Primary care quality improvement

A positive response to external factors

A. HUTCHINSON

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Abstract Although general practitioners and other primary care practitioners have concentrated on quality improvement projects generated from within organisations, there are many other external factors which can have a positive influence on quality of care. Three examples of British quality improvement projects are used to demonstrate the extent and the impact of influences on primary care, varying from national policy to the opinions of hospital doctors. Each of the projects required external stimulus to generate the motivation and collaboration to produce a result. The effect of the projects is discussed in the light of the many pressures on primary care to deliver a quality product. Experience in one country is seen as indicative of what might be possible in many developed primary health care systems.

Prof. A. Hutchinson, FRCGP, MFPHM, Department of Public Health Medicine, University of Hull, Hull HU6 7RX, United Kingdom.

Introduction

Recent reviews of quality assurance in general practice[1] and more generally of European health systems[2,3] have pointed out the changing environment in which primary care must operate. In many countries, value-for-money is a principle being enforced by policy makers, with general practitioners acting as gatekeepers to secondary care, often with devolved budgets.

Because primary care has been much concerned with improving standards within the profession, there has been a tendency to focus inwards on quality issues. That is, rather than look to the many other impacts of the quality environment which can be used as a positive force for change, there is a trend towards trying to set the profession's own house in order first. Many general practitioners will see this as a sensible first step. If there is a substantial task to be undertaken in quality improvement within general practice and primary care, concentrating effort in that area may be both effective and efficient.

Yet there is also a need to be aware of the opportunities which are arising outside of primary care, in health services evolution in both the developed and developing world. For although the structure and process of health care systems vary from country to country and direct comparison is often not possible, many of the influences on primary care are common.

By drawing on some recent examples from UK general practice, this paper aims to show that the external quality influences which are often either ignored or viewed negatively can actually be used to enhance the process and the result of primary care quality improvement.

Those clinicians who have been at the front line of change will often relate how difficult and complex a task it has been to respond to the pressures. For instance, changes resulting from reforms in the British National Health Service have led to quality influences from at least five important directions. These influences have come in the fields of policy making, finance, service management, health care commissioning and professional development.

For example, as a part of the NHS changes, and overall as an element of broader Government policy, the Departments of Health have published a document entitled 'The Patient's Charter – and family doctor services' which sets out for patients a list of explicit standards of care and service relating to the functioning of the family doctor services. The *box* on page 459 gives some examples from the charter. While both doctors and patient organisations remain sceptical as to the value of such external standards, nevertheless each household in England and Wales has been provided with a copy. Policy makers intend to make both patients and clinicians quality sensitive. One effect seems to be a sharp rise in the number of complaints against family doctors.

Financial policy is also having an effect on quality improvement in primary care through the mechanism of competition. In particular, the experiences of general practitioners of having a devolved budget through fundholding is now beginning to result in real competition; not just old-fashioned 'poaching' of patients, but real concerns for the viability of the business.

Competition between doctors is already well established in some European countries. While it is difficult to find evidence that this has led to an improvement of quality in those countries (although it has probably caused an increase in cost), anecdotal evidence from General Practice Fundholders suggests that competition has brought a focus on quality. The effects have been two-fold. Within the practice, doctors holding funds have often felt a need to be more sensitive to patients' wishes in terms of service quality. Outside of the practice, fundholders have been involved in trying to buy better or more appropriate care for their patients. There is considerable debate in the UK in relation to the benefits of fundholding but there seems little doubt that, for some patients, fundholding has been the mechanism for improving the quality of both their primary and secondary care.

The effect on quality of primary care

services management has been felt particularly by British general practitioners through the 'New Contract', in which the rigour of general management has been greatly increased. It has not been a popular event. But the sudden dramatic improvement in childhood immunisation rates across the UK as a result of the New Contract bears witness to improved quality in the public health, and therefore in the delivery of services.

Changes in the direction of health service philosophy can also provide an environment in which primary care may seek to influence the quality of service provision. General Practitioners have recently joined forces with Health Authorities to 'commission' care from hospitals (that is, to purchase care for patients or groups of patients in the NHS 'managed market'), often in a manner which puts an obligation on general practitioners to assure their own quality as well as that of their hospital colleagues. This is one of the most exciting elements of the changes, in which managers and general practitioners are now beginning to take control of, rather than be controlled by, the hospital services. Equally importantly, health care commissioning has led to an increase in clinical guideline development, particularly around the area of referral to hospital.

At the level of the individual clinician there is a substantial number of influences on the quality environment in which family medicine must operate. The most significant forces for quality improvement in relation to the general practitioner and primary health care teams (PHCTs) are:
- patients;
- third party payers/policy makers;
- health service structure;
- medical science;
- quality organisations;
- professional organisations.

In almost every European country, organisations related to these forces have an impact on general practice in one way or another. These influences are not unifactorial; they arise from many different sources, in different ways, perhaps all at the same time. General practitioners and primary health care teams have to develop a means of dealing with these external quality influences.

In order to rise to the challenges from a developing external quality environment, primary care – and general practitioners in particular – will need to develop a set of methodologies with which they may be as yet unfamiliar. Particularly, they will have to draw on the range of sciences to be found within health services research, those of understanding the nature and causality of illness in their practice populations (epidemiology), of qualitative and quantitative evaluation and of critical appraisal of the results of quality initiatives. Some general practitioners will wish to become very much involved with these methodologies. Many more will wish to make good use of others who are skilled in these methods.

In the North of England, a multidisciplinary group of researchers have worked with general practitioners to undertake a series of projects in response to a range of opportunities from the external quality environment.

Examples from 'The Patient's Charter and family doctor services'

As a patient using general medical services of the National Health Service you have the following rights:
- To change your doctor easily and quickly
- To be offered a health check:
  - when joining a doctor's list for the first time
  - if you are between 16 en 74 and you have not seen your doctor in the previous three years, and
  - a yearly home visit if you are 75 years old or over
- To have appropriate drugs and medicines prescribed
- To be referred to a consultant acceptable to you when your family doctor thinks it necessary, and to be referred for a second opinion if you and your family doctor agree this is desirable
- To have access to your health records, subject to any limitations by law

Methods

Patient satisfaction

A small group of general practitioners who were part of a quality group in the City of Newcastle upon Tyne decided that patient satisfaction with access and consulting style was a priority issue for them. Two questionnaires were developed, one for each topic, using the populations of six practices. For the access questionnaire, a random sample of the adult population aged 16-75 was selected (n=1800). For consultation style, a register of patients consulting over a 3 month period was developed and a random sample was taken on which to collect data. The questionnaires were developed in a standard manner – literature review, patient and doctor groups, face validity review, feasibility study. Data was collected over a 6 month period in 1991.[4]

Communication between doctors

As a result of concerns raised by hospital doctors on the standard of communication between themselves and general practitioners, a project was devised to understand the expectations of the parties involved in the referral process. A by-product of this project was a questionnaire for hospital doctors and general practitioners to seek views on the appropriate content of referral letters and their replies. This topic was considered important by a local manager of family health services who saw it as a potential means of improving the quality of care at the interface between the community and hospitals. Two questionnaires were developed, based on literature and discussions with clinicians. They were sent to all 200 general practi-

tioners in the City of Newcastle and all 260 hospital doctors who take primary referrals. One reminder was sent to non-responders after 3 weeks.

Referral practice priority setting

A local general practitioner quality organisation wished to take advantage of the opportunities afforded by the changing nature of the health service through identifying priorities for improvement in the referral process. In order to give all the 150 general practitioners the opportunity to contribute a Delphi methodology was utilised.[5] Through a two-stage process the top five priorities for change or influence were identified. For each of these priorities, doctors were asked how the changes might be achieved. These results were fed back to the quality organisation by reports and presentation.

Results

Patient satisfaction

Response rates from patients in the practices were in excess of 70 per cent. In the *figure* an example is given of the feedback one of the practices received, indicating the level of satisfaction patients felt with ease of access. This particular practice seems to be doing quite well in comparison with other colleagues, although there are no norms as yet to allow comparison with a wider constituency and no standards for what is appropriate. As another example from the same project, *table 1* shows the reasons patients in the practice gave for not raising questions to which they wanted answers from the doctor.

There is evidence that the feedback of audit results is not a powerful agent for change when unsupported by other strategies. Although no explicit strategies for enabling change were put in place for the satisfaction project, a number of changes in professional and clinical practice did result,[6] possibly because of the ownership which the doctors had of the project. Hence doctors agreed to let health service managers have sight of the project results, despite general concern in the UK that such results should be seen as 'profes-

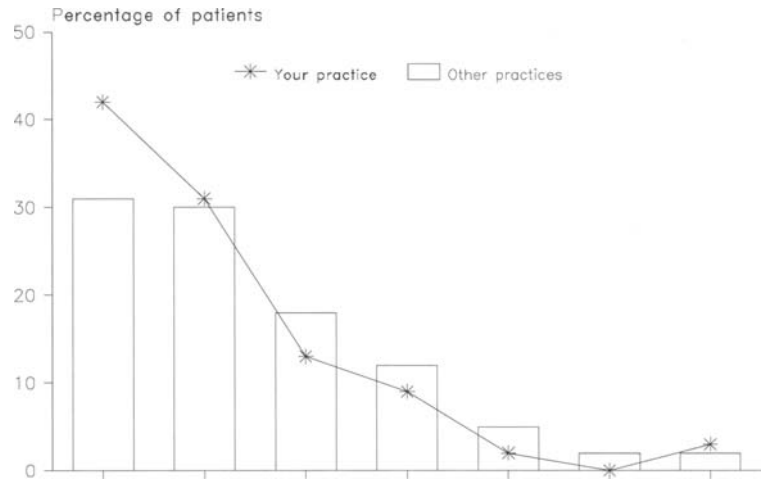

Figure *Overall satisfaction with getting to see the doctor (After Bamford & Jacoby[4])*

Table 1 *Reasons patients give for not raising questions with their doctors. Percentages*

	Your practice	The other practices	Range	All practices
It didn't occur to them at the time	30	35	29-46	34
They didn't want to bother the doctor	25	20	25-39	33
They felt rushed by the doctor	36	20	7-36	23
They were worried about other patients waiting	6	5	0-13	5
Other reason	3	5	2-10	5

Table 2 *How change might be achieved – suggestions from general practice*

Waiting lists	Increase resources Referral protocols Decrease hospital follow-up
Open access	Consultation/negotiations with hospital/purchasers
Knowledge and training	Protected time Courses/meetings
Benefits of secondary care	Meetings/communication Referral protocols
Knowledge & relationship with consultants	Meetings Outreach clinics Guides to services

sional, in confidence'. Furthermore, in 5 of the 6 study practices, changes in patient access arrangements were made as a result of receiving the feedback information. More than 20 practices across the Northern Health Region are now using the methods.

Communication between doctors

Almost 80 per cent of doctors in the City of Newcastle responded to the questionnaires which sought to develop a consensus on letter content. This high level of response was unusual in itself but more so in that hospital doctors provided an equally high level of return.

The general practitioners believed a referral letter should contain the following seven principal clinical features, with the proviso that the emphasis will vary according to clinical problem and specialty:

- initial sentence stating reason for referral;
- outline of the history or statement of the problem;
- important medical history
- findings on investigation;
- current medication
- socio-psychological matters;
- known allergies.[7]

Features of the content of the specialists' reply were:

- summary of history;
- findings on examination;
- findings on investigation
- appraisal of problem (including diagnosis where applicable);
- management plan;
- what the patient or relative has been told
- time to follow up appointment;
- who saw the patient.[7]

As with many projects it is sometimes difficult to see the product from such work, other than as a contribution to the quality of care literature. In this case, however, local general practice quality organisations and a major teaching hospital have used the results to set standards for professional communication.

Referral practice priority setting

Through the Delphi process, five top priority concerns relating to the quality of the local services were identified, using a panel of over 100 doctors:

- the length of hospital waiting lists;
- the range of open access services available to me
- my medical knowledge and training
- my perceptions of the benefits of what is available in secondary care
- my knowlege of, and relationship with, consultants

These were an interesting mix of structural and process issues, relating to the doctors' concerns about their own skills as much as the weaknesses of secondary care services.

In the second Delphi round the general practitioners were asked to translate their concerns into proposals for action which could be taken up by their quality organisation. *Table 2* is one example of this phase of the project, in which the doctors' proposals relating to the five priority areas have been synthesised into action objectives relating to quality improvement.

Two or three years ago such a list of action points would have been seen as something merely for a researcher, an impossible dream for the practising doctor. But the changing quality environment in the UK has made it possible to effect improvements of this nature. The influence of general practice, primary care teams and their quality organisations is in the ascendancy, commissioning health care is on the general practitioner's agenda and many of the recommendations made in the Delphi project are already under active consideration.

Discussion

All of these three quality projects have a number of common themes. Firstly, they were stimulated by various developments or stimuli in the external quality environment – the growth in patient representation, pressure from secondary care and the impact of health purchasing. Secondly, they required active collaboration between clinicians, their quality organisations, methodologists and managers. Thirdly, they each have had a limited impact on quality but they probably have not fulfilled their potential, if viewed critically.

It is not surprising that general practitioners tend to be inward-looking in their own quality initiatives. Primary care is a complex process and most primary health care teams are still learning the methods of clinical audit. On the other hand, the use of the external quality environment to identify some topics for quality improvement means that a wider range of topics can be seen as relevant. This can lead to bridges being built between primary care and other sectors of the health services, to the benefit of patients. Furthermore, there is likely to be broad managerial and political support for the process, allowing access to funds and increasing involvement with scientists who have appropriate methodologies to hand.

Unfortunately, there still seems to be a gap between the potential of quality projects (at least the three outlined here) and their actual impact. There are many blocks which might account for this. Probably the most important of these is the lack of an identified implementation strategy as an integral part of the project. Future projects will include such strategies.

The thesis of this paper, then, is that the external quality influences in the health services can and do have an impact on the general practitioner. The primary care services do not stand in isolation and increasingly they are being seen as the pivot for health care provision. Experience in the United Kingdom shows that these influences can be used by doctors as a stimulus to improve their own quality of care. Furthermore, it is possible to use the influence of general practice to improve quality of care in other parts of the service.

None of this is easy or straightforward. At times there are so many external influences that family doctors will feel almost overcome by them. Models which work in one country are not necessarily transferable to another. Yet the growing evidence from European colleagues suggests that many quality problems and opportunities are common.[1] By taking a posi-

tive attitude, the message from British general practice suggests that external quality influences can be used to the advantage of general practitioners and of patients.

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