trainers, paediatricians and health care research workers — as well as 75 000 children and their parents — have been collaborating on a study of standard setting and performance review in 65 teaching practices.²¹ The trainers have been working together in groups to construct clinical standards for common symptoms in childhood and have been estimating the effect of these standards on their clinical performance.

No one should expect a clinician to follow slavishly a working clinical standard when dealing with an individual patient; the doctor still has to exercise clinical judgement. Nevertheless, where a standard of good practice has been agreed, the doctor or nurse should always be prepared to justify significant departures from this to other colleagues in the primary health care team.

Surveys of patient outcome satisfaction

Direct evidence of patient satisfaction is collected only rarely. However, an indication of the outcomes of care and patient satisfaction can be obtained from patients using questionnaires, interviews, or a combination of both. For example, in the North of England study²¹ we had response rates from the parents of the children involved of well over 80%, suggesting that patients are interested in this type of appraisal.

Data of this type should influence practice standards by providing valuable feedback from patients, especially on such important aspects of a practice's care as kindness, a sympathetic attitude, listening to what patients say, making time for patients, ease of access to the practice team, and the atmosphere and comfort of the building. These are all aspects of a doctor's performance of which I think patients are the best judges.

The benefits of standard setting

What are the benefits of standard setting and performance review? I have emphasized the main purpose, that is improving patient care. However, there are other benefits. For example, standard setting is educational. If done well, everyone concerned has to think hard about what they are really trying to achieve and why, and this cannot be done without reviewing the current literature and considering the work of colleagues. Formulating clinical standards should also promote teamwork through the sense of shared ownership and the strength of shared objectives for patient care. Having clear and unambiguous aims should help reduce the possibility of misunderstanding within a practice and increase the likelihood that all team members will achieve their objectives for care. Making standards explicit in this way should encourage high performance in the well motivated, lead to incremental improvement in the practice overall, and so enhance morale among the practice team and satisfaction among patients.

Outside the practice there is a strong probability that standard setting will facilitate inter-practice and practice-hospital understanding, and so lead to greater consistency of care.

In conclusion

So, what can we say now about the quality initiative? We have

come a long way in seven years. First and foremost, it has helped to concentrate our minds on the question of quality in general practice. As a result the very idea of incorporating quality assurance into everyday practice, once feared or dismissed as the dotty idea of a few enthusiasts, is now broadly accepted by the profession. The debate has moved on; it is no longer about whether we should do these things, but how.

There has been one hard lesson. We have discovered, through our experience with deputizing, the limited list, performance related pay, and the proposed extension of audit to include all practices, that government means what it says about tightening up on our accountability for patient care. We have seen that, when professional self-regulation is found wanting by the public, government will apply contractual controls.

I have concentrated quite deliberately on the practice as the focal point for assuring quality. The more that we question ourselves the less need there will be for others to intervene. Practices which can show and justify the results of their work have nothing to fear from outside scrutiny because good results speak for themselves. When we reach the 1993 target date which the RCGP set for implementing the principles of the quality initiative in every practice, we should find that the majority of general practitioners will want and will be able to give a good account of their stewardship of their patients' health.

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