

Capturing general practice quality:

a new paradigm?

THE CONCEPT OF QUALITY

While overwhelmingly quality is presented by policymakers as measurable and as meeting predefined top-down targets, we argue that quality in general practice is multiform and multifaceted. Quality is a notion that is hugely difficult to pin down in all its richness and complexity and countless attempts have been made at defining quality in health care. Definitions range from the more concrete (quality as access and effectiveness for instance,¹) to the abstract (quality as purely a social construct rather than an objective entity²). Therefore, there exists a clear challenge of unifying the practical realities of general practice with subjective norms into one concept.

MONITORING BY NUMBERS

The coalition government's agenda preaches values of openness and transparency through improved information capture to raise the quality of patient care.³ The type of information favoured for this purpose tends to take a numerical form, usually lending itself more quickly and readily to comparisons across services and strategic decision making than its 'softer' qualitative counterparts. The dominant method of data facilitation in general practice is of course the Quality and Outcomes Framework (QOF), which has been with us since the introduction of the new general medical services (nGMS) contract in 2004. There is no doubt that measurement plays a key part in enabling focused quality improvement initiatives, for instance by identifying need in specific patient populations, and on a wider-level is likely to be a valuable tool in supporting commissioning decisions. QOF monitoring has also resulted in the creation of the largest general practice database in the world, prompting research around processes and outputs and their relationship to outcomes in general practice.

However, increasingly, monitoring is viewed as instrumental to quantifying quality. In the face of austerity, top down monitoring feeds into wider aims of justifying spending, delivering tax-payer value, and continued growth in productivity. It could be argued that all of these policy aims have become ingrained as NHS values no less, introduced into the public sector by Margaret Thatcher with the advent of market incentives to improve the

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efficiency of public services.⁴ We are all too aware that the policy rhetoric of raising general practice quality through data submission has been wholly embraced by successive governments. Yet, it is likely that instinctively this view feels rather short-sighted to those 'at the coalface' of general practice. Bold policy aims such as the implementation of 'a more comprehensive, transparent and sustainable structure of payment for performance' where 'funding should follow the registered patient, on a weighted capitation model, adjusted for quality'³ appear to ignore the complexity of quality in general practice.

Increased monitoring poses a further challenge for quality capture. The resulting bureaucracy and a feeling of being 'watched' can lead to GPs' sense of professionalism being undermined. It is not a new point of view that potentially reducing patient care to a 'pay for reporting' approach⁵ can be demotivating and even reduce quality in non-incentivised areas. There is a further risk that data capture through monitoring is no longer simply a tool for improving the measurable, but becomes an end in itself, superseding its original purpose. This view is likely to resonate with the thousands of GPs across the country as they chase elusive QOF points come the end of the financial year.

THE PARADOX OF QUALITY IMPROVEMENT

Nevertheless, Lord Darzi⁶ claimed that 'we can only be sure to improve what we can actually measure' and here we face the key paradox of quality measurement. Usable definitions pertaining to process and output tend to reduce quality down to just that. In policy rhetoric, high general

practice quality has become synonymous with high QOF scores. Yet, quality lies also beyond this, in facets of general practice that can never be fully reduced down into measurable indicators such as rapport, patient-centredness, kindness (that value described as the 'most curative herb' by Nietzsche); those human dynamics of a consultation that make general practice the hub of the community that it serves. In fact, reflecting even on the four basic principles of medical ethics, autonomy, justice, beneficence and non-maleficence, suggests that what lies at the core of high quality care is greater than that which can be captured through measurable indicators. This is clearly one of the challenges for new clinical commissioning groups (CCGs). While it is claimed that by placing the GP at the centre of local decision making we can work towards true quality, it is simultaneously of great importance that a reductionist approach, despite easily lending itself to policy creation, does not overshadow the finer aspects of what it means to deliver quality in general practice.

Our own ethnographic research exploring the reality of practices labelled as 'poor performing' by the QOF (M Kordowicz & M Ashworth, unpublished data, 2013), suggests that top-down target frameworks based on an arguably limited definition of what constitutes quality are only a partial lens through which to view general practice. However, in ways that QOF can never truly capture, these practices had intrinsic flaws with their organisational practices and knowledge of IT systems, problems with teamwork, and burnt-out GPs who are out of touch with recent professional guidance. They had evolved into chaotic organisations, unable to adapt to new practices,

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particularly in the face of a challenging deprived patient population. They were poorly performing in both quantitative measures and in terms of the three core values described by Marshall: excellence as medical generalists, commitment to whole person care, and patient advocacy.⁷ Yet, even more strikingly, we have met GPs whose low QOF scores are often the result of an outright rejection of the Framework, and they proudly continue to be exemplars of the four principles of ethical medical care within their communities. It is not inconceivable that GPs who do not prioritise achieving high QOF scores are able to remain outstanding holistic practitioners, central to preserving what their patients perceive to be high quality care. The danger of continuously producing a reductionist picture of general practice quality is real. We need to be clear that this is because the two models of understanding quality, the measurable on the one hand and the qualitative on the other, run in parallel rather than in conjunction with one another.

TOWARDS A NEW PARADIGM

This raises the question of whether the time has come for a new enhanced model for understanding general practice quality. Undoubtedly, the focus on metrics has resulted in a demonstration of primary care exceeding expectations and able to deliver far more than anyone expected when the QOF was originally introduced. However, metrics distort the very activity that is being measured, producing contortions, sometimes extreme, as targets are at risk of becoming prioritised over patient care. It is not that targets are inherently misguided, nor inevitably de-professionalising, nor worse still, unethical. Rather, it is more the case that targets have become the sole arbitrator of quality with no countervailing model for articulating alternative definitions. We would argue that the qualitative needs to be put back into quality.

What is needed now is research that generates robust qualitative concepts of quality enabling the essence of excellence to be captured more clearly. The four principles of medical ethics may well be a useful starting point. Then for these concepts of quality to be tested on

professionals, patients, and health service managers alike until a consensus emerges of the key domains or components of quality. CCGs should develop a strategy for recognising and preserving the excellence within their practices which remains outside the breadth of current metrics. The College's *Good Medical Practice for General Practitioners*⁸ was one of the first publications to define 'excellence' within primary care. The original concepts have remained relatively static since and many could be developed into criteria which GPs may consider to be more closely aligned to shared professional values than current quantitative metrics.

In the model which we propose, quantitative indicators will have a central role both to define minimum acceptable standards but also to offer 'stretch targets' rewarding practices for exceptional achievements. However, these will be balanced by the development of qualitative quality indicators primarily focusing on excellence and more clearly capturing the narrative of a primary care which so often goes the extra mile, and beyond. However, it needs to be recognised that to develop a qualitative insight, more time and resources are needed to capture general practice quality in all its richness and complexity. Furthermore, quality is a self-evolving, fluid concept and as such, indicators have to allow for continuous adaptation. It is a tall order, but undoubtedly one that gives due recognition to the true values at the core of high quality general practice.

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