From cottage industry to post-industrial care?

The RCGP response to the King's Fund report on the quality of care in general practice

INTRODUCTION

'Most of the care provided by general practice is good ... however, there are variations in performance and some quality gaps which need to be addressed ...'

With these words, the King's Fund report sets out the challenge for general practice in the 21st century.¹ This report is a product of an independent inquiry and represents the most extensive examination of quality in general practice for many years.

In his foreword, Sir Ian Kennedy describes general practice as 'not given to self-reflection and self-challenge'. Little evidence is provided for this contention. General practice has been at the forefront of the profession in promoting reflective practice as part of its specialist training programmes. General practice was an early adopter of clinical audit and significant event analysis to improve clinical care.² Not for the first time, preconceived ideas about general practice have run ahead of the evidence, and such assertions should not go unchallenged!

The recommendations of the report have been categorised into five key themes as the basis for the Royal College of General Practitioners' (RCGPs') response.

CREATING A CULTURE OF QUALITY IMPROVEMENT

General practice must 'own' the quality agenda and provide effective clinical leadership. College members are encouraged to consider professional leadership roles over the course of their careers and the RCGP is committed to providing opportunities to support them.³ The RCGP Leadership Programme helps GPs develop skills in thinking strategically, leading, persuading, and challenging colleagues, and working collaboratively.

Awareness must be developed among GPs and their colleagues of the extent of the variation in clinical practice and the 'gaps' in quality. Quality improvement needs to be understood as a key component of the 'core business' of general practice. All professionals must be more open to scrutiny by their peers and by their patients, and quality data from practices should be widely available.

The RCGP has developed a range of initiatives to drive up quality in practice. The Quality in Practice Award is a criterion-

based quality-accreditation process undertaken by primary care teams to improve patient care by encouraging and supporting practices to deliver the highest-quality care to their patients.⁴ The RCGP Practice Accreditation Scheme is a voluntary scheme that assesses practices on the non-clinical aspects of care in six domains: health inequalities and health promotion; provider management; premises, records, equipment, devices, and medicines management; provider teams; learning organisation; and the patient and carer experience.

Quality of care is central to the requirements for revalidation. The recent RCGP *Guide to the Revalidation of General Practitioners*, supported by the Revalidation ePortfolio, contains proposals for the essential processes and standards for revalidation.⁵ The RCGP awards programme offers a number of quality awards to GPs, practices, and teams, which include GP of the Year, Caring for Carers Awards, Practice Team of the Year Award, and the Disability Care Award.

DEVELOPING APPROPRIATE MEASURES OF QUALITY IN GENERAL PRACTICE

Some aspects of quality cannot be captured easily by national measurement initiatives or by existing quality standards. There is a need to develop other approaches to quality, such as practice audits, which will be more applicable to dimensions of quality such as continuity of care and the therapeutic relationship.

College initiatives in evaluating the quality of clinical practice include the RCGP Peer Review Audit Programme launched in December 2010,⁶ in which College members are invited to submit their audits for peer review and comment, in preparation for their revalidation portfolio. At national level, the College is engaged in a number of audits, such as the multisite safeguarding audit, which examines how GPs contribute to cases where social

services are involved and reviews the structures and processes in place in primary care.

The recent statement on continuity of care makes a number of recommendations for policy makers, managers, commissioners, and practices and asks how quality can be improved with the withdrawal of many GPs from out-of-hours services.⁷ The College has made a large contribution to the development of indicators for the Quality and Outcomes Framework. The Essence of General Practice project initiated by RCGP Scotland looked critically at contractual and educational developments in UK practice. The underlying concern of this project was that the focus on measurable activities in the (at the time) new general medical services contract would lead to the 'loss of something important' but 'hard to measure' in general practice.⁸ Indeed, the current College position statement on quality indicators recommends that they should allow comparisons between practices and motivate change, as well as ensuring accountability and identifying unacceptable performance.⁹

HELPING TO ENSURE THAT RECOMMENDED STANDARDS OF CARE ARE MET

Much work is under way to develop initiatives that help GPs to know whether they are meeting quality standards. For example, the *Coding, Classification And Diagnosis Of Diabetes* report, produced by the RCGP and NHS Diabetes, provides advice and support to all clinicians in the diagnosis of diabetes, as well as providing free downloadable practice audit tools to aid accurate diagnosis.¹⁰ The College guidance on the use of substitute prescribing in opiate dependence in primary care is intended to aid primary care clinicians and others when prescribing for maintenance or detoxification.¹¹

However, the College has no regulatory function and is primarily responsible for

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setting professional standards in general practice. It has a key role in supporting practices and members to identify and meet their educational needs through the provision of resources and opportunities for continuing professional development. This is particularly important in practices that are struggling to manage demand and require additional support. The GP's role has become much more complex, with increasing specialisation within larger practices: GPs with a specialist interest (GPwSIs) now make up 16% of all GPs in the UK, and this brings its own challenges to the quality arena. Big, however, is not necessarily better as there are also many examples of excellent care provided by small practices. A practice of two partners and two locum doctors, for example, was awarded the RCGP's prestigious Quality Practice Award for 2011.

Undergraduate medical teaching is organised through university departments of general practice, which attach students to practices within their region: approximately one-third of all general practices in the UK are engaged in undergraduate teaching.¹² This represents both a challenge and an opportunity for general practice. Early student clinical experience needs to be of high quality, not only for reasons of patient care but also because a good experience of general practice is more likely to translate into a choice of general practice for subsequent specialty training.

INCREASING COLLABORATION ACROSS TEAMS AND SETTINGS

The RCGP has long recognised the importance of collaboration and delivering integrated care. The RCGP concept of federations is one of the main models put forward in the report for addressing this key component of the quality agenda. It recognises the potential advantages of cross-practice working, and the creation of federations of practices has been promoted since the publication of the roadmap document in 2008.^{13,14}

RCGP Wales has recently published a document on the central role of general

practice in the evolving health service, which recognises the need for closer collaboration between primary care and other parts of the health service, social services, housing, and educational services.¹⁵

The Living Better project from RCGP Scotland recognises the importance of multidisciplinary teams in improving the mental health and wellbeing of people with diabetes and other chronic health problems. A working party of the RCGP, Royal College of Physicians (RCP), and Royal College of Paediatrics and Child Health produced the *Teams Without Walls* report,¹⁶ which highlights the fact that patients with long-term conditions move between primary and secondary care at different times in their lives, and as they get older and more unwell these moves become more frequent and complex, requiring ever closer collaboration between primary and secondary care. The recently published RCGP document *Care Planning: Improving The Lives Of People With Long Term Conditions* provides practical guidance for primary healthcare teams.¹⁷ The recent joint statement from the RCGP and RCP, *Making The Best Use Of Doctors' Skills: A Balanced Partnership*, sets out how a specialist and generalist can work together to improve the quality of care for patients in the NHS.¹⁸

The RCGP Patient Partnership Group has been instrumental in producing the RCGP patient information leaflet, *It's Your Practice*, and collaborates with the National Association of Patient Partnerships, which helps patients to set up patient partnership groups.¹⁹ The new RCGP online course, *Commissioning: Improving Patient Journeys*, has been launched on the RCGP online learning environment.²⁰ The College has also created a 10-point plan to help patients navigate their way through the 'maze' of out-of-hours services, and has recently launched a patients' charter on end-of-life care.²¹

Over 1200 GPs and practice managers have now attended the Achieving a Responsive Practice workshops to help practices become more responsive to patients' needs.²² Finally, the RCGP General

Practice Foundation has been developed as a pioneering way of engaging members of the whole practice team — nurses, managers, and physician assistants — with the work of the College.²³

DEVELOPING DATA STANDARDS AND ENABLING DATA TO BE SHARED

General practice has been at the forefront of developments in electronic health records, but data standards and management in primary care need to be improved to allow meaningful comparisons. Better use of data will be needed, to identify the health and social care needs of registered populations and to meet the challenges of commissioning. The RCGP Health Informatics Group provides advice on data management and technology, and has produced a range of papers and policy statements in this area.²⁴ The RCGP Shared Record Professional Guidance project has developed a set of professionally-led guidelines that considers the governance, medicolegal, and patient-safety consequences of shared electronic patient record systems. The College has also published *Towards Consensus For Best Practice: Use Of Patient Records From General Practice For Research* with the Wellcome Trust and the British Medical Association, which provides a quality framework for the sharing of data between practices and researchers.²⁵

FROM COTTAGE INDUSTRY TO POST-INDUSTRIAL CARE?

The King's Fund report describes 'post industrial care' as comprising three key elements: standardising care, measuring performance, and transparent reporting.²⁶ The aim is to eliminate unwarranted clinical variation, waste, and error. However, general practice has come a very long way since it could be truly described as a 'cottage industry', and the advent of clinical commissioning groups will encourage further improvements in quality of care. Some of the quality indicators for aspects of care particularly valued by patients, such as continuity and the therapeutic potential of the relationship between doctor and patient — essential components of general practice — remain undefined, and the danger of metric-driven quality initiatives is that they will create an increasing focus on the 'measurable' rather than the important.

Generalism lies at the heart of the future of the NHS and the system needs to value this. The RCGP and the Health Foundation recently set up a Commission on

Generalism in Medicine to consider how this might be enhanced alongside the development of specialism. A resulting report,²⁷ published in October 2011, raises questions about the concept of generalism and the role of the GP in today's health service, as well as making recommendations for developing and strengthening medical generalism to deliver effective patient care in the NHS of the future.

Although the King's Fund report emphasises variation in performance as well as some 'gaps' in quality, most of the care provided by general practice is good. This fact has received insufficient recognition and it is now time to accelerate the work to develop the RCGP model of

federations, and to ensure that isolated practices are brought more formally into larger provider organisations or networks, essential in the context of GP commissioning. There is a wealth of evidence that, despite the assertions in the report, general practice is, in fact, given to self-reflection and self-challenge and has been for many years; the College has provided leadership in all aspects of supporting GPs to improve patient care. However, the King's Fund has performed a useful service in reminding us that the majority of GPs provide a good quality of care to their patients and that quality improvement should continue to be an essential component of our 'core business' as GPs in the 21st century.

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Provenance

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