KING's FUND CENTRE

MANAGING FOR QUALITY IN GENERAL PRACTICE

Donald Irvine

MEDICAL AUDIT SERIES 2

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FOREWORD

This book continues the King's Fund Medical Audit series, and extends its coverage into general practice. In the first of the series Charles Shaw wrote 'It is only a matter of time before medical audit becomes an established part of all medical practice.' Audit has now become obligatory for all doctors in hospital, and is expected of general practitioners — developments which have been broadly welcomed. There is, however, relatively little in the way of guidance on how to proceed for either.

Dr Donald Irvine has written a guide to the benefits and problems of trying to achieve excellence within general practice, drawing on his extensive experience of training future practitioners. He extends this into a more fundamental examination of ways of achieving the highest standards in the delivery of health care.

He reminds us of the theoretical background to quality assurance, of the implications of implementing it in practice, and of the vital need to be clear about its purpose. In addressing comprehensive quality he recognises that it is inextricably linked to the management of resources, requiring good cooperation between doctors and managers. Building on these discussions he outlines ways that general practitioners might go about establishing a greater emphasis on quality within their own practices, and argues why it is important for them to do so.

Dr Irvine, in writing this book, has put on the agenda many issues which are of concern and which have yet to be resolved. The King's Fund welcomes this opportunity to encourage the debate, without necessarily subscribing to any particular view.

David Costain
Barbara Stocking

King's Fund Centre

FOREWORD

1 – INTRODUCTION

The year of 1989 is likely to go down as a watershed year in the history of the National Health Service (NHS) and of the medical profession in the United Kingdom. It was dominated by three major White Papers [1–3] and a new contract for family doctors.[4] In combination these were intended by the Government to promote health through the improvement of the quality of patient care in hospitals, general practice and in the community care services. To achieve this, the NHS and community services were to become actively managed and internally competitive with the aim of making them more responsive to patients, more accountable at all levels for the care given, and more capable than hitherto of giving value for money.

Although the health professions have responded to the Government by endorsing these aims, many doctors and nurses have disagreed with the main proposals for achieving them, especially the concept of an internal market that will include self governing hospitals and fund-holding general practices. The debate has been particularly vigorous in general practice where the new contract has had the object of specifying the work of general practitioners more precisely, enhancing accountability both to patients and to NHS management, sharpening performance, and containing costs, especially of prescribing.

In the course of the debate both the government and the professions have found some common ground in the perceived need that medical audit should become part of the everyday practice of doctors. Here, the Secretary of State for Health has built on initiatives intended to improve the quality of care already taken by the medical Royal Colleges and Faculties and by the Royal College of Nursing within the past decade or so.

PURPOSE AND STRUCTURE

This book develops the idea of managing for quality in general practice. There are many aspects to the subject, and it is difficult to see it as a whole. In Chapter 2 the main elements are brought together in an overview which relates the principles of quality assurance to current ideas about the future management of

general practice in the UK. It is deliberately selective, concentrating on those aspects where the potential practical relevance to general practice may be highest.

Chapters 3, 4 and 5 look at the application of these principles and concepts in the individual practice, in the regional postgraduate organisations providing graduate medical education for general practitioners, and through the new medical audit advisory groups (MAAGs) of Family Practitioner Committees (FPCs) which have been renamed Family Health Service Authorities (FHSAs). These chapters are an attempt to produce a framework useful to those general practitioners, practice managers, regional advisers, course organisers, FHSA general managers and members who are keen to look beyond the rather restricting dimensions of medical audit towards an approach to management in general practice in which the pursuit of quality is an integral part of the management philosophy.

The appraisal begins with the Quality Initiative of the Royal College of General Practitioners (RCGP) which the College launched in 1983.[5] This starting point was chosen because it seemed to herald a new approach to general practice. For the first time the College combined in a unified concept a high priority for quality, the idea of actively managed, clearly defined services for patients, and performance assessment against previously determined objectives and standards for patient care. The Quality Initiative, the College's subsequent development of this policy [6,7] and its relationship to the requirements for better NHS management which underlie the Government's White Papers, have been described elsewhere.[8]

THEMES

There are three dominant themes in the quality of care debate. The first is the overriding preoccupation of contemporary governments in different countries and of quite different political complexions with the quest for value for money in health care. In the ever present and natural tension between the desire for comprehensive high quality care and cost containment, those paying the bill, be they government, insurers or employers, incline to give more weight to the latter while providers tend to urge more and better care, irrespective of cost. Since democratic societies need to be seen to temper a concern for cost containment

with a desire to improve general quality, it is not surprising that the imperative of value for money (rather than the professional aspiration for open ended improvement) is the most potent of the forces driving quality to an open, public agenda.

The second theme is the rising influence of consumerism on quality matters. People want and expect to have more say in their health services in future, and consider that they, rather than providers, are often the best judges of such characteristics of quality as responsiveness, accessibility to care, the setting and ambience in which care is given, and the attitudes of health professionals to patients. Any consideration of quality must therefore take account of the consumer perspective; any system of quality assurance that does not will fail. Some British doctors are finding the consumer dimension difficult to handle because in the NHS they have not been exposed to normal consumer forces by virtue of the constitution of the NHS.

The third and consequent theme is about the accountability of health professionals, especially doctors. Governments wanting value for money and people wanting more responsiveness from the service are intent on making health professionals more accountable for their work. Indeed today's health care requires this. Yet, by tradition the values and training of doctors are based on the premise of professional self regulation, involving accountability to self, individual patients, peers within the profession and the law. However, the nature of modern health care, and therefore modern management, demands collective (corporate) responsibility and accountability within individual hospitals and general practices. So the boundary between doctors and health services management is yet another faultline, another area of tension. The situation is complicated by the fact that all forms of accountability — to self, professional peers, patients and management — are almost certainly required in the pursuit of high quality care. One of the main objectives of this book is to see whether it may be possible to reduce the chances of disruptive tension and to increase constructive working along the interface between professional and managerial responsibility for quality in British general practice.

MANAGING FOR QUALITY

In the search for the most appropriate way forward, the model of managing for quality in the setting of individual practices is by far the most promising, and the one most likely to achieve high standards and a well motivated workforce. The ultimate object is to achieve an enhanced health status for patients using systems of practice management which should enable practices to know that they can deliver the right care of the right quality to the right people in the right place at the right time and at the right price. The more that this can be accomplished at the level of the individual practice the more it will give satisfaction to the practice team and patients alike, and the easier it will be for FHSAs to work with their contractor practices using only highly selected and discrete indicators of performance.

It has to be recognised, however, that many general practitioners and practice managers still have difficulty in making the connection between the value of what is done with individual patients in the consulting room and the organisational systems of the practice. Indeed, although things are changing, it is by no means certain that all practitioners will have either the ability or the wish to manage their own businesses for quality in the way outlined. If so, and it will become clear sooner rather than later, alternative models, such as the salaried service option incorporating hospital outreach, will surely emerge. In such an event the principles of managing primary health care units for quality would remain the same. However, the application of those principles would involve more direct professional managerial control in the day to day conduct of a primary care unit and in the work of health professionals.

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2 – QUALITY ASSURANCE: AN OVERVIEW

There is a considerable literature, mainly North American, on the complicated and sometimes contentious matter of defining quality in relation to health care, and of creating a satisfactory conceptual framework and methodology for assessing it. However, the principles are international in their application, a fact emphasised by the World Health Organisation (WHO). This chapter describes current thinking on the basic principles on which most people agree, sufficient to indicate the basis for the development of a programme in UK general practice.

CONCEPTS OF QUALITY

Avedis Donabedian [1] states that every health care practitioner and institution should have two major objectives: to provide care of the highest possible quality, and to provide that care at the lowest possible cost.

In theory, he argues, these two objectives are separable, but in practice they are closely interrelated.

The US Joint Commission on the Accreditation of Health Care Organisations [2] (JCAHCO) takes a similar view, identifying high quality with the objective of providing excellent patient care in a cost effective manner. It defines quality as

> *'the degree to which patient care services increase the probability of desired patient outcomes and reduce the probability of undesired outcomes, given the current state of knowledge'.*

These and similar definitions provide a necessary starting point but they are too general to be more than that. Most writers have therefore found it helpful to subdivide quality into its component parts.

THE COMPONENTS OF QUALITY CARE

Donabedian[3] states that quality in health care comprises three closely interrelated components. His first is what he calls the 'goodness' of technical care. There is, he argues, a value attaching to technical care which is proportionate to its effectiveness, that is its expected ability to achieve the greatest improvement in health status that science, technology, and clinical skills can offer at any point in time. Put another way, technical quality equates with the best that can be done within the 'conventional wisdom' of medicine.

His second component is the 'goodness' of the interpersonal relationships among all concerned with care, with special regard to the relationship between the patient and the doctor, nurse or other health professionals. Thus, for example, patients should be treated with sensitivity and understanding, and their autonomy, privacy and other interests should be protected.

Donabedian's third component of quality is the 'goodness' of the amenities of care. He means by this the creature comforts and the aesthetic attributes of the setting in which care is provided, for example, whether the surgery is clean, comfortable, warm and welcoming.

This way of looking at the constituent parts of quality may be compared with the components described by the 1985 World Health Organisation Working Group on Quality,[4] which suggests that quality must reflect at least the following four concerns:

- Performance (technical quality)
- Resource use (economical efficiency)
- Risk management (the identification and avoidance of injury, harm or illness associated with the service provided)
- Patient (or client or customer) satisfaction

Maxwell,[5] on the other hand, lists six components of quality:

- Access to services
- Relevance to need (for the whole community)
- Effectiveness (for individual patients)

- Equity (fairness)
- Social acceptability
- Efficiency and economy

Each of these components, he notes, needs to be recognised separately, and each obviously requires different measures and different assessment skills.

Blending the components

Despite the high degree of overlap in the components of each definition cited above, and in similar definitions from other writers, it is evident that differing views on quality will be provided by patients, practitioners and purchasers of care. Different groups of individuals within each of these categories will produce subtle differences in emphasis, different blends of what is meant by quality. The JCAHO[2] concludes that in general terms quality for patients means responsiveness, politeness and relief from symptoms or an improvement in function; for practitioners it means technical skill, freedom in care provision, and desired outcome; and for purchasers of care it means efficiency and savings.

Of particular interest to British general practitioners is the blend of characteristics of quality outcomes described at an RCGP seminar on audit 16 years ago.[6] Eight elements were listed:

- Prevention of disease or control of the disease process
- Improvement or preservation of the patient's level of function in the family, at work, and in social activities
- Relief of the patient's symptoms, distress and anxiety, and avoidance of iatrogenic symptoms
- Prevention of premature death
- Minimising the cost of the illness to patient and family
- Giving the patient satisfaction with care provided
- Relieving or at least clarifying the patient's interpersonal problems
- Preserving the human integrity of the patient from an ethical point of view

None of these definitions or summaries explicitly reflects the importance of an attitude of caring, although naturally this is implicit in the very nature of the term 'high quality care'. Yet, the attitude and sense of commitment shown by a doctor, nurse or other health professional will have a profound effect on the quality of care provided by those professionals individually and therefore by the team or organisation to which they belong.

Given the wide scope for subtle but significant differences in interpreting notions of quality of health care, it is important that doctors and managers developing quality assessment and quality assurance should try to gain a reasonable consensus on the particular mix of components that they will use so that the risk of misunderstanding is kept to the minimum. In achieving such a consensus, the JCAHO points out that any attempt to ensure or improve quality of care has to refer to what the providers of care think quality is, in order to secure their commitment. Provider consensus on what constitutes quality helps providers themselves focus on those aspects of care which may be most usefully monitored. Provider commitment may also be an important safeguard. Without it health authorities would have more freedom to define quality as they choose, and may well err on the side of economy.

So, for several important reasons, the blend of components chosen to reflect quality has to be comprehensive. For instance, a general practitioner whose care is clinically sound may nevertheless be habitually rude to the patients and staff. He or she will be regarded as providing high quality care, or somewhat less than optimum care, depending on whether or not both characteristics in this case are included in the valuation.

Various attempts have been made over the years to try and draw the components of quality together into one comprehensive expression of quality health status. In the UK by far the most thoughtful and authoritative has come from Maynard and Williams at the Centre for Health Economics at York. They introduced and developed the concept of the Quality Adjusted Life Year (QALY) in search of an instrument which could assist policy makers in resource allocation decisions.[7,8]

A FRAMEWORK FOR ASSESSING QUALITY

The general ideas on the nature and components of quality described above are still insufficient in themselves to provide a framework within which assessment can become possible. Donabedian [1,3] has provided such a framework with his concept of structure, process and outcome. This concept has been refined by Donabedian and many others since; [9–11] it is still acknowledged, certainly by clinicians in the UK, as providing the best foundation for considering the assessment of quality. It is worth summarising here.

Structure

Donabedian uses the term *structure* to describe the physical features of health care. Structural characteristics would thus comprise, for example, the surgery premises, the number of doctors, nurses and other practice personnel, the range and type of equipment, the records and all the many other features which in combination make up the health care environment. Donabedian believes that good structure, that is a sufficiency of resources and proper systems design, is probably the most important means of protecting and promoting the quality of care.

This said, structural characteristics are nevertheless regarded as rather blunt instruments for indicating quality because they can only demonstrate general tendencies. Structural characteristics are relevant in that they may increase or decrease the probability of good clinical performance, but the causal relationship between structure and performance is tenuous. For example, a practice may have an electrocardiograph, but there is no guarantee that the doctors will use it or, even if they do, that they can interpret electrocardiograms effectively. But if there is no machine, there will be no electrocardiograms to assist in diagnosis anyway.

Process

Donabedian defines the massive complex of clinical interactions and activities between doctors and their patients as the *process* of care. Process characteristics therefore reflect, for example, examinations undertaken, prescriptions written, tests carried out, patient management advice given, and the countless other

transactions between doctor and patient. Information about the nature of process is obtained either by direct observation, that is by sitting in, watching video consultations or listening to tapes, or most commonly by a review of data in patients' records which may allow a more or less accurate reconstruction of what has gone on in the consulting room or at the patient's bedside.

An evaluation of process, what the doctor does, is a primary objective of performance assessment. Given that, Donabedian goes on to say that a judgement on the quality of process will depend upon what is known about the relationship between its characteristics and their consequences for the health and welfare of individuals and of society, in accordance with the value placed upon health and welfare by the individual and by society. The characteristics of the process of care and its consequences are therefore, he argues, determined partly by the state of medical science and technology at any given time and partly by norms which govern the management of the relationship between health professionals and patients. Inevitably, these may change. For example, the prescription of a drug which is regarded as good practice in one year may be seen as dangerous in the next because scientific advance has revealed new knowledge about its effects. Similarly, doctors may decide to give patients a clearer explanation than they have hitherto because society begins to attach more value to such explanations as an important part of the consultation. In other words, the quality of the process of care is defined primarily as normative behaviour, in which the norms derive either from the science of medicine or the ethics and values of society. In either case the norms are meaningful in so far as they contribute to valued consequences.

Linking process with quality is therefore attractive to doctors. It simplifies matters for them; they feel reassured that they are giving good quality care if they do their best within the current 'conventional wisdom' of medicine, irrespective of whether such care can be shown ultimately to result in a definitive beneficial effect on the health status of a patient.

Outcomes

Donabedian defines *outcome* as the changes in a patient's current and future health status that can be attributed to antecedent health care. Outcomes are therefore the definitive indicators of health. For example, the modern treatment of childhood asthma should lead to a restoration of health as indicated by such measures as no wheezing, or a return to normal school attendance. Donabedian

prefers a broad definition of health. Good outcomes would therefore include the improvement of social and psychological functions in addition to the more usual physical and physiological aspects of health.

His definition of outcomes also includes patient attitudes including satisfaction, health related knowledge acquired by the patient, and health related behaviour. This broad definition encompasses the concept of intermediate outcomes (see below) and is especially relevant to patient care in general practice because of the often ill defined nature of problems which people bring to the doctor and which may be difficult or impossible to define in terms of definitive outcome.

Process and outcomes compared

Much mental energy and many trees have been expended in arguing the relative validity, reliability, feasibility, accessibility, cost and so on of process and outcome measures as expressions of quality of health care. The problem is that specific process variables are relatively easy to identify (though not as easy to measure as some claim), but their causal relationship to changes in health status is not always easy to establish. Conversely, outcome measures are often hard to define and yet harder to relate to antecedent care because of the problem of removing extraneous variables.

In reality process and outcome variables may merge one with another in a linear progression. For example, a general practice may so order its activities (process of care) as to achieve a 100 per cent immunisation rate against certain infections, an achievement which should improve the health status of the practice population at risk. But the definitive indicator of outcome would not be the immunisation rate, but rather the (zero) incidence of the diseases against which protection had been given. Looked at in this way the immunisation rate of the practice population is thus actually part of the process chain. But if one had started at a stage further back, at the point where immunisations were done on an *ad hoc* basis, the achievement of a defined point such as an explicit immunisation rate would be of itself an outcome. The term 'intermediate outcome' is used to describe measures which may be either process or outcome, depending on whether they are on the input or the output side on an imaginary continuous line. The great value of intermediate outcomes is that they predict, or are assumed to predict, definitive outcome; and they are invariably easier to measure than definitive outcomes.

The development of definitive measures of outcome remains one of the golden goals of research in the field of quality assessment. Equally important is the establishment of the relationship between outcome and process measures which would, where possible, let a process measure be established as a *de facto* (or proxy) indicator of outcome.

These limitations notwithstanding, practical doctors and quality assurers have to work with measures which are available now, which is why they tend to focus on the process of care.

Donabedian energetically defends this stance on the grounds that most people identify good care with what actually happens in the caring situation; it can be seen immediately, and is immediately accessible to assessment. Those who work with process variables have simply to be careful that they understand the limitations of what they may be measuring, with particular regard to the causal relationship with outcome.

ELEMENTS, CRITERIA AND STANDARDS

Having decided on the nature of quality the next stage in the sequence of development is to translate structure, process and outcome into measurable and assessable entities. While the principles described below apply to all three, it is process and outcome which are in fact the most appropriate for an exploration of clinical quality because together they describe a doctor's performance, that is what the doctor does and with what effect.

Questions of definition

The definition of the basic measures used to describe quality of care, notably elements, criteria, norms and standards, is the subject of persistent debate and not a little confusion. The problem arises partly because of the difficulty of interpreting complex concepts, and partly because there is a tendency to use the terms interchangeably. In the description which follows there is no attempt to enter the debate; rather, the purpose is simply to convey the general sense in which such terms are used today.

The term *element* is frequently used to indicate the great number of basic pieces of data which together describe the condition from which a patient is suffering and the care given. Their number alone points to the need for selection if they are to be used as the building blocks for assessing quality.[12]

In making a selection of elements, and in turning these into measuring instruments, Donabedian [13] identified three steps. First, there is a need to select a set of discrete, clearly definable and precisely measureable elements which describe either process or outcome, and which are specifically related to quality. Elements possessing such properties are referred to as *criteria.* A criterion should be capable of being so closely defined that it is possible to say whether it is present or absent, and thus how often it may be present. Using the example of blood pressure recording in a patient with hypertension as an illustration, Donabedian thus defines the taking of the blood pressure as a criterion of the process of care whose frequency can be established, and the actual blood pressure level as a criterion of the outcome of the care whose magnitude can be determined. A criterion is thus a carefully selected element which may be used to measure and assess a clearly defined aspect of care, and therefore the performance of the doctor providing that care. Criteria are developed by professionals relying on professional expertise and on the professional literature.[14]

In the next step Donabedian uses the term *norm* to mean a general conception of what is good relative to a criterion. Using the example of blood pressure, a norm would reflect the claim that blood pressure measurements in general contribute to the quality of care of patients with hypertension by indicating, for example, that more means better or that, statistically speaking, a lowering of an abnormally raised blood pressure is a desirable outcome. In ascribing a value to a norm Donabedian differs somewhat from others who use the term to describe neutral, numerical or statistical measures derived from the observation of actual practice. The difference is not as significant as it may seem, for in real life such statistical norms are often invested with a value.

In the third step Donabedian uses the term *standard* to describe the precise numerical level of a criterion of care. Continuing with his example, it might therefore be stated that 90 per cent of all patients who see a doctor for any reason should have their blood pressure taken within a six month period. This statement would constitute a process standard. Equally, it might be agreed that, of younger patients with hypertension, 70 per cent should achieve a blood pressure of 90 millimetres or less within a year of starting treatment. This would be a standard of intermediate outcome.

Standards thus specify a level, and such words as 'ideal', 'optimal', 'reasonable' and 'minimal' are used to qualify them. Standards relating to clinical practice are thus professionally developed expressions of the range of acceptable variation from a norm or criterion.[14]

Elements, criteria and standards are terms which have been used in the Donabedian style to describe the care given to the children of general practitioner trainers in the recent North of England Study of Standards and Performance in General Practice.[15–17] In this study the term 'standard' has been broadened to encompass aggregated criteria, and so describes the total span and quality of care for a condition in which performance is to be assessed. Extracts from two of the 'branching' standards, constructed by doctors taking part in the study, illustrate criteria for diagnosis and management set out in an algorithm format (Figures 1 and 2).

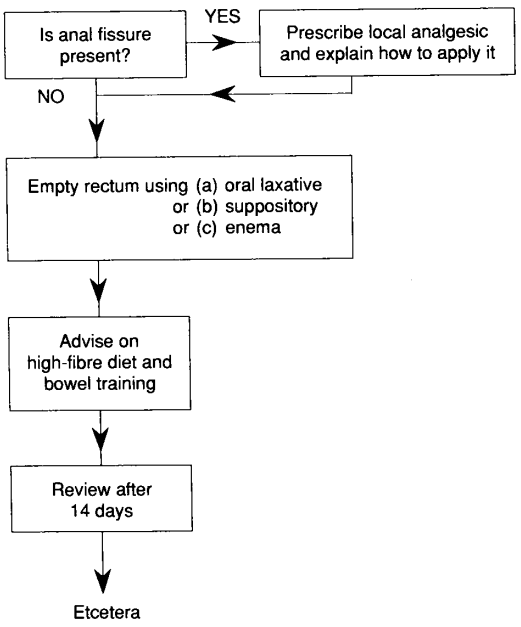

Figure 1. Extract from Branching Standard for Management of Constipation in Children (Source: North of England Study of Standards and Performance in General Practice, 1990)

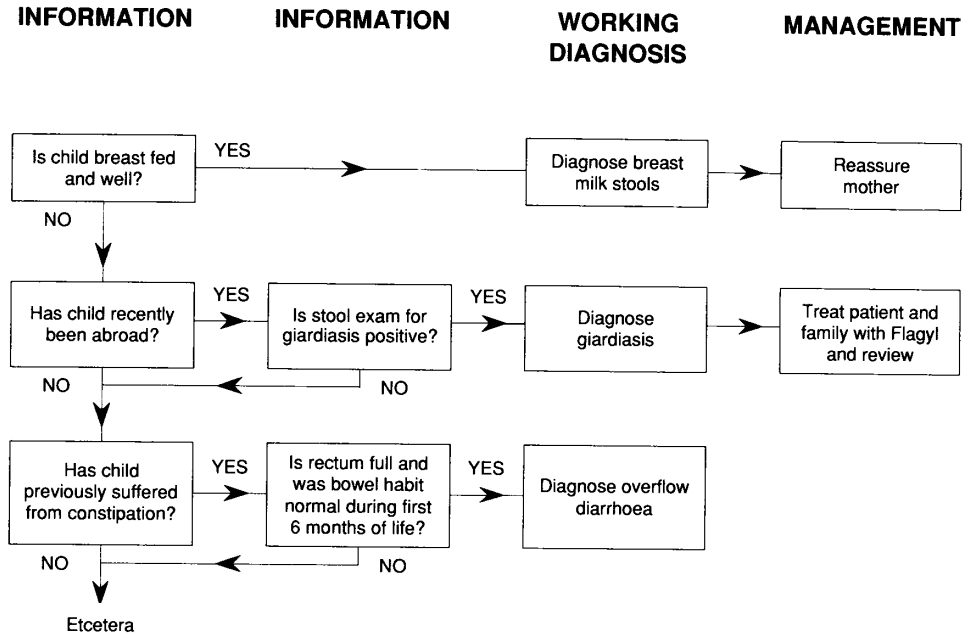

Figure 2. Extract from Branching Standard for Diagnosis of Acute Diarrhoea in Children (Source: North of England Study of Standards and Performance in General Practice, 1990)

Criteria and standards

Criteria (and standards) can be further classified by a range of characteristics and attributes, the more important of which are described below.

Criteria may be *implicit* or *explicit*. Implicit criteria require that assessors relate the care observed to what they think they would have done in similar circumstances. They are therefore highly subjective, unreliable and now not often used for formal quality assessment. Explicit criteria are carefully compiled statements about the quality of care which are constructed in advance of an assessment. They therefore have more of the characteristics of a good measuring instrument; they are objective, relatively reliable and thus bring consistency to repeated measurements.

Criteria (and standards) may also be classified as 'normatively derived' or 'empirically derived' depending on whether they are based on opinions about a doctor/patient interaction or are inferred from the actual measured behaviour of patients and practitioners.[3] *Normative* criteria may be ideal, that is based on the best knowledge available about the condition being assessed; such knowledge would be drawn from the literature, the opinions of experts and the values of society. They may also reflect opinions about good practice under local conditions as expressed, for example, by a group of doctors trying to define a yardstick against which their care could be judged. *Empirical* criteria, drawn from actual observations of performance, have the disadvantage that they may present a numerical picture of average care, and so within this conceal poor care.

Criteria may be *external*, that is they may be formulated by a person or groups whose performance is not to be assessed, for example, by local peers, medical experts, patients or a combination of these or others. *Internal* criteria, on the other hand, are created by the doctors (and where appropriate other practice team members) whose performance is to be assessed.

Lastly, criteria may be *representative* or *elitist* depending on whether they are an expression of the care which would be expected from the generality of health professionals whose care is to be assessed, or whether they reflect special expertise or experience of the disease or symptom under study.

There are also other ways of expressing 'standards', particularly when the term is used to describe the aggregated criteria for the broad span of care of a condition. For example, a standard for clinical performance may be described as *deterministic* when the recommended action in the process of care is predetermined. Or it may be described as *branching* when the recommended course of action at each stage in the process of care depends critically on the information available to the doctor, as in Figures 1 and 2.[15]

To summarise, the elements of care constitute all total data available which together describe the process and outcomes of care for a particular condition. Criteria and standards are carefully selected elements of process or outcome, assembled as statements that distinguish (or indicate) particular characteristics and levels of care, which are held to describe quality for that condition. It is against such criteria and standards that the performance of a doctor may be assessed.

Here, then, is the theoretical and practical basis for the cycle of performance monitoring which is described on page 21.

QUALITY ASSURANCE

Given this general framework for handling quality, it is now appropriate to consider how quality can be assessed, protected and improved through the functions of quality assessment and quality assurance. Quality assessment describes the monitoring and appraisal of care against predetermined standards. Quality assurance goes a step further, requiring action to be taken on any deficiencies revealed through quality assessment.

Preconditions for quality assurance: Accessibility and money

Donabedian [18] describes two important preconditions for assuring quality. The first is accessibility. People have to be able to get at care; it has to be in the right place and at the right time. Thus, for example, high quality technical care is of little meaning if it is relatively inaccessible. Some [2,5] regard accessibility as a feature of quality itself rather than a condition for quality assurance. This could be a hairsplitting argument; it may be more helpful to think of accessibility as both a characteristic of quality and a condition for effective quality assurance.

Donabedian's second precondition is money. While the level of quality can be maintained or even improved by providing care more efficiently (a proper objective for health professionals), quality normally costs money. There may be certain exceptions; for example, some bad prescribing can be expensive. Clearly, however, the notion of value for money is a legitimate objective. Quality in the equation is more likely to be protected if the service being provided and paid for is of a standard (or quality) which can be described in objective terms.

The components of quality assurance

Donabedian describes quality assurance as having two components, namely, system design and performance monitoring. Both are necessary, he asserts, and neither can succeed without the other. This simple classification may be helpful precisely because it is simple. It invests quality assurance with the desirable characteristic of comprehensiveness spanning all an organisation's activities.

(i) System design

Donabedian uses this term to describe the structural features of an organisation including the arrangements for health care. It includes the people, the physical facilities, the equipment, records and organisational characteristics. It embraces also the policies, systems and mechanisms which determine what the organisation is trying to do, what its detailed policies are (both in clinical terms, and in terms of recruitment, remuneration, staff training and the allocation of skills and resources), and what mechanisms it has for ensuring that it achieves its objectives as effectively and economically as possible.

Clearly the extent to which an organisation such as a general practice is imbued with the philosophy of quality, which is reflected in its system design, will depend to a large extent on the attitude of the most influential members among the nurses, health visitors, practice managers, secretaries and receptionists, as well as the doctors in the practice team.

All these features create the environment for promoting and protecting the quality of care.

(ii) Performance monitoring

Whereas system design is concerned with structural characteristics, performance refers to the processes and outcomes of care. An organisation which is well run and has good systems is likely to have available to it a considerable amount of information about the continuing performance of individual health professionals and the organisation as a whole. This information flows from everyday activities, and as a consequence there will be regular opportunities for analysing and assessing the importance and relevance of such information through informal discussions, practice meetings and so on.

Nevertheless, there is a general consensus among all who have practical experience of operating quality assurance in the health care setting that such informal arrangements for monitoring performance are insufficient. They have to be reinforced by a clearly identified, properly established system whose function is to monitor the performance of an organisation continuously, impartially, and consistently. In the context of UK general practice this principle could be applied within individual practices, pragmatically in the regional postgraduate organisations providing education for general practice, and certainly in the MAAGs, which are being established as the *de facto* performance monitoring groups of FHSAs.

Steps in performance monitoring

Donabedian [18] gives a good description of the basic steps in performance monitoring which a monitoring group would be expected to follow (Figure 3).

Step I. Gathering information

The first step involves collecting data on current performance which should ideally include data on both process and outcome. The key thing is to specify the purpose of the monitoring in the first place; the specification of indicators then follows logically. For example, a practice may want to make a detailed examination of the workings of its appointments system in order to achieve an improvement, an assessment of process. Equally, it may also decide to assess the quality of care given to children in the practice who have recurrent earache by relating the clinical management — process — to outcome as evidenced by, for example, the restoration of hearing or the complete cessation of attacks. Both choices would be perfectly valid and complementary.

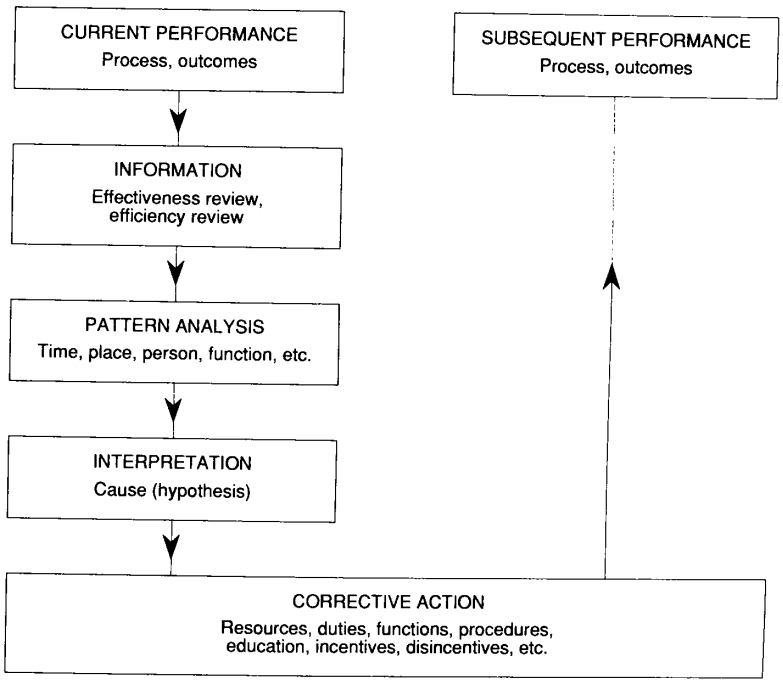

Figure 3. Steps in Performance Monitoring (Source: Donabedian A, 1989)

Step 2. Pattern analysis

The second step involves the analysis of data, to look for distinctive patterns of performance, to make comparisons both within the organisation and with other comparable organisations, and to identify and localise both good practice and questionable practice.

Step 3. Interpretation

This is about trying to explain the patterns observed, and in particular trying to find out why substandard practice has happened. Where substandard practice and the explanation for it are revealed, the findings need to be transmitted in an agreed form to those able to do something about it.

Step 4. Corrective action

The fourth step is about identifying the actions necessary to correct the deficiencies observed. Clearly the action taken will depend on the nature of the problem. It may involve the technical skills and therefore the performance of an individual.

Step 5. Checking that the remedy works

The final stage involves the monitoring of subsequent performance after remedial action has been taken. This follow up monitoring should focus on problem areas identified to ensure that the solutions proposed actually work.

Tracer selection

There are several ways of looking at performance. One is to examine specific critical events which may occur in the course of handling a patient's illness. Another important method is to use a 'tracer', that is a standard which describes the quality of care for a given clinical condition against which performance will be assessed. Kessner [19] proposed that the following criteria should apply to a successful tracer:

- The condition should be easy to define
- The condition should be amenable to improvement by medical care
- There should be a sound basis for discriminating between good and less than good care for the condition

- The effects of non medical factors on the condition should be adequately understood
- The condition should yield enough patients for audit

To be relevant to performance monitoring in British general practice the Northern Region Study [15] modified Kessner's criteria in two ways. First, it was decided that tracers did not have to be clinical conditions. There might well be organisational tracers, such as how well the practice appointments system works, or how effective the cervical cytology recall is. Secondly, the study added three criteria by stipulating that tracer conditions should cover the range of:

- The morbidity presented to the doctor whose performance is to be assessed
- The skills exercised by those doctors
- The resources used by those doctors

Factors contributing to successful performance monitoring

Eisenberg,[20] Donabedian [18] and others have identified certain general characteristic of a quality assurance programme which are essential for success.

(i) Leadership

This is perhaps the single most important determinant of success. Donabedian notes that

> *'practitioners with the highest professional standing and prestige, as well as administrators in the highest positions of authority, should be genuinely committed to the performance monitoring enterprise. The commitment should be expressed not merely in words but also in deeds, including actual participation in the activities of performance monitoring when possible and appropriate'.*

This principle of leadership should apply in the leadership of the performance monitoring system itself.

(ii) Organisational characteristics

The organisation as a whole should provide moral and material support. In general, it should be orientated to recognising and rewarding good performance,

while it also identifies and discourages performance which is less than fully acceptable. In particular, there should be a clear link, known and understood by everyone, between the rewards that individual health professionals can expect and the findings of the clinical monitoring system. Clearly the nature of these rewards will differ according to the nature of the personnel involved.

(iii) The characteristics of health professionals

The attitudes of professionals in an organisation to the principles and practice of performance review are important, and should include a commitment to performance review as part of their professional ethos. Given this, it would be also important to establish that new personnel accept that ethos, that they are willing to take part in performance review and be responsive to its findings.

(iv) The technical quality of the monitoring system

Clearly quality assurance will only work if performance monitoring is technically adequate. It is important, therefore that the organisation specifies the technical and organisational standards to which its own monitoring system should perform. The methods should derive from, and clearly reflect, concepts of quality which practitioners recognise as central and legitimate rather than peripheral or even foreign to quality. In other words, the methods must be seen as legitimate, reasonable and fair.

(v) Influencing the behaviour of health professionals

It is important that the methods chosen for influencing the behaviour of health professionals whose performance is to be assessed should be acceptable, appropriate and therefore likely to achieve the desired outcome. Not only is feedback crucial; it is also essential that feedback is given in a way that makes an impact. More often than not this is likely to involve talking rather than writing reports to people.

Eisenberg argues that feedback is more effective if it is conveyed by a professionally respected person, if it is face to face, and if the individual is compared to colleagues. Rubin,[21] on the other hand, cautions that interpersonal comparisons at the wrong stage in the monitoring process may be confrontational and counterproductive; the moment for introducing them must be carefully chosen.

As Donabedian concludes, much depends upon the nature of individual organisations and the people who work within them, and the judgement which the clinicians concerned make about the methods which may be most appropriate for their work.

(vi) Resources

Effective performance monitoring cannot be achieved without the appropriate resources of money, people and skills. When embarking upon performance monitoring for the first time it is important for an organisation to recognise this, and to make provision from the outset.

Rubin[21] seemed to capture the essence of performance monitoring when he wrote that

> *'the greatest improvement in quality is most likely to result from attention to standards that relate to activities of commission or omission which are of self evident, non debatable, positive value, and which are totally achievable, but nonetheless frequently violated'.*

Habitually keeping patients waiting or failing to write up the records from emergency visits are good examples.

ARE QUALITY ASSURANCE AND MEDICAL AUDIT THE SAME THING?

Medical audit has come only lately to medical practice in the United Kingdom. Indeed, despite pioneering initiatives by some individuals, and the collective initiatives of the obstetricians through the maternal and perinatal mortality surveys, medical audit has really only come onto the UK scene within the last decade or so.

In the White Paper *Working for Patients*[22] the government states that it attaches great importance to the development of a comprehensive system of medical audit covering all aspects of the health service. It defines medical audit as

> *'the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient'.*

It is seen as being essentially about the process of clinical care because a patient's primary concern is for a correct diagnosis to be made and for the right treatment to be given.

Definitions from the profession tend to be more narrowly focused. For example, the Royal College of Physicians of London [23] sees medical audit as primarily a mechanism for assessing and improving the quality of patient care, enhancing medical education by promoting discussion between colleagues about practice, and identifying ways of improving the efficiency of clinical care. The Royal College of Surgeons of England [24] describes audit as the systematic appraisal of the implementation and outcome of any process in the context of prescribed targets and standards. The medical profession generally seems to accept these approaches to medical audit, namely, that the purpose is the encouragement, improvement and education of the individual doctor.[25] It is not seen as primarily a corrective process for identifying doctors whose performance is persistently below par. Indeed there is a fear that if used for this purpose, the confidence of the profession in medical audit could be seriously undermined.

The position of medical audit in British general practice has been the subject of several recent reviews. Baker [26] and the Mourins [27] have both published excellent literature reviews, and these have been complemented by the policy papers linking audit methods with practice management.[28,29] A practical approach to audit in general practice has been described in two recent handbooks,[30,31] and given a broader context within quality assurance by Shaw.[32]

The growing volume of single practice audits, some of which have reached the published stage, have mainly involved a retrospective analysis of practice activities, that is aspects of the process of care. These have ranged over a wide field of clinical activity, and have been designed basically to answer the question 'what happened?' rather than 'did we do what we said we would?', that is 'did we have some predetermined plan or standard against which performance would be monitored?' Occasionally data of the 'what happened?' type has been collected centrally, most notably by the RCGP in the mid 1970s,[33,34] so that interpractice feedback and comparisons could be made.

Random case analysis, that is the arbitrary selection of patient records for teaching or review in general practice, is the other approach which comes closest to significant event performance monitoring in the UK. However, there are no recorded instances in the British literature of the use of the confidential case enquiry in a rigorous and systematic manner, intended specifically to monitor and evaluate performance in the care of patients where there may be cause for concern. It remains to be seen whether this potentially high yield activity will be taken up, but it would seem likely that it would only happen in a worthwhile way in the context of properly managed, continuous performance monitoring.

There have been two major multipractice studies of standard setting and performance assessment in general practice, one in the UK and the other in the Netherlands. The British study was carried out among Northern Region trainers.[15,16] In this, trainers constructed working clinical standards for five common conditions in childhood, three acute and two chronic, which in combination reflect the knowledge and skills which general practitioners would be expected to use in this sector of care. Data on performance were abstracted from the clinical records before and after the standard setting exercise, using an abstraction methodology which has been specifically designed for use in British general practice. This has been essentially a process and outcome study, although it has been possible to relate process and outcome variables to the structural characteristics of the practices as well.

While the Northern Region study was in progress, colleagues in the Netherlands had also embarked on a study of standard setting in general practice which was comparable in many respects. Perhaps the most important difference between the two was that, whereas the British study was based on internal standards written by doctors whose performance was to be assessed, and complemented by external expert standards for comparison, the standards in the Netherlands study were created by experts and then considered more widely by practitioners in the field.[35] A comparison of standard setting and performance review in general practice in the two countries may yield information which would be useful to British and Dutch practitioners.[36]

Perhaps the commonest form of performance monitoring, and the approach most broadly accepted, has been the external assessment of teaching practices by visiting peers. This method, initially developed by the RCGP, is used today by the Joint Committee on Postgraduate Training for General Practice (JCPT) and the regional postgraduate organisations for the selection of training practices, and most recently by the RCGP for the selection of fellows of the College. In some cases peer inspections have become relatively structured, and the most widely used format for this is the grid approach known as 'What Sort Of Doctor',[37] in which four areas considered to be indicative of performance are assessed; these are professional values, accessibility, clinical competence and ability to communicate. The appraisal for fellowship, on the other hand, includes clinical and organisational standards against which the performance of the applicant is assessed.

These interesting developments notwithstanding, it would be true to say that medical audit in British general practice is still in its infancy, the pattern being single practice audits carried out by one or two enthusiastic members of relatively few practices on a sporadic basis. Although the new contract will generate considerably more activity, the framework set for this by both the government and profession could be said to envisage more of the same of these simple reviews for the foreseeable future. The intention seems to be that there should be a fairly prolonged phase in which practitioners get used to the idea of looking at their own work and of using the results as creative learning opportunities if they wish to do so. Seen in this light, medical audit may be said to contribute to quality assurance, but cannot be equated with it in full.

QUALITY ASSURANCE: TO IMPROVE OR REGULATE?

It would seem that the more a practice can do within itself to assure comprehensive quality and continuously to seek to improve its services, the less need there will be for external intervention by management or other agencies. It is also true that any effective total system of quality assurance has to incorporate selective external monitoring from time to time. There is an active debate in progress on the relative balance to be struck between internal and external review, and as part of this the relative weight to be given to the principles of encouragement and improvement on the one hand and the principles of fault detection and correction on the other. Even a cursory examination of the literature will reveal just how far reaching this debate has become. In Britain, where the profession has been lightly regulated in the NHS, the new contract is perceived by doctors as introducing oppressive external standards together with a powerful system for reinforcement. The contract refers to the objective of bringing all practices up to the standard of the best, and of making all practices more responsive to patients. It is not yet known whether it will achieve its objective, particularly of influencing the behaviour of practitioners at the lower end of the spectrum of quality. However, it can be said that it has upset most doctors, including those who are already offering high quality care. The main reason given for the effect on the high quality providers is that it is too clinically prescriptive, and so diminishes them by diminishing their sense of professional responsibility. There are also doubts about the effectiveness of some of the preventive procedures such as the routine examination of all adults and the regular measurement of height.

The dilemma goes wider than Britain. Berwick [38] recalls that there are two basic approaches to quality assurance in the USA. The first and best established is the pursuit of 'quality by inspection', that is of discovering bad apples and removing them. Recertification and deterrents through litigation come into this category, and those who promote it are always looking for better tools of inspection with good measuring qualities. Bad apple theorists, Berwick argues, publish mortality data, invest heavily in systems of case mix adjustment, and fund vigilant regulators. The result of this approach is hostile defensiveness on the part of those whose performance is being assessed.

The alternative approach is based on what Berwick calls the theory of continuous improvement. In this the good apples, that is the average professional rather than the outliers, are enlisted in their hearts and minds to pursue better ways of doing what they do. The modern quality improvement expert therefore cares far more about promoting learning and cooperation among the majority of conscientious doctors than about censoring the minority who are deficient.

Earlier, Rubin [21] had described the evolution of a pioneering system for the improvement of medical care in the Kaiser–Permanente Medical Group in Northern California. The comprehensive quality assurance system (CQAS) started from the premise that quality assurance is basically an improvement process. Given this, the best results would be achieved by addressing local problems using local criteria and standards devised by local health professionals, who would be committed to them by virtue of ownership. The technique used for performance monitoring was the micro-sampling of patient records in a highly time and cost effective manner.

Rubin [39] contrasted the CQAS philosophy with the traditional approach thus:

CQAS

- Find out what is wrong and fix it
- Demonstrate good care

Traditional

- Demonstrate good care
- If bad care is discovered, address it

Continuous improvement, he said, starts from the assumption that all care can be bettered no matter how good the professionals think they are. But, since this approach always attacks problems, and tends to ignore things that go well, quality assurers have to take great care that the health professionals whose care is being assessed in this way do not become demoralised, and give up. Preserving a sense of proportion between the good and somewhat less than good is usually all that is necessary to maintain a positive attitude.

Berwick [38] identifies nine factors necessary to make the improvement approach a success. These are:

- Leaders in health care must take the lead in quality improvement
- Investment in quality improvement must be substantial
- Respect for the health care worker must be established
- The dialogue between patients and health professionals must be open and carefully maintained
- Modern technical, theoretically grounded tools for improving processes must be put into use in health care settings
- Health care institutions must 'organise for quality'
- Health care regulators must become more sensitive to the cost and relative ineffectiveness of relying on inspection to improve quality
- Professionals must take part in specifying preferred methods of care, but must avoid minimalist standards of care
- Individual physicians should commit themselves to continuous improvement

Berwick's own commitment to continuous improvement has been reflected in the excellent results achieved at the Harvard Community Health Care Plan. Meanwhile the trend continues. The JCAHO [40] has, for example, published its agenda for change in which it defines two major goals: the stimulation of health care organisations to create an environment focused on quality of care, whose governors, management and clinical leaders are devoted to quality improvement, and the development and implementation of a national performance measurement data base that will help to stimulate continual improvement.

The first goal, the Commission states, will be advanced by having fewer standards, and by focusing those standards on the functions that are essential to

good patient outcomes. The second stems from their belief that health care quality improvement requires a standardised, universal, affordable, flexible and reliable data system which can provide risk adjusted, comparative feedback to health care providers.

In an enthusiasm for the encouragement of good apples it is important to keep a sense of perspective, and to understand that there have to be ways of dealing with people whose performance is persistently below par for one reason or another. The Japanese, for all their commitment to the principles of improvement in industry, are strict disciplinarians. It is also interesting that in the United States those health care organisations most committed to the principle of improvement for their established workforce are highly selective about the doctors they choose to work for them in the first place.

TOWARDS COMPREHENSIVE QUALITY

In the business world and increasingly in health care, the pursuit of quality is being seen as the foremost operational goal of an organisation. Walton[41] gives an excellent account of how Deming brought this kind of approach so successfully to Japanese business that it is being reimported into the United States and applied to the improvement of health care. Chase,[42] for example, describes a total quality strategy. In the UK, Handy[43] reflects the quality objective when he describes 'flat' management structures in 'clover leaf' organisations. These are designed to enhance the role and performance of professionals, to promote greater effectiveness by redistributing the balance between core personnel and others to whom work may be delegated by contracting out, and to allow for and utilise fully the more flexible approach to work patterns and career tracks which young people have today.[44]

How does the NHS experience compare with this? The government's general philosophical direction, set out in *Promoting better health*, would seem on the face of it to give the pursuit of quality a high priority in a more actively managed service. However, many of the specific proposals and much of the rhetoric have given the impression, rightly or wrongly, that managing for efficiency and therefore for cost containment carries an even higher priority; hence much of the controversy which the proposals have caused.

RESOURCE MANAGEMENT AND QUALITY ASSURANCE

It is simply not possible to think in terms of quality without taking account of the resources available and the way in which they are used. The two will always be in a state of tension, in which the natural purchaser drive for cost containment can only be reasonably reconciled with quality considerations if the latter are clearly defined and understood. Thus, it would be relatively easy for purchasers to take less than optimum services for less money if the services in question are so vaguely defined that it is not possible easily to distinguish the acceptable from the unacceptable. Conversely, purchasers would be hard put to justify a low investment if it could be seen immediately and obviously that this would have an adverse impact on the health status of those whose care they were charged with providing. For general practice the message is plain. The more that practices can specify the range, standard and cost of the services they provide, the better chance they will have of securing the appropriate resources.

IN CONCLUSION

Quality assessment and quality assurance embrace highly complex concepts which can be difficult to translate into practice. The pursuit of quality raises questions and issues which in particular impinge upon the respective roles of individual professions (and their professional bodies) and management, both at the local level of the clinical team and within the NHS management structure.

A successful quality assurance programme will be comprehensive, and will therefore address both the organisational and clinical aspects of patient care. It will be systematic, planned, and it will be developed with the full cooperation of the staff concerned. It will concentrate on and expect to find areas for improvement. It will bring about improvement mainly by incentives and encouragement, with punitive measures reserved as a longstop. It will cultivate a high level of confidence among participants and ensure a high level of confidentiality about the detail of individual and health personnel involved.

Two things stand out in the UK. The first is how the aspirations of health professionals and managers are to be reconciled in the pursuit of effective quality assurance in the service of patients. The problem is exacerbated in the UK

because, paradoxically, British doctors and patients have been used to an under managed system of care in the NHS, compared with a higher order of management which has been found to be essential in private or quasi-private health providers. The second point is whether the vision can be raised from the relatively narrow concept of medical audit as it is being considered today, to embrace the broader dimensions of comprehensive quality assurance and the habit of managing for quality.

The question is whether this philosophy can be applied in British general practice?

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3 – FOCUS ON THE PRACTICE

Modern general practices have to be prepared to take corporate or collective responsibility for the standards of their care. This requires a major shift in emphasis and direction away from the concept of the practice as a loose collection of individuals who work together.

The change towards corporate responsibility should offer the opportunity, some would say the obligation, to manage a practice's services for patients in a way which promotes the pursuit of quality as the guiding philosophy. Managing for quality in this way would go a significant step beyond current ideas for the use of medical audit in general practice. Such ideas tend to concentrate on the improvement of the individual practitioner's personal knowledge and skills through education, and therefore see the relationship with management, in this case practice management, as minimal.

This chapter shows why and how the general principles of quality assessment and quality assurance described in Chapter 2 should be applied in individual general practices as part of the general management process.

THE CONTEXT

The modern general practice is evolving as a managed system of primary health care serving the defined list of people who have chosen to register with it. Its purpose is to provide the best possible care for patients on the list at the lowest possible cost, relating such care to the health status of patients, what they need and want, and therefore to an understanding of how their health might be improved.

Good patient care is thus dependent on practices having the people, policies, organisation, management skills, data generating information technology and performance monitoring arrangements which, in combination, can best ensure that they achieve their purpose. Good care today means planned care, for patients with chronic illness, for promoting health and preventive medicine, and for handling acute illness promptly and effectively. Planned care requires teamwork especially when several health professionals in a practice are looking after the

same patient. It also requires good data for informed decision making, especially in determining aims, objectives and priorities for care, in setting standards and in assessing the performance of individual members of the practice team.[1]

The new contract for general practice, and the proposal for fund-holding practices, have served to focus attention on the role of practice management as the vital instrument in enabling practices to see and to describe better what they are trying to do, how they can achieve their objectives, and at what cost. Such a role has already been described in some detail.[2–4] With this instrument it is possible to see beyond the level of simple practice audits carried out from time to time by enthusiastic partners on subjects which appeal to them, or less enthusiastically as a response to a contractual demand, to a position where comprehensive managing for quality can become a reality, integral to comprehensive patient care.

There is a proviso. It is probably true that the gap today between 'innovating' practices [5] which can see this new horizon, and traditional practices which have yet to come to terms with the principles of medical audit, has never been wider. It is likely to widen once again under the clinical and managerial imperatives of the practice fund-holding development as these practices develop their policies, systems and standards for quality assurance.

In this situation there are three major tasks. The first is to develop and deploy the skills and methodologies required for total quality management in innovating practices. The second is to create a critical mass of practitioners and practice managers who are both committed to and skilled in the new approach, so that the initiative achieves its own momentum. The third task is to begin and sustain a supporting educational initiative and network of good communications in each health region, so that the philosophy, and the knowledge and skills required are disseminated quickly to all other practices.

WHY COMPREHENSIVE QUALITY ASSURANCE?

It is important to say why comprehensive quality assurance should be the aim of every practice. Many general practitioners brought up in the philosophy of professional self regulation will question the need for it, and will therefore want an explanation of why it should be part of practice management. After all, these

doctors may say, surely it is enough to carry out personal or peer medical audit from time to time without going further?

The following (see also Figure 1) are the most important reasons why practices should think beyond medical audit to comprehensive quality assurance.

1. Quality assurance is an essential component of good management and clinical practice, both of which are substantially interdependent. Giving a good personal service of itself cannot assure quality. In relatively complex organisations involving many people, and modern practices are just that, there need to be resources in terms of people, time, money and skills to translate a general notion of quality into structures, policies, systems and results.
2. Quality assurance contributes to personal professional development. Primary health care, more than most services, is intensively dependent on the knowledge, skills and attitudes of individual health

QUALITY ASSURANCE

- Is an essential component of good management and good clinical practice
- Contributes to personal professional development of health professionals
- Provides a means of accounting to the local community for services given
- Raises consciousness about quality of care provided by hospitals and community services for patients of practice
- Helps practices to explain their services to patients and colleagues
- Is a necessity when seeking resources
- Is a pre-requisite for effective defence
- Offers a practice best protection against external interference and control

Figure 1. Reasons for Comprehensive Quality Assurance in General Practice

professionals, and is relatively independent of high technology at the point of service. The personal professional development and therefore the technical performance of health professionals, be they general practitioners, nurses, health visitors, or receptionists, is thus of central importance to the success of a practice overall. An effective practice will know what mix of skills it requires for the job it is trying to do, what training and continuing education it requires of its individual members, how it is going to monitor their performance and what package of incentives it will apply to help ensure that individuals realise their full potential.

3. Quality assurance is a means of 'accounting' for services given. General practices will be expected in future to give the communities they serve a reasonable account of their services. Practices which do this systematically will be well placed to discharge this responsibility. This accounting may also be required in future if independent agencies with responsibility for accrediting individual practices are established, rather as training practices are accredited now by regional postgraduate organisations.
4. Consciousness about quality within a practice should make the practice equally conscious about the quality of care given by other professionals to whom patients may be referred. Comprehensive quality assurance in a practice should thus extend to the assessment and evaluation of the care given by hospital consultants and workers in the community services. Practices should be prepared to make their own assessments and, where appropriate, specify their own standards for such services. For example, are the waiting times for hospital outpatient appointments acceptable? What are the complication rates for surgery? What is the standard a practice specifies for access to diagnostic radiology or to the laboratory? Are the consultants to whom patients are referred kind and considerate? This extension of quality assurance should open up the relationship between a practice and its related services, and should help to establish the practice as the patient's guardian and advocate in achieving secondary care of good quality.
5. Comprehensive quality assurance should help practices to explain their services. In future practices will be expected to disseminate much more information about their services so that patients

understand what they are trying to achieve, and therefore how to make the best use of the services available.

6. Effective quality assurance is a necessity when bidding for resources. In a climate within medical care when the competition for available resources is keener than it has ever been, and will remain so whatever the political complexion of the government in power, practices will find it essential to be able to demonstrate the range, quality and cost of their services. Indeed, the ability to attract money for new services or resources for the improvement of existing services will be heavily dependent on a practice's professionalism. Similarly, effective quality assurance will be a virtual precondition for success in securing experimental and developmental funds paving the way for the introduction of new ideas and technologies.
7. Effective quality assurance is a prerequisite for effective defence. Although in the UK there has hitherto been only limited litigation against doctors, the pattern is changing. Quality assurance should reduce risk by allowing a practice to identify and correct areas of potential hazard before a disastrous mistake is made.
8. Lastly, effective quality assurance is the best protection a practice can have against excessive external inquisition, interference and control.

MANAGING FOR QUALITY: THE DEVELOPMENT PLAN

There are many ways in which a practice may set about the business of managing for quality, and individual practices will want to work out their own. It is helpful to start with a development or business plan for the practice which projects forwards for five years or so, and which is subject to regular revision in the light of experience. The development plan is also used, incidentally, as the template for graduate education and audit in the chapters which follow. The plan provides the framework within which certain general principles and issues can be considered, and a record of what the practice is going to do. The process of working up such a plan is usually helpful to participants — indeed some would say more useful than the product.

The headings and structure of a conventional development or business plan are shown in Figure 2.

1. OVERALL PURPOSE

Where are we now and where are we going ?

- Aims
- Activities

Each of which will have their own purpose, aims and activities

2. RESOURCES

What do we need to get there ?

- Time
- Money
- People
- Data
- Organisation
- Systems
- Standards
- Capital stock

3. CONSTRAINTS / STRENGTHS

What are the current constraints, and what others will we meet ?

- Identify constraints
  Internal and external to the practice

What factors are working in our favour, and what others are likely to arise in the future ?

- Identify strengths
  Internal and external to the practice

4. MONITORING OF PERFORMANCE

How will we know when and if we have got there ?
If we don't make it, will we know why ?

- The standard setting / performance review cycle

Figure 2. The Development Plan

Overall purpose and aims

(i) Statement of purpose

The development plan should start with a statement of overall purpose, often referred to as the 'mission statement'. This will express, at the highest possible level and in the most general terms, what the practice is about. These statements can be deceptively simple. In fact securing agreement, based on a full understanding by all who work in a practice, may well generate considerable discussion and reveal unexpected diversity. Members of the practice team need to relate the corporate direction to which they will become committed, and to which they will have to work, to their own personal career agendas.[6] The effort of securing a general consensus on such a statement will be repaid many times when difficult aspects of implementation come to be considered later.

It is from this statement of overall purpose that the aims of the practice can be extrapolated. These break down the statement into its component parts and so begin to identify actionable, implementable activities. It is from these that the priorities of a practice can be derived, and targets agreed for short term action with dates for achievement attached.

The process can be illustrated from the author's own experience. Last year all the partners in the practice decided that they wanted to try and define, with their local community through the FPC, the range and quality of service their patients need and want from them. They wanted to identify aspects of their patient care for which explicit standards could be set and to adopt implicit standards, based on judgement, where precise definition was not possible. They felt they should be prepared to justify their performance against such standards. This approach they could see as the basis of their contract with the NHS in future, a contract subject to periodic review. They would expect to be judged by their results; and given this, they would not expect to be told in detail by government how they should achieve them, as the 1990 contract tends to do.

The overall purpose of the practice, first described provisionally in an outline five year development plan,[7] is

> *'to provide services for patients which always reflect, and whenever possible are on the leading edge of, the latest clinical, technological, organisational, social and economic advances in primary health care'.*

The partners described the following provisional 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
- To develop the means of determining unit costs

To implement the plan the partnership has been reconstituted as a board of management and has brought in new management skills. Partners have areas of responsibility for which they are accountable, for example, finance, personnel, clinical policies, buildings and equipment, teaching, fund-holding development, external relationships and so on.

This kind of development reflects the aims of the quality initiative of the RCGP. In pursuing this philosophy the practice has placed the question of quality at the top of its list overall, and intends to try and apply the test of quality to all parts of its organisation and activities. The result should be a situation in which the practice can describe its work and its results in some detail, and so be able to justify these to whomsoever.

The intrinsic self-sufficiency of a practice is fundamental to success both for patients and for health professionals in future, for it will encourage innovation and experiment at the point of service where these are most needed. It will leave providers with sufficient room for independent manoeuvre in how they set about their tasks, since judgements of performance will be based on results.

There are at least three other matters which will need to be thoroughly discussed as a practice decides on its future direction. These concern corporate responsibility and accountability, the case for the philosophy of improvement, and a practice's attitude to assessing patient satisfaction with care given.

(ii) Corporate responsibility

For historic reasons most British general practices have functioned as partnerships of individuals in which the concept of corporate responsibility has been limited to certain basics, such as how to share work and income equitably, and how to arrange holidays and off duty rotas for mutual convenience. In many

practices there is also a philosophy of general practice which results in practices choosing partners who are of similar outlook and who share similar values. However, it has not been seen as necessary to secure a higher level of consensus, and commitment to that consensus, on major aspects of clinical and operational policy either among partners or with other professional staff. Many who have remarked that genuine team care in British general practice is still a myth would recognise this as part of the unsolved problem of achieving a true understanding of corporate responsibility.

Some practices recognise that a change towards greater corporate responsibility is coming. In this respect the new contract threat of contract penalty has had a galvanising effect by extending an awareness of the meaning of corporate responsibility beyond the practices of enthusiasts to almost all. In the light of this the notion of corporate responsibility will need to extend to, for example, such features of a practice as an agreed framework for record keeping, agreed clinical standards and operational policies for aspects of care which lend themselves to this approach, agreed indicators for hospital referral, laboratory and other diagnostic service use, agreed levels of expenditure for prescribing, and an agreed method of changing practice standards and policies in the light of the findings of performance monitoring and evaluation. In reaching such agreements it is important to indicate areas where a doctor may retain individual discretion, the doctor option within a corporate policy. This introduces a necessary element of flexibility in that it allows for legitimate and indeed desirable variations in style of practice within limits specified by all partners.

Achieving a commitment to corporate responsibility is one side of the coin. The other is the commitment of individuals to be accountable to the practice for personal performance, which means a willingness to abide by the agreements to which each individual is party, and also a willingness to justify to colleagues significant departures from agreed policies or standards where these occur.

These twin concepts of corporate responsibility within a practice and personal accountability to the practice are fundamental to managing for quality and are therefore inherent in good general practice today.

In the ultimate application of the principle of corporate responsibility, it is the practice which would account to the outside world for the adequacy of its overall performance and therefore of all its members. Critics of this line of development could rightly point out that under a general practitioner's terms and conditions of service the line of accountability is still between individual prac-

titioner and FHSA. Of course community nurses have their own line to the district health authority. However, it is worthwhile noting that recently the functional relationship between some FHSAs and practices has concentrated on practices as entities rather than on individual partners. This is a development foreshadowed in the changing relationship between regional postgraduate organisations and teaching practices[8] in choosing practices to provide teaching services.

(iii) The approach to improvement

In managing for quality a practice will need to decide how it is going to achieve sustained improvement and, when necessary, confront persistently poor performance. In Chapter 2 it was shown that contemporary thinking in modern business and health care management has swung decisively in favour of the encouraging approach, that is the search for continuous improvement based on the premise that most health professionals are well motivated and want to do a good job. This is the kind of positive philosophy which will appeal to most practices.

Working for improvement should provide the main thrust. Much more difficult is the question of identifying and taking action on persistently poor clinical performance from any member of the practice team. Identification and solutions will be obvious in flagrant cases. Less obvious cases will almost certainly emerge through performance monitoring. Knowing is one thing; the difficult part is selecting and following through the most appropriate action particularly in practices unused to confronting the consequences of poor performance. It is essential, therefore, that a practice should anticipate such situations by establishing an agreed procedure for handling them before specific cases arise.

(iv) Patient satisfaction

Chapters 1 and 2 referred to the importance of the consumer interest in modern day managing for quality. Nevertheless, most general practices in the UK are unaccustomed to thinking about enlisting patients of the practice, when they are healthy as well as when they are ill, to help determine the direction and mode of working. They should. For example, some practices have explored the use of patient representative groups, practice newsletters and user friendly practice leaflets.

Some others have used questionnaires to representative samples of patients, or had someone ask patients in the waiting room what they think about the service they receive and what suggestions they would make. Patients will provide

excellent feedback on, for example, how friendly the reception is, how punctual the doctors are, how easy it is to get an appointment, whether the telephone is answered promptly, or how convenient the surgery opening times are.

Yet other practices have used community health councils to seek indirect feedback and further guidance on services to patients.

It must be remembered that the FHSAs are expected to carry out consumer surveys to solicit opinions about the services provided by their contracting practitioners and practices, and to find out how far such services accord with what people want.

It will be a matter for individual practices to decide how consumer/patient involvement in their business is to be achieved. The key point is that the subject has to go on the practice's main agenda, to be seen as a constructive and distinctive part of the development and evaluation of patient services rather than as an afterthought there for appearance sake.

Resources

The second step in the development plan is about resources. Resource allocation, whether of people, time or money, is destined to become a new component of general practice. It means a major step beyond the simple ledger keeping and accounting systems which check the flow of money in a practice to the wider aspects of management accounting.

Faced with new or different demands, some partnerships tend to say 'this task is impossible for we do not have the time or the money or the people'. Others, however, find ways of solving the problem by reappraising their priorities, reassessing skill mix, finding different ways of doing things, and also by identifying new resources where this is genuinely appropriate.

In future it is likely that practices will need to show not only the range and quality of the service they provide, and its impact and significance on their community, but also how resources are deployed in achieving these ends. Practices which can handle the resource allocation/utilisation and quality issues competently should be well placed to ensure that they can secure and maintain their resources because they will be able to justify their requirements.

There are four resource areas which merit further discussion here.

(i) People

People are the basic resource of a practice. The quality of care is critically dependent on the attitudes, skills and knowledge of each individual, working separately and together, and on the way these are combined and deployed in the organisation as a whole. People are not only the most important but also the most expensive and the most delicate resource. Given this, one would expect the partners of a practice which is managing for quality to pay meticulous attention to developing, maintaining, motivating and generally nurturing them.

There are many sides to this. For example, does the practice know precisely what range and mix of skills it needs to achieve its object? Do job descriptions and contracts accurately reflect these? Is there a properly established programme for promoting the personal development of employees and partners through training, continuing education and regular performance monitoring and appraisal? Do the proprietors, the partners, explain regularly where the practice is going, and what part each person has to play in helping it to get there successfully? Is good performance recognised and are the reasons for poor performance identified, discussed and acted on? Does delegation include the delegation of appropriate authority to the practice manager and practice nurses?

Perhaps the essence of the good management of people is in stimulating and encouraging each person to take as much personal responsibility as they can for their job, and for their performance of it. Delegated responsibility, including responsibility for decision making, is the heart of the matter.[4]

(ii) Management skills

Skills are another basic practice resource. The quality of patient care is heavily dependent upon the personal performance of a practice's individual health professionals. Effective practice management is therefore about managing people, to ensure that each person is motivated, trained and equipped to do their job well.

Managing small groups, which is what modern practices are, requires more than the one to one interpersonal skills acquired in vocational training for handling the consultation. Practices need to think consciously about the managerial skills they will require, and to decide whether these are to be found or cultivated in house or bought in. In fact, as current experience shows, practices are finding it necessary to do both, to bring in skills and to introduce further training for their doctors and other team members.

(iii) Protocols and standards

An increasing number of practices are using protocols and standards to describe and specify expected performance in discrete areas of their activity. These may be organisational or define acceptable access or they may be clinical, indicating appropriate pathways for the diagnosis and management of specific diseases or common symptoms. They are becoming an important practice resource, and are the basis of performance monitoring.

More is now known about the generation and use of protocols and explicit working standards in general practice. The practice team needs to know how to construct and use these to get the best results.

(iv) Time

Time is one of a general practitioner's most precious resources. The board of management of a practice has to bear in mind that time shares with money the principle that what matters is not the rate of spending or the total amount spent, but rather the value of goods and services obtained. In other words, cost effectiveness is mirrored by time effectiveness, and a key policy decision must be on what is the most time and cost effective way of using a doctor's skills and knowledge.[3]

Constraints / strengths

Being clear about the purpose of the practice and the resources required to achieve it is only part of the story. Another important stage in the development plan is the identification of those factors which may constrain or even obstruct progress, and those other factors which are likely to be a help. SWOT stands for 'strengths, weaknesses, opportunities, threats', and is perhaps the best known method to use in strategy analysis. In making a SWOT analysis it is necessary to know about the history of a practice and the professional values of the partners and practice manager, for these constitute the identity of the firm. The purpose of the strategic analysis using SWOT is to establish the distinctive competencies of a practice and hence its current scope, and to identify the strategic options for future growth and development.[9]

Perhaps the best example of an internal constraint is to be found in partnerships themselves. There is a growing body of evidence that the presenting symptoms of dysfunction in a practice ranging from, for example, appointment systems which do not work to complaints of excessive workload to persistently excessive

prescribing, can be traced back to the decision making processes of partnerships.[10] Yet is it still common to find that practices treat the presenting symptom as the problem, and indeed may be quite reluctant even to think that the partnership may be the nodal obstacle standing in the way of proper resolution.

External obstacles are easier to identify because, by definition, they involve other people and therefore evoke less defensive responses. A common contemporary example is the constraint which nurse management may place on the development of teamwork in a general practice, by virtue of the separate line of accountability inherent in the 'attachment' of community nurses and health visitors from health authorities.

It is important to have every possible constraint accurately identified and listed, so that a complete picture is available. In doing this, a practice is more likely to succeed in finding solutions which either remove the constraints or find ways round them. Similarly, it is important to identify and mobilise the internal and external assets of a practice, so that these are used with maximum effect.

Performance monitoring

The fourth part of the development plan is the place of performance monitoring. As indicated earlier, quality is identified as an all pervading feature of the activities of an organisation and its individual members. It is an integral part of the management cycle (Figure 3). This contrasts with the habit in some commercial organisations of packaging quality assurance under a separate heading, to be handled as virtually a separate entity.

This concept is inappropriate for general practice partly because the units are of small size and comprise a relatively small number of people, and more especially because the 'hiving off' mentality can have the effect of detaching quality from being seen as the mainstream theme of an organisation's activities. And indeed, the approach advocated here is entirely consistent with the comprehensive approach to quality adopted by effective businesses and health care organisations mentioned in Chapter 2.

Nevertheless, it is necessary to accept the importance of performance monitoring as a distinct function which requires resources and skills dedicated for the purpose.

(i) General conditions for monitoring

The general conditions required for effective performance monitoring have been described in Chapter 2. These comprise leadership, the willingness of all members of a practice to provide moral and material support for performance monitoring, a commitment on the part of all health professionals to take part in performance monitoring, a willingness on the part of practice team members to receive feedback and to take appropriate action, and the effectiveness of the performance monitoring system itself.

To give full benefit to a practice, performance monitoring should be carried out on a planned, regular basis. Practices should be prepared to draw up a specific development plan for this purpose with its own aims, activities and targets. If this is not done, practices will find it difficult to pace and direct this aspect of their

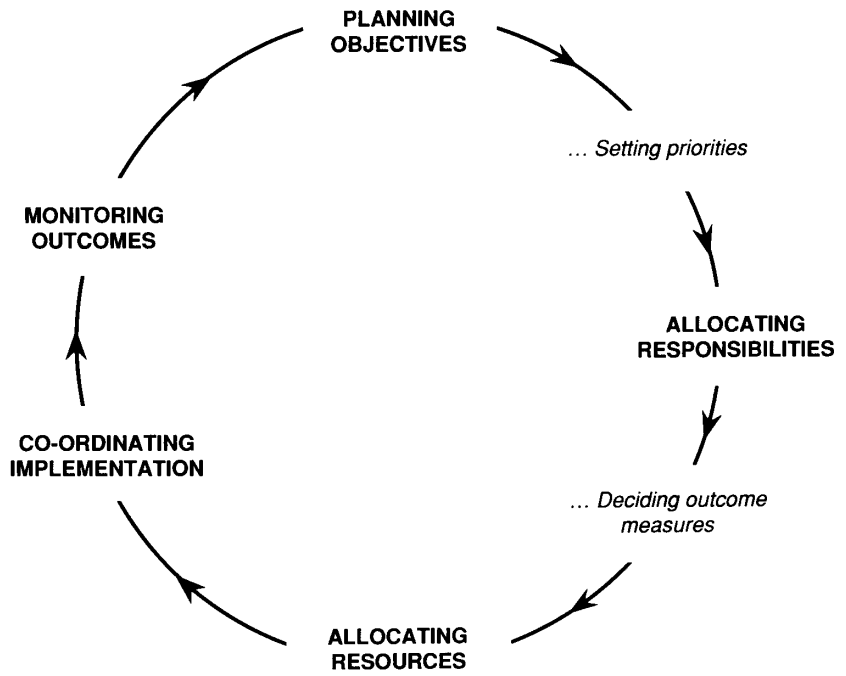

Figure 3. The Management Cycle

work, and so be effective. The plan should be reviewed regularly, perhaps on an annual basis, by both the partners and by all other members of the team.

The practice has to decide the indicators of performance to be used. For example, what tracers should be used to monitor performance through patient records? Or, if more emphasis is to be given to the assessment of known problems, what problems should be selected? Or, if effort is to be directed to event monitoring, will the exploration of difficult cases or the routine examination of the case histories of patients who die or where things have gone wrong give the best yield? Precisely what selection and combination of indicators is to be used is a matter for the practice to determine. The key decision to make at the outset is the commitment of all practice staff to act on results which demonstrate that there are better ways of doing things in future.

(ii) Designating responsibilities

Some larger practices may decide to set up a subgroup within the practice specifically for performance monitoring; where this happens, the leadership and composition will have to be considered carefully. The chairperson should be a senior and respected member of the practice, and should be reasonably familiar with the methods and techniques of performance monitoring *per se*. The practice should consider the representativeness of the subgroup, in particular seeking nominations from each main group of health professionals working in the practice. Specific groups of health professionals, such as nurses or health visitors or practice nurses, are likely to have more confidence in a system which is examining their performance if one of their number is party to the operation of monitoring. The presence of the practice manager is also essential. The practice manager and the chairperson (or senior partner) in particular will have special responsibility within the group of ensuring that the findings of performance monitoring are fed back to the practice as a whole, so that the results can be considered and acted upon as part of the general management process.

Practice performance monitoring subgroups should limit their remit to just that. Preferably it should not be part of their function to generate standards or protocols nor should they try to devise solutions to problems uncovered; to do so would be to risk their impartiality and would make it easier for the practice to avoid difficult issues. However, there will clearly be a continuing dialogue between the subgroup and the practice overall in which the experience gained in performance monitoring will raise questions about existing standards, prompt new ones and suggest areas for assessment and evaluation.

Where practices do not establish a monitoring subgroup, it is important nevertheless to designate resources and responsibility for the task; otherwise the effort required for effective performance monitoring will be difficult if not impossible to sustain.

(iii) Records

Chapter 2 established that a major part of performance monitoring is the recording and assessment of the process of care, what happens between health professionals and their patients. It can be revealed by direct observation, normally through the clinical records but also through video tapes of consultations and through other records kept in a practice such as appointments books, visiting books and day books.

It is acknowledged that the records in British general practice are generally insufficient for reasonable performance monitoring. This applies particularly to the old 'Lloyd George' envelopes, especially if they are bursting apart with paper, and may be without summary cards. Thus an early decision, which has to be taken by all practice members, is what the minimum data set to be collected in a practice should be. Are the records to show summaries of major conditions? Are the smoking and drinking habits of patients to be recorded? What other essential data should the front sheet of a record show? Is the record expected to give a reasonably clear and coherent account of the care given to a patient at any particular time, and if so what format will best achieve that? Other questions will concern the use of records by non medical personnel. For example, are nurses and health visitors to use the clinical record and if so will they agree to collect similar data in a similar way? Other questions will concern the reliability of records. For example, if records are typed, are they initialled to show that what is typed is actually correct? What responsibility will each user of the record accept for checking on the accuracy and up to date state of entries in the record, so that the reliability is as high as possible? And, through this, what checks does the practice operate to test the reliability of its database, particularly the reliability of the age/sex and patient registration sections? The more accurate the data, the better performance monitoring will be; and those whose performance is being assessed will have more confidence in it.

It should go without saying that the development of the clinical record and of practice information systems should not be driven by the needs of performance monitoring alone. Rather, there is the general management function of ensuring always that the data systems and data produced relate directly to the aims of the

practice, which are about services to patients, and that time and money are not wasted in collecting data which is irrelevant or unreliable. It is the responsibility of the general practitioners and practice managers to convey to staff the supreme importance of good records to good patient care.

(iv) Data collection

Performance monitoring requires specific resources. For example, at its simplest level random searches of the records for data, which will demonstrate compliance or non compliance with single statement standards, can be done by trained non medical personnel whom the practice may decide to recruit specifically for that purpose. The collection of data for matching against more complicated standards, on the other hand, may embody a judgemental element which requires a different order of skill and a different background, and may well need a medical input.

Computer data on performance should derive from the general management process, which should have included the specification of standards against which performance will be expected to be judged. The design of such information systems is a matter for the whole practice but clearly, as those charged with monitoring acquire experience and expertise, so they will be in a position to make a particularly informed input to system specification.

(v) Data analysis

The collection of data is one aspect. The next step is in the analysis of those data, in their provisional interpretation and in the dissemination of the results. Here again there are both policy and practical aspects which will need to be worked out and thought through within the practice. For example, are data about performance to be anonymised? If so (and they should be in the early stages of the monitoring cycle), at what stage are individual doctors or nurses identified? If individuals have to be identified, to whom within the practice do the performance assessors give this information?

It is a function of practice management to help a practice to collect and present data which facilitates comparative studies with other practices. This raises more questions. For example, are the data being collected in a form which enables inter-practice comparisons? Are there certain aspects of a subject where compatibility with other practices is essential, and other aspects of the same subject which are peculiar to that practice, and if so what does each aspect consist of?

CONFIDENTIALITY

Performance monitoring is raising ethical questions in relation to the confidentiality of patient records.

The present position may be summarised thus. The General Medical Council (GMC) insists that confidentiality should be preserved in all cases, except in certain specified exceptions where the release of information is permitted, provided always that doctors can justify their action. Nurses have similar guidance governing their relationship with patients. Clinical confidentiality may extend beyond the individual doctor to other practitioners and to other members of the practice team who are concerned with the care of a patient. Within a practice, therefore, performance monitoring should be within the framework of confidentiality already regulating clinical care. In general terms it is accepted by the GMC and by lay organisations both in this country and abroad that it is in the best interests of patients generally that doctors and other health professionals in a practice should be able to look at medical records in confidence within a practice for the purpose of improving standards of patient care.

An important part of performance monitoring and assessment in training practices involves the external appraisal of individual doctors and a practice by visiting peers. In these visits there is invariably an inspection of patient records. In 1986 the GMC was asked to advise on the confidentiality aspects of these record reviews. The Council, in its Annual Report,[11] recommended that the existing arrangements for inspection should continue, but asked all doctors carrying out such inspections to act with sensitivity and discretion, and always to be conscious that they are themselves bound by the rule of professional secrecy. The Council also recommended that each training practice should ensure that all its patients are fully informed of the circumstances in which their medical records might be disclosed to doctors other than their own, for educational purposes. Such information could be given to patients through practice leaflets and notices in the surgery. The Council concluded by saying that it should be made clear to all patients that anyone has the right to refuse consent to the disclosure of their medical records for this purpose, if they should so wish. This guidance to training practices is becoming relevant to all practices as medical audit is introduced into NHS general practice.

Patients now have right of access to data held on computer and manual records. Few doctors dispute the desirability of a more open relationship with patients which would include their right to see their records. However, in relation to performance monitoring, one of the problems is a concern among clinicians that a revelation of their thought processes and their opinions, rather than the facts, could expose them to litigation. Yet, it is this development of the case and the doctor's thinking which is the basis of performance assessment based on records.

At the time of writing the matter is unresolved. However, from a practical point of view, it may be said that conscientious doctors who write careful and accurate notes, and who could justify their opinions and reasoning to colleagues, would have nothing to fear from having those records seen both by patients and by colleagues undertaking performance review.

IN CONCLUSION

The modern general practice is becoming a managed care organisation whose purpose is to maintain and improve the health status of patients who are registered with it, through the provision of primary health care services of good quality and acceptable cost. The best results are likely to be achieved by the adoption of an approach to management which places quality at the centre of everything a practice does, using the principles and methods outlined in this chapter.

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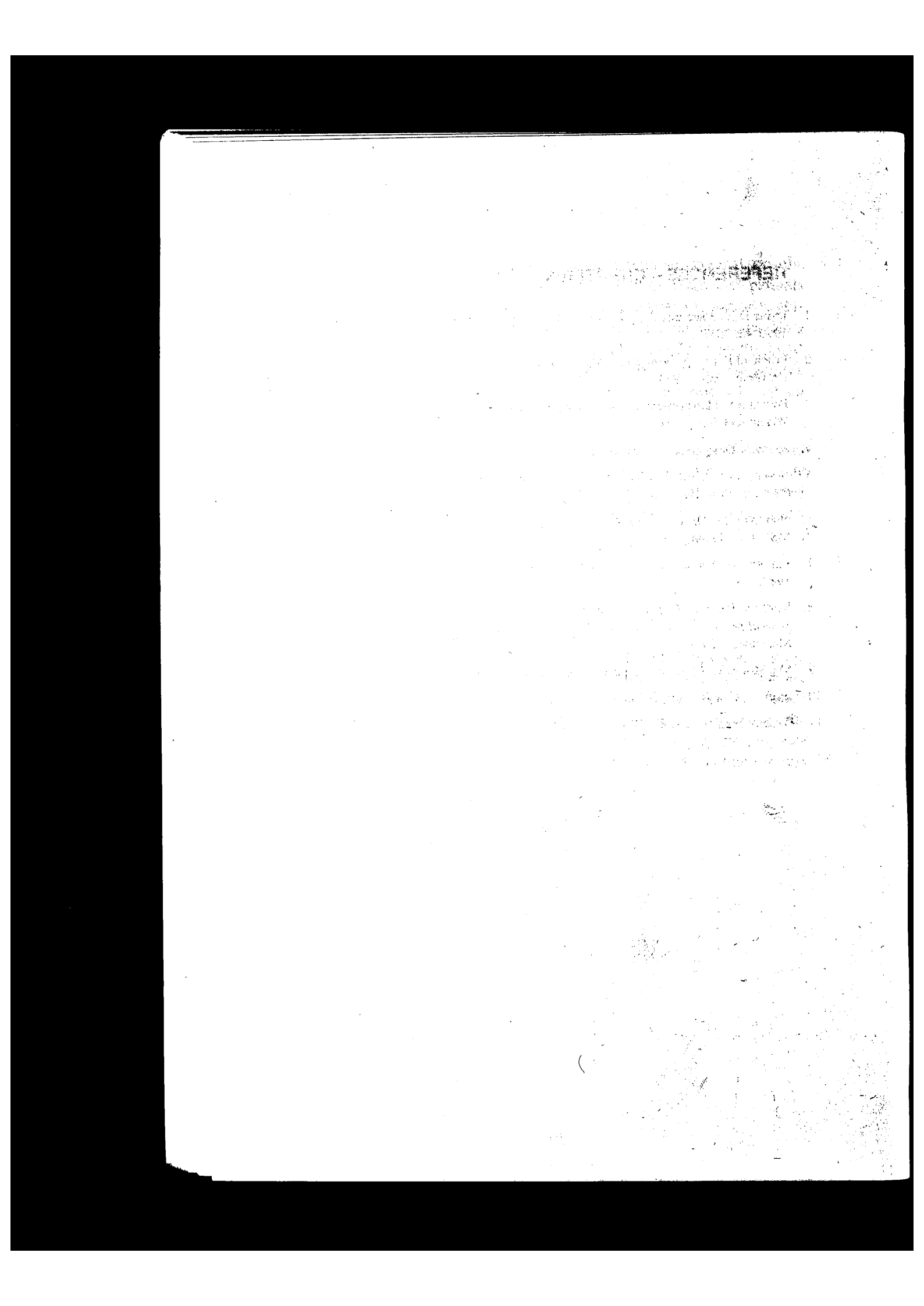

4 – QUALITY AND EDUCATION MANAGEMENT

This chapter continues the theme of managing for quality by showing its relevance to the training and continuing education of general practitioners and other members of the practice team. There are two main applications. First, there is the need to apply the general principles to the organisations which provide training and continuing education. They should manage the provision of educational services to the health professions with quality foremost in mind. To illustrate the point in this chapter, the example used is the regional postgraduate organisations which provide vocational training and continuing medical education (CME) for general practitioners. But the same principles can be applied equally to the bodies which train nurses, health visitors, practice managers, receptionists, and all other team members.

The second application refers to the need to expand the content of current educational programmes for doctors by adding the principles and skills of management to the clinical knowledge and skills which practitioners have to learn. They should understand the direct connection between the quality of care which results from their personal performance with individual patients and the quality of care provided by the practice in total, and the fact that these two are substantially interdependent.

THE CONTEXT

In Britain it is traditional that general practitioners turn to specialists for their CME. This habit stems from the acceptance of general practice as a combination of several specialties practised at a more superficial level. General practitioners would therefore have little to contribute by way of new knowledge and skills to their own formal education compared with specialists. This philosophy, although tempered substantially in recent years by the effects of vocational training, still predominates today.

The three year programmes of vocational training for general practice, which began in the early 1970s in experimental schemes, were fundamentally different from the outset. In a series of challenging papers which culminated in *The future*

general practitioner: Learning and teaching,[1] the RCGP defined general practice as a discipline with its own distinctive body of knowledge, skills and attitudes. This professional and intellectual framework has been shown to be well founded. Vocational training is based on it and the more innovative programmes of practice based CME reflect the new thinking. Even more importantly, the breed of teaching general practitioners introduced in the 1970s into vocational training were stimulated to question and examine their own and their colleagues' clinical practice, and to share the results of these informal assessments with each other. Thus were sown the seeds of clinical standard setting and performance assessment in British general practice.

Today it is the RCGP's concept of general practice which is in the ascendancy. For example, young doctors now have to acquire further knowledge and skills beyond those possessed at graduation. The College's teaching methods, especially those which use small groups, are as popular with general practice principals as they are with trainees. The principle of external performance review by peers, built into the teaching practice system, is accepted and will be extended to all general practices through the adoption of medical audit.

The infrastructure

The infrastructure for graduate education in general practice is an important part of the current context. Without it a systematic approach to the dissemination of knowledge and skills to all practitioners who should benefit is not possible. There are two components, the regional postgraduate organisations (including their network of postgraduate centres), which provide courses and other educational activities, and the national organisations which set standards.

(i) Regional postgraduate organisations

The regional postgraduate organisations for general practice, based on regional postgraduate committees and their subcommittees for general practice, have evolved piecemeal with vocational training. Today, these structures are mainly geared to the support of vocational training. They comprise networks of practice trainers complemented by course organisers and a tier of regional and associate advisers who organise the training schemes and academic activities. These doctors together comprise the 'academic staff' for graduate education in general practice. The vocational training structures are being adapted to cater for those

principals who want to take part in peer led small group activities. Nevertheless, most CME is still organised and provided largely by specialists through clinical tutors and postgraduate centres.

Within this infrastructure, the best schemes of vocational training have been managed with quality in mind. For example, most schemes choose as trainers doctors who are prepared to learn the basic principles and skills of graduate education so that they can perform professionally as teachers as well as clinicians. Other examples of good educational management include the habit of evaluating half day release courses and the involvement of trainees in the improvement of their training by inviting them to carry out consumer surveys and to provide a consumer input to trainer assessment.

There is also a down side. For example, trainee assessment in the regions is underdeveloped because there is still no generally accepted national standard of competence to indicate the satisfactory completion of vocational training. Therefore there is no great incentive to put assessment onto a sound basis in vocational training schemes. Also most CME activities do not pretend to address the learning needs of individual doctors or try to relate these to the needs of patients and the NHS other than in very sporadic or general terms.

The position is changing. The 1990 contract will extend the functions and responsibilities of regional advisers and their organisations to include the accreditation of educational activities for the postgraduate education allowance (PGEA). Further responsibilities are envisaged. As medical audit is introduced to all practices, so regional advisers will be asked to ensure that doctors, and other team members, have the opportunities to learn how to carry out standard setting and performance review. They will be expected to demonstrate leadership through quality assurance in action in their own practices. They are asked increasingly by the GMC, and in future probably by the MAAGs as well, to supervise the further education of general practitioners whose performance has been shown to be unsatisfactory.

Moving even further in the direction of total quality assurance, regional advisers and their colleagues will also be expected to make a specific input to the provision of managerial skills for general practice through the training of the relevant personnel, especially general practitioners and practice managers.

Clinical teachers in general practice now agree that the current rather primitive regional structures and arrangements for managing graduate education are no longer appropriate to the new tasks. Improved regional and local structures are now essential and will have to be considerably bigger and more sophisticated than anything which exists at present. These will have to go hand in hand with new management practices to ensure that vocational training, CME and the educational aspects of medical audit are of a consistently high standard, and are well founded. Hence the relevance of the philosophy of managing for quality to the regions.

(ii) National organisations

Three national organisations, the RCGP, the JCPT and the GMC, complete the picture of the bodies influencing standards of practice and of education for general practice.

The RCGP — The RCGP, like its sister medical Royal Colleges, exists to set standards in its own specialty. The College exercises this influence most directly through its membership examination.

The MRCGP examination is a comprehensive and well tested instrument used to assess the clinical knowledge of practitioners wishing to become members of the college. The college holds that the standard of the examination reflects the knowledge and skills appropriate to the completion of vocational training. College certification through the MRCGP examination, which is voluntary, extends to an increasing proportion of new general practitioners, but still falls well short of all who become principals. For example, in 1987/88 the proportion of trainees choosing to take the exam, as a proportion of all eligible, ranged by region from 43 to 100 per cent. In the same year the pass rate among the takers varied from 63 to 89 per cent in different regions in the UK; the overall pass rate was 74.7 per cent.[2] In the same period over 95 per cent of trainees who sought JCPT certification achieved it, and so were eligible to become NHS principals. Thus, because the possession of the MRCGP diploma is not a normal precondition of becoming a principal in the NHS, doctors whose standards are judged by the College to be less than optimum, that is they fail the examination, are generally accepted on the lists of FHSAs as principals. This is a fact which has obvious and serious quality implications for patients using the NHS.

The College is developing other performance assessment methods. For example, the mid career assessment of those doctors wishing to become fellows has just been established, and it is anticipated that this will become the normal route to

fellowship in time. At a less formal level, the College is contributing actively to the development of methods for standard setting and for monitoring performance. It actively encourages its members to use these in their everyday practice along the lines described in the Quality Initiative.

The JCPT — This is the professional body responsible for setting standards of vocational training for general practice. It does this in two ways. First, building on the early work of the RCGP, the joint committee sets national standards for training programmes. It monitors these through the system which it operates for the accreditation of regional postgraduate organisations and vocational training schemes in the UK (see page 65). Secondly, the committee was nominated by Parliament to handle the certification of individuals completing vocational training in the UK. JCPT certification is required for all doctors who want to become principals in the NHS under the vocational training regulations (see below).

The GMC — The GMC is the medical licensing body in the UK. Its powers derive from the medical registers which it keeps on behalf of Parliament. Entry to the medical register is restricted. It is confined to people who can satisfy the Council that they have been trained as doctors in an institution which follows a programme of basic medical education of a content, length and standard approved by the Council, and that they have personally achieved a standard recognised by the Council. Practitioners may be removed from the register if they have been found guilty by the Council of serious professional misconduct or if their health is shown by the Council to be seriously impaired.

Certification and accreditation

No description of the current context of graduate education for general practice would be complete without some mention of certification and the accreditation procedures which are used to set standards and to monitor performance in the following ways.

(i) Certification of completion of training

As indicated earlier the certification system operated by the JCPT is limited at present. Joint committee certificates of prescribed or equivalent experience are issued on the basis of statements of satisfactory completion of the various periods of training which make up a training programme. These statements, which are subjective, are signed by the supervising general practitioner or consultant

trainer. There has been a wide difference of opinion about whether JCPT certificates should reflect attendance at vocational training or whether they should indicate the achievement of the level of competence appropriate for unsupervised general practice. The main professional bodies (the RCGP, JCPT and GMSC of the BMA) have recently agreed that this ambiguous position is not in the public or the profession's interest; they now consider that it must be resolved in favour of an interpretation denoting satisfactory performance. However, they are not able to say how satisfactory performance is to be assessed, nor is there any agreement on a single national standard.

The JCPT certificate is likely to be underpinned by the GMC's proposals for registering the completion of specialist training. The Council is in the course of introducing an indicative register which will publicly denote practitioners who have acquired special knowledge and skills in one or more fields of medical practice.

General practice is one such field, and the indicator used will be the vocational training certificate issued by the JCPT. The purpose of this indicative register is to inform the public better about a doctor's qualifications, and so indirectly to raise standards by raising public awareness about who has had specialist training and who has not.

(ii) Recertification

The recertification of the established doctor is regarded as an even more contentious and provocative matter. However, there is a growing professional and public interest in the principle that all medical practitioners, including general medical practitioners, should be prepared to demonstrate the sufficiency of their clinical performance on an ongoing basis. This may be informally, on an *ad hoc* basis, where assessment is an integral part of an educational activity or as part of medical audit. But there are other, more formal methods. For example, RCGP fellowship by assessment is a mid career external appraisal of performance which amounts to voluntary recertification in all but name. Trainers are also subject to a periodic review, normally three yearly, when they apply to have their appointments renewed (see page 65).

Experience from overseas may give insight into possible future directions. For example, the American Board of Family Practice requires practitioners who wish to remain Board Certificated to be reassessed every seven years. The

certificate is based on a written examination, largely on factual knowledge recall, but this has recently been supplemented by a records review. The Canadian College of General Practitioners is introducing a voluntary system of recertification based upon a comprehensive assessment of a doctor's performance in the consulting room and practice. The purpose of the assessment is primarily educational, to help the doctor identify weaknesses and so bring about improvement. In some Provinces of Canada the licensing body also monitors performance through doctors' medical records. Thus, for example, the College of Physicians and Surgeons of Ontario selects doctors' names at random from the register, and then carries out a records review. Poor performers may be referred for a full assessment and a programme of further training, which they must undertake successfully if they wish to keep their registration. The Royal Australian College of General Practitioners was instrumental in introducing vocational registration in Australian general practice in 1989. This carries a commitment to CME, and a commitment also to take part in (admittedly so far ill defined) quality assurance activities. Practitioners in New Zealand are being encouraged to take part in CME activities which give prominence to personal assessment and to personal achievement through a system known as triadic learning.[3] Also the Medical Council in New Zealand is considering asking for evidence of continuing competence when practitioners pay their annual retention fee for the register.

(iii) Accreditation of teaching practices

In general practice the best system for setting standards and assessing performance today is operated by the JCPT and the regional postgraduate organisations jointly. This is a system of accreditation, although it is not formally described as such. The JCPT publishes national criteria and standards, which the regions are expected to follow when they devise their own local criteria and standards for the appointment of trainers. Both the JCPT and the regions have their own programmes of practice visiting, to monitor compliance.

In the early years the national and regional criteria for choosing trainers emphasised the structural features of a practice such as, for example, 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 such clinical activities as access to care, prescribing and the use of protocols for the management of chronic illness.

In the Northern Region accreditation has been taken a stage further by the adoption of a personalised agreement between the regional postgraduate organisation and each teaching practice.[4] In this, both parties agree certain standards prior to the accreditation (and therefore the appointment) of a practice against which subsequent performance will be assessed. At the time of the review, normally after three years, 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 appropriate local medical committee and RCGP faculty led by a regional/associate adviser. Subsequently, the practice profile and visitors' report are made available to the trainers' appointments committee at which accreditation and reappointment are being considered. The trainer's interview with the committee lasts about half an hour. Decisions may range from reappointment for a further three years through conditional reappointment for a shorter period where problems may have been identified, to no reappointment. Normally, if the steps in the procedure up to the final interview have been implemented appropriately, reappointment without conditions should be the usual decision because practices will have had the chance to bring themselves into line with the required standards.

The regional advisers in the UK and their colleagues have considerable experience of operating the national system of accrediting teaching practices, especially of the methods used in carrying out the peer based inspections. Most regional advisers would probably agree, however, that the system countrywide is capable of being improved considerably. In particular there is a need for better data systems to handle practice profiles and feedback.

(iv) Accreditation of regional postgraduate organisations

The JCPT also accredits regional postgraduate organisations and vocational training schemes as part of its remit to promote high standards of vocational training for general practice. The committee aims to assure quality by carrying out an organisational audit. It asks regions and schemes to define their policies, standards, methods of performance monitoring, the results they achieve, and the justification for their particular policies, methods and results, as the basis for accreditation.

The accreditation procedure is in two stages. The first, conducted between the joint committee and the regional adviser, asks for information about the main

areas of vocational training. The headings are shown in Figure 1. This stage builds up a detailed picture of the region or scheme and shows not only the strengths but the gaps in training programmes.

The second stage is the visit to the regions and selected schemes by the joint committee. The purpose of these visits is to amplify and clarify information already given, to verify that what the regional organisations say they do is actually put into effect, and educational, to pass on information about standards and training from the visitors to the providers and *vice versa*. The visitors are all active practitioners and so these verification visits are very much a vital part of this national system of external review by peers. In the visits a half day is now devoted to a further questioning of the regional/associate advisers and the scheme organisers about the functioning and effectiveness of the training for which they are responsible.

HEADS OF INFORMATION REQUIRED FROM REGIONS

- Overall aims and policies for training
- Regional criteria for trainer selection and arrangements for performance monitoring
- Regional policies for selecting / reselecting associate advisers and course organisers
- Regional policies for trainee selection
- Regional policies on academic courses
- Regional policies, methods and results of trainee assessment
- Regional policies on trainee participation in programme development
- Financial, organisational and systems support from the regional health authority
- Regional statistics

Figure 1. JCPT Accreditation of Regional Postgraduate Organisations Providing Vocational Training for General Practice

In many ways the joint committee's programme of accrediting regions and schemes is akin in principle to the JCAHO's accreditation of managed care organisations in the USA, where it is the local contracting organisation, such as a health maintenance organisation, rather than individual practices or hospitals to which most attention is given by a national standards body.

(v) PGEA accreditation

The new contract for general practitioners requires every practitioner to take part in a minimum of five days of formal study per year, in areas covering the diagnosis and management of disease, health promotion, and practice management and other supporting activities. In England the regional advisers in general practice, and in Scotland, Wales and Northern Ireland the regional postgraduate deans, are responsible in the regulations for accrediting educational activities which they consider to be of the required nature and standard.

The system came into force on the 1 April, 1990. It is too early to say whether this form of accreditation will have a worthwhile impact on the quality of educational activity. However, that is the intention. The organisers of CME are being asked to give the kind of information about their aims, methods and evaluation which has been standard practice in vocational training for some time.

Here is yet another area where the methodology of vocational training is being applied to CME with the object of improving quality.

THE DEVELOPMENT PLAN

From this summary of graduate education for general practice, it must be apparent that a managed approach has now become a necessity.

Managing for quality will require regional general practice education committees and the regional advisers, course organisers, clinical tutors, general practitioner tutors and all others involved with provision to develop a planned strategy. This will need to be set out in the form of a development or business plan in which the aims, priorities and objectives for graduate education in general practice are regularly defined and reviewed and in which continuing progress and performance are regularly monitored. This planned approach should be helpful in at least three ways. First, there should be greater consistency of purpose and standards in educational activity. Second, the contribution which graduate education for

general practice makes to patient care should be demonstrated far more clearly than it is at present. And third, and as a consequence, it should become easier to identify and secure the resources necessary to do the job properly because the need for them can be better justified.

Overall purpose and aims

The overall purpose of graduate education for general practice has to be couched in terms which reflect the need for doctors to acquire the necessary knowledge, skills and attitudes required to be an effective practitioner. In working out the aims the achievement of a consensus will be more difficult than in an individual practice because of the number of doctors involved and the diversity of their background and experience.

Here are examples of the kind of issues that need to be thought about when considering the aims of graduate education for general practice:

- Whether education should be linked more specifically to the work of the general practitioner
- The priority attaching to cultivating the habit of disciplined self learning
- Whether three year programmes of vocational training are sufficient, or whether a period of voluntary higher training is now indicated
- The extent to which CME should be self directed, and the extent to which it should be determined by the needs of the practitioner's practice
- Whether personal assessment should become the norm in both vocational training and CME
- Where and how medical audit fits into graduate medical education

In considering these and similar issues there may be at least three ways in which the solutions would come more easily if there were guidance from the national educational bodies. First, it is essential that the national and regional bodies define more clearly than they do at present just what range of knowledge, skills and attitudes are necessary for safe and effective general practice. The need for greater clarification was stated explicitly by a JCPT working party three years ago[5] and is now more urgent than ever. It should be the foundation of clinical practice from which all education stems.

Secondly, it would be helpful to clarify those parts of a general practitioner's work which are exclusively professional, involving only individuals and their professional bodies, and which are the areas in clinical practice where professional and managerial concerns overlap. As the NHS moves to managed primary health care, this question needs to be addressed with urgency, because the boundary between the educational function and managerial responsibility for performance is likely to be as sensitive as it is at present unclear (see Chapter 5).

The third approach should be directed at certification and recertification. National standard setting bodies, through their certificating arrangements, now need to indicate agreed national professional standards for individual doctors. These should be indicators which the Medical Practices Committee and FHSAs should look for when taking on contractors, and which practices should enquire about when engaging partners. They should also reflect the standards required for continuing performance. The designation of such standards would greatly assist the regional postgraduate organisations, who would know better than now what range and standard of training and CME should be provided.

These and similar issues need to be thought about and discussed widely, in order to achieve a worthwhile and implementable strategy around which regional and local programmes can be constructed. The effort would be considerable, but could be repayed handsomely in terms of greater commitment and professionalism among both learners and teachers.

(i) Learning about management

No consideration of the aims of either vocational training or CME would be complete without a reappraisal of the place of management in the work of the modern general practitioner and nurse in the community. Some doctors and other team members have seen the relevance. However, for many more the clinical work in the consulting room is still the centre of attention, with other activities of the practice seen as requiring little more than a bit of organisation. These doctors have still to make the connection between their work in the patient's home or in the consulting room and the strategic management activities in which partners need to engage if a practice is to maximise its overall performance. Education has a vital part to play.

Ideally the medical student should experience the management process in a teaching hospital or teaching practice as part of the clinical routine. Unfortunately, such experience is still unusual today.[6] Similarly, the young graduate

should be exposed to the relevance of management in the preregistration year and in vocational training for all specialties. So far as general practice is concerned, this exposure is likely to be most effective during the trainee year. In this period the trainee should come to appreciate the complementary characteristics and values of the clinical and management processes to good patient care by the example of the practice team and by personal involvement in such experience. Complementary academic courses, which provide the necessary theoretical framework, knowledge and skills, should be a desirable adjunct to this experience but can never be a substitute for it.

By the time young doctors become principals they should be well grounded in the relevance of management to good general practice. They should be in a position to develop this aspect of their work when they assume real responsibility for the performance of their own practice in future.

It would be fair to say that the regional postgraduate organisations are not at the moment geared up to provide the kind of training and further education in management which is now required, and for which there is a growing demand. There will be no such comprehensive provision unless management is incorporated into the aims of graduate education for general practice with an appropriately high priority. Given this, it will become easier to specify the kinds of educational experiences and activities which should be provided at differing stages in the doctor's career. These experiences and activities should be harmonised with the arrangements made for the training of practice managers and other practice personnel, through their own professional bodies.

There is a growing body of knowledge and skill from which to draw. The main stimulus has come from the RCGP through its courses on practice management and computer appreciation, its videos (*Management in practice; We need a practice manager; Who killed Susan Thompson?*) and through its distance learning materials including the CLIPP programme 'If only I had the time'. Experience has shown the value of general practitioners and practice managers learning together, but it is also showing the value of having an independent network through which practice managers can learn from each other.

For those who believe in the philosophy of total quality management there is every reason for teaching the methods and skills of medical audit as part and parcel of the teaching of practice management. If handled in this way, there would be less risk of medical audit being seen as an educational pursuit of only

passing relevance to everyday practice, and a better chance that it will be seen and understood for what it really should be, namely, a discrete but important part of the management cycle in which learning and change in behaviour go together.

Resources

It has already been said that the infrastructure for graduate education in general practice is inadequate. Any development plan must include a realistic appraisal of the time and money which will be required to fund a programme of graduate education properly. If this seems obvious, it is necessary to restate it firmly here because of the almost universal difficulty which regional advisers have encountered in persuading the NHS and universities that an investment in the educational infrastructure is a precondition for successful training and CME activities.

(i) The teachers

Like individual general practices, education for the discipline is heavily dependent on people rather than on equipment or technology. Therefore, as in the practice, the management (in this case the regional advisers) need to assign the highest priority to the professional development of those clinicians who are prepared to teach.

In nurturing this resource general practice has made a good start especially in the preparation of trainers. When vocational training began the RCGP decided that the teaching of general practice should be taken seriously, and that doctors who wished to become trainers should therefore be expected to learn the basic principles of education as they would be applied in graduate medicine. All regions provide basic training courses for trainers, and complement these with the regular trainers workshops which are there to help the established trainer develop and keep up to date in educational matters. This policy contrasts with the situation in the other clinical specialties of medicine where the consultant is not expected to give the educational aspect of the job the same attention. Given this commitment of general practice trainers, underpinned by a policy on which there is a national consensus, it is reasonable to expect high standards from them.

The situation is not the same for course organisers. These general practitioners, the vital middle management in the hierarchy of general practice education, are not currently expected to have any special preparation for their work. For example, there is little provision either nationally or within the regions for

teaching about small group methods even though work in small groups is one of the preferred ways of learning. Moreover, these doctors (and indeed most regional and associate advisers) have had little or no training in the principles of management and their application to graduate medical education even though this is part of the job. Altogether, there are too few opportunities and incentives for these doctors to develop the qualities and skills which are necessary for what are part time academic appointments. It is hardly surprising that they feel undervalued as they attempt to handle teaching tasks with perhaps less than optimum knowledge and skill, with little in the way of moral or practical support, and within a career structure which can only be regarded as a disincentive to take on these considerable responsibilities at all. Here is a situation which demands a fresh approach in which the functions and responsibilities of the job are reappraised, within a proper academic career framework.

This chapter began by reiterating the widely and properly held belief in medicine that the quality of the education that a doctor receives will have perhaps the predominant effect on the quality of care which he or she ultimately provides for patients. In making such educational provision, the extent to which the regional postgraduate organisations succeed will be determined by their management of their most important resource, that is their teaching staff.

(ii) Data requirements

The data requirements of graduate education for general practice will need much closer attention in future. These concern several areas. The data available about vocational training should reflect the kind of questions which the JCPT is asking for accreditation. More detailed data are required to document teaching practice profiles and performance. Another area should document patterns of CME so that it is possible to describe the range of educational provision and to gain some numerical estimate of its value for future policy and planning purposes. The final area encompasses the data describing the performance of the regional postgraduate organisation and its various district subcentres; these are the data required for internal performance monitoring.

Up to the present data provision and information gathering have had a low priority, partly because regional advisers have not seen the need for them and partly because the people and money needed to organise them have not been there anyway. In this respect general practice is little different from other specialties in British medicine.

Constraints / strengths

Adequate resourcing is likely to be cited as one of the main constraints on the development of educational activities in general practice. However, there are other constraints of a practical or professional kind; two examples are given below.

Perhaps the first and most difficult constraint to overcome will be in achieving a sufficiency of excellent clinicians who are also well trained teachers showing leadership qualities. The presence of a critical mass of such individuals will constitute a tremendous asset, and virtually assure success. Conversely, as said earlier, the absence of a critical mass of such people will present an almost insuperable obstacle to the achievement of the overall purpose.

One of the assets of education, whose popularity is overwhelmingly acknowledged, is the use of the small group in vocational training and in CME settings such as young practitioner groups, standard setting groups and medical audit groups. This is an asset which is capable of being developed, particularly in the standard setting field, by extending the boundaries of its use to encompass joint work between general practitioners and specialists and multidisciplinary learning within the practice team.

Performance monitoring

If the regional postgraduate organisations begin to think quality then by the same token they must make specific arrangements for monitoring their own performance. These do not exist at the moment in any region, other than for the assessment of teaching practices. For example, there would be the arrangements necessary to monitor the performance of the core organisations, that is the regional and district postgraduate organisations. Similar but separate arrangements would be required for monitoring the performance of *ad hoc* contractors such as CME course organisers who provide educational activities on a demand led basis.

The establishment of performance monitoring would force questions about the data required, which would in turn reinforce questions about the policies and standards to be followed in the first place by the parent body. Indeed, the

questioning of regional committees by the JCPT about their policies, arrangements and results in vocational training is having just this effect. There is scope for extending these principles to the assessment and evaluation of CME and audit activities in a similar way.

IN CONCLUSION

This chapter has attempted to show why the approach of managing for quality in general practice can be and should be applied to the regional and local professional organisations through which education is provided. As standard setting and performance review become part of general practice, and of managed primary health care through FHSAs, so it is now important that educational organisations identify more clearly what their contribution to the setting and maintenance of standards in general practice should be.

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5 – MEDICAL AUDIT AND MANAGEMENT: THE INTERFACE

In the introduction it was suggested that one of the most difficult areas in managing for quality in British general practice would be in the refashioning of the relationship between practitioners and practices on one hand and the FHSAs operating their contracts on the other. It is important to try and get this right, which is not easy in the hostile climate within the profession engendered by the new contract. The MAAGs provide the key. While strict contract matters are relatively straightforward, at least in terms of the relationships involved, the MAAGs straddle the boundary between NHS and profession. To a large extent the quality of the relationship between FHSAs and practitioners will thus depend on whether both sides see the MAAGs as imaginative, helpful and constructive, or something much less.

At issue is the question of accountability and its relationship to self regulation. This must be clarified first.

ACCOUNTABILITY IN CONTEXT

The history of the medical profession in the UK is rooted in the belief that the nature of medicine is itself unique, and that therefore only doctors can regulate the standards of those who belong to the medical profession. This deeply held tradition permeates all medical bodies concerned with professional standards, and is built into the system of values which doctors absorb from the moment they begin their medical training. In recent years this view of medicine and medical practice has come under challenge; the challenge is reflected in the writings of such distinguished non medical observers in this country as Professors Ian Kennedy,[1] Margaret Stacey,[2] Raymond Illsley[3] and others. In presenting a different view, each of these writers in their own way follows a common train of thought, namely, that medicine and medical care are not as exclusive as doctors like to think, and that lay people (including other health professionals) can and should contribute appropriately to judgements about the performance of doctors.

Here it is sufficient to acknowledge that there are two points of view with various shades between, and that the debate has already brought about some change in the continuing relationship between doctors and society. There are three aspects in particular which have an important bearing on quality of care issues in general practice. These concern the changing nature of a practitioner's accountability, the changing nature of the relationship between practitioners and FHSAs in particular, and changes in the nature of self regulation which the profession itself is examining with a sense of commitment and urgency.

The changing nature of accountability

There are six main lines of accountability for general practitioners working in the NHS. These are shown schematically in Figure 1.

Doctors would assert with confidence that the first line of accountability is to self. Professional people are expected, by definition, to set and maintain their own standards. The integrity and quality of medical practice is heavily dependent on this self discipline, for no amount of external regulation of any kind can compensate for the conscientious and rigorous way in which a practitioner adheres to self imposed standards of conduct and performance in everyday practice.

The next line of accountability is to the partners and other members of the practice to which the doctor belongs. Here, the concept of accountability may be quite narrowly defined, and indeed is usually expressed in terms of a business arrangement. The notion of accountability to non medical members of the practice team is usually quite rudimentary; however this would change especially if the principle of corporate responsibility within a practice becomes commonplace.

The special relationship between the practitioner and individual patients reveals the third line of accountability. Doctors hold the accountability implicit in the doctor/patient relationship to be especially valuable and important. It may be effective, in that patients are free to change their doctor, and thus deprive the doctor of one part of his/her livelihood, if the patient is dissatisfied with the doctor's performance.

As an extension of accountability to self, most practitioners would recognise their accountability to their peers. This may be exercised informally when, for example, carrying out medical audit acitivites using peer review, or it may be regulatory as in submitting to the judgement of colleagues if brought before the disciplinary machinery of the GMC.

Contract relationships provide the fifth line of accountability. Since the vast majority of general practitioners are in contract with the NHS, the accountability is to the FHSA for the delivery of a contract for service which is set out in the doctor's terms and conditions of service.

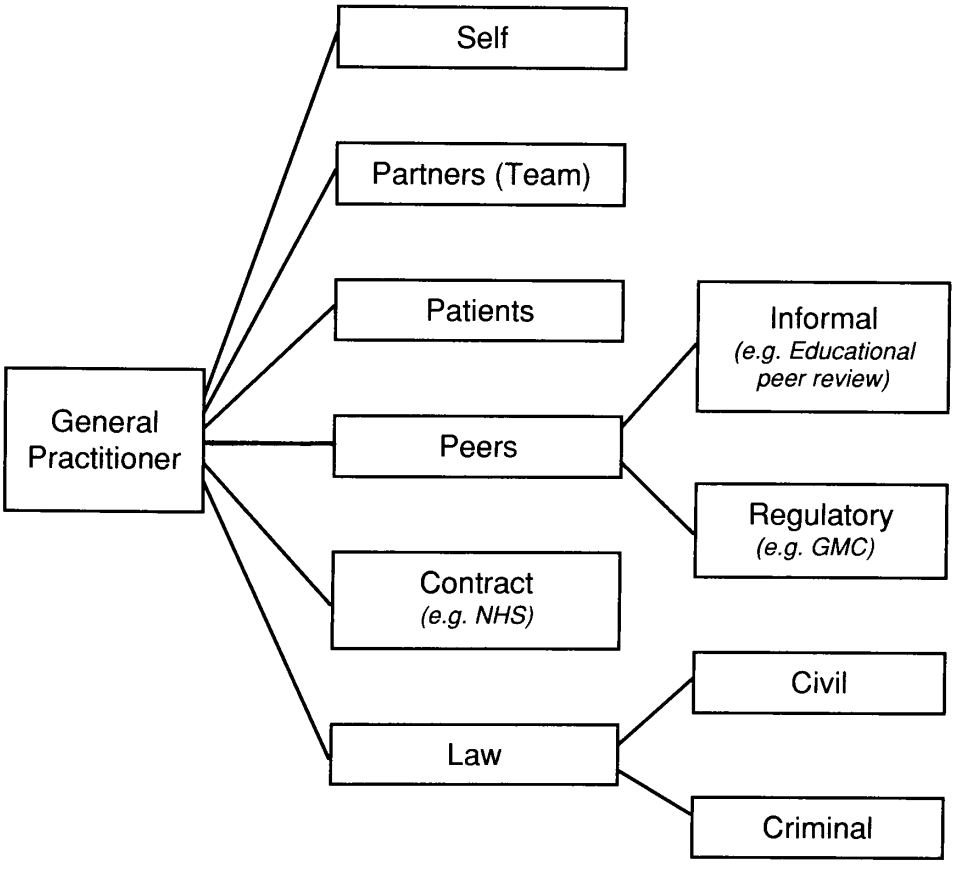

Figure 1. The General Practitioner: Accountability

Lastly, there is the accountability of the doctor before the law. Any patient or contracting authority or anyone else aggrieved or hurt by a doctor's professional conduct can bring a civil or criminal action. Recourse to the civil law happens most commonly when a practitioner is thought to have committed a single grave error which has usually either maimed or killed a patient, and where the recovery of damages may therefore be high on the agenda.

Today many FHSA managers, and some doctors, would argue that this conventional view of the parameters of accountability needs some further adjustment. Modern general practice is dependent upon team work, not only between doctors, but between doctors and other health professionals. This applies particularly to the care of patients with chronic illness and the care of the dying where doctors, nurses and the supporting administrative staff have to work closely and effectively together in the care of an individual patient. The quality of patient care is thus a function of team work; therefore it is the performance of the practice to which a doctor belongs which is on trial, hence the notion of comprehensive quality assurance.

So there is one major question which British general practitioners now have to confront. How is team accountability to be exercised externally, in relation to the professional regulating bodies to which individual health professionals may belong and in relation to NHS management? Somehow external accountability has to be apportioned between the professional self regulatory machinery on the one hand and the arrangements for quality assurance which NHS management has to make to ensure optimum performance from the practice as a whole.

The principle of accountability for a practice's performance is already established to some extent in teaching practices. In several regions there is an informal commitment to take part in peer led medical audit activities. However, the contract for teaching service, and the periodic review of practice performance upon which the renewal of teaching status is based, are operated through the appointed trainer by 'management' in the form of the regional adviser and the education subcommittee for general practice.

Accountability and the FHSA

The experience in teaching practices notwithstanding, in any conversations today between general practitioners and FHSA managers, anxiety and uncertainty soon focus on the issue of accountability to the FHSA. The matter has

become acute and sensitive because accountability has been exercised in NHS general practice in the past with only a light rein. Thus, for example, the nature and standard of the care provided has been very much a matter for personal decision by individual practitioners. The former FPCs had circumscribed powers, acting essentially as pay and rations provisioners, rather than as purchasing authorities commissioning care of a certain range and standard. This tended to inculcate FPCs with a passive attitude to standards even where they had powers, such as in the standard of general practice premises. Moreover, although FPCs operated a disciplinary machinery to handle complaints about practitioners who appeared to be in breach of their terms and conditions of service, there was a clear understanding that this machinery would not stray into areas involving clinical judgement and the appraisal of clinical performance.

All this is changing. FPCs have become FHSAs, health authorities in their own right, charged with defining the health status, health needs and health expectations of the people they serve and of arranging for care of the appropriate kind and quality to be provided through their contractors. The redefinition of the relationship between FHSA management and contracting practitioners has already moved apace under the imperative of the new contract. For example, FHSAs are required to seek much more information about such clinical activities as prescribing and hospital referral. The introduction of targets for aspects of preventive care, such as immunisation and cervical cytology, is taking the FHSA directly into the field of clinical performance monitoring, with payment conditional on the demonstration of results achieved. Every practice is required to produce an annual report detailing important aspects of its structure and (voluntarily) its performance. From 1992, every NHS general practitioner may be required by contract to take an active part in medical audit. In support of this the MAAGs are being established as committees of FHSAs charged specifically with seeing that medical audit is implemented as public policy. Overall, FHSAs are gearing up to manage for quality acting with their contracting practices as managed care organisations.

Accountability within the profession

While these changes are going on, other changes are under active consideration for the governance of the profession. Mention has already been made in Chapter 4 of the admittedly tentative moves within general practice to establish a national standard reflecting competence on completion of vocational training. This

should furnish a much needed entry standard to principal status in general practice if implemented. The accountability of trainers to their peers in teaching practices has also been emphasised. These developments notwithstanding, general practice, like its sister specialties, has no proper mechanism for handling poor performance in the established doctor.

The GMC is seeking to remedy this by establishing a professional machinery for handling cases where doctors in any specialty show evidence of persistently poor clinical performance. It is thought that the GMC will establish a central machinery complemented by local professional arrangements to which doctors about whom there may be cause for concern may be referred in the first instance. These mechanisms could be established within the next three or four years. They would have to be quite separate from any structures handling medical audit for educational purposes. Consequently they could have an important bearing on the relationship between individual practitioners and NHS management because they would offer an alternative to the FHSA disciplinary procedures.

Looking ahead only a little, there ought to be two routes in future for the handling of persistently poor performance in a general practitioner. One would be the FHSA, the most appropriate for complaints inclined towards the doctor's contract as is the case today. The other would be professional through the GMC, and therefore best suited to handling complaints which involved questions primarily of clinical competence and performance. Both would have teeth. Breaches of contract could incur defined contract penalties and poor professional performance could result in conditions on a doctor's registration, with erasure as the last resort. These two complementary mechanisms would enable the profession in general practice and the FHSAs to handle the small number of doctors who perform badly. As a result the new MAAGs would be able to function positively, and be seen as agencies to encourage good practice among the majority of general practitioners rather than as regulating bodies concentrating on poor practice among a small minority.

MEDICAL AUDIT AND MANAGEMENT: THE INTERFACE

The boundary between profession and management has to be seen in the context of the developments just described. In this regard the main function of medical audit — performance monitoring — is to try to improve the performance of in-

dividual doctors by showing them where they stand in relation to their peers, through either internally or externally set standards. This should lead to changes in behaviour and improved competence through education. Ultimately such improvements should benefit all doctors' patients.

This situation presents two immediate problems. First, medical audit, as doctors define it, is really about the clinical aspects of care, only one component of quality assurance. British doctors are wary of any wider interpretation, in particular any idea that the content should be broadened (for example, to include patient outcomes/satisfaction) or, as already mentioned, that managers, patients or others could profitably comment on some aspects of the clinical process. The second problem is about accountability, that is whether doctors should decide whether change is necessary as a result of performance monitoring, or whether management in the form of the FHSA should have some say in the matter, or whether there is a place for both.

Pollitt,[4] in a thoughtful paper, considers this question in his examination of managers and their role in promoting quality in the public services in the UK. He argues that managers can rarely intervene on the grounds that they know more about quality assurance than the professional service deliverers. In medicine this may be true for the highly technical aspects of care, but managers are likely to know a great deal about such indicators of performance as accessibility, availability and acceptability to patients and colleagues.

Managers may have a stronger claim for intervention on the grounds that they may know more about the available methodologies of quality assessment even if they cannot match the professionals' command of their body of substantive expertise. Pollitt doubts, however, whether managers will have the time (or the motivation) to undertake such a consultant like role. He wonders also whether doctors would seek methodological advice elsewhere, from others who may be perceived as less threatening because they are also of the medical profession.

He feels that the strongest argument for managerial intervention is that managers represent the collective interest of an organisation, in particular the chief stakeholders which in the case of a public service like the NHS are the stake funders.

In any event, he says, all these reasons for managerial intervention are normally contested by professions. They argue that, by definition, they monitor their own standards of quality. Managers, far from being neutral representatives of the

general will, 'have their own territorial interests and are often obliged to bow to the ideologically coloured concerns of their political masters in the short term'.

It is against the background of this general appraisal that he offers a spectrum of options which management could use to operate quality assurance in a professionally delivered public service. These range from minimal intervention to something like total control and are shown below:

(i) Give general exhortation to professionals, but no direct intervention or sanctions

(ii) Offer positive incentives to professionals if they will develop quality assurance programmes (for example, the possibility of more resources, a privileged status in future developments, etc.)

(iii) Require professionals to develop and maintain a quality assurance programme (with penalties, for example, withholding of organisational recognition or resources if the requirement is not met)

(iv) Require a quality assurance system to be put in place and specify necessary design features of the system (for example, that it should involve comparison with other units or with regional or national or international norms; that there should be a peer review committee with a specified membership and powers; that some aggregated results should be publicly available, etc.)

(v) Require a quality assurance system, specify key features of its design and directly participate in the system, at least in the sense of demanding fairly full access to the data it generates

(vi) All of the above but with the additional feature that management claims the right to use these aggregated quality assurance data to deploy, promote, and discipline individual professionals

Generally speaking, Pollitt would expect professional resistance to quality assurance to increase as managers move from the first to the sixth role he describes. He notes that roles (i) and (ii) do not compel the professionals to practise quality assurance, and roles (i), (ii) and (iii) all leave the features of the quality assurance system to be decided exclusively by professionals themselves. Roles (v) and (vi), however, not only give management control over key design features of the system, but they also entail direct participation in the system by management representatives.

MEDICAL AUDIT ADVISORY GROUPS

Pollitt's classification provides a useful template against which to assess the proposed professional/management relationship described in the Government's health circular *Medical audit in the family practitioner services*.[5] The circular describes medical audit in family practitioner services as a means of assessing performance, and of establishing its quality. Additionally, it will help to assess the adequacy of current services. It will be professionally led, building on the foundations already laid in the existing commitment of general practitioners to the principles of self audit and performance review, and will have a strong educational component.

Having emphasised the advisory and largely professional nature of the MAAG, the circular then describes what is essentially a management instrument. The membership will be appointed by management. The group will be accountable to the FHSA for:

(i) The institution of regular and systematic medical audit in which all practitioners take part in every practice in the FHSA area

(ii) Adequate procedures to ensure that the results of medical audit in respect of individual patients, doctors and other health care staff remain confidential

(iii) Ensuring that problems revealed through audit are dealt with

(iv) Providing the FHSA with a regular report on the general (anonymised) results of the audit programme

Thus, at the time of writing, the boundary between the individual practitioner's traditionally independent stance and modern NHS management requirements, certainly for performance monitoring and quality assurance purposes, is still to be both clarified and harmonised.

The work of the MAAG

Although professionally led, MAAGs are to be committees of the FHSAs and are to be accountable to them. They are to be paid for and serviced by their FHSAs and it is the FHSAs which will decide at the end of the day what the composition shall be, and also which external advisers shall be chosen. They are thus likely

to function as the performance monitoring units of the FHSAs along the lines outlined in Chapter 2, and will drive medical audit locally. The DoH circular is of course only concerned with the function of MAAGs in relation to NHS general practitioners. The responsibility for the performance of other members of the practice team, notably the community nursing and health visiting staff who are accountable to the district health authority, is mentioned only in passing. However, it is implicit in the circular that in establishing medical audit in general practices the work of the practice team as a whole may be assessed.

Earlier, reference was made to the range of options proposed by Pollitt in defining the role which management could adopt in operating quality assurance in a professionally delivered public service. As MAAGs are introduced, it seems that there will be some local discretion as to how far along the line of control an FHSA may decide to go. However, the minimum already specified by the DoH through the circular would appear to equate to the Pollitt option (iii), requiring professionals to develop and maintain a quality assurance programme.

The extent to which decisions can be made which are generally acceptable both to practitioners and the FHSA, and which therefore achieve mutually agreed objectives, will depend substantially on the way in which the MAAGs approach their task at the formative stage. It will be essential that they have at least one adviser who has a sound working knowledge of the principles and methods of quality assurance including medical audit. They will need to facilitate the progress of the committee by providing the information and understanding necessary for the making of good decisions in which everyone will have confidence. The choice of chairman will also be critical. Donabedian emphasised the importance of leadership as perhaps the predominant factor for success. Ideally the doctor chosen will have leadership qualities already obvious to the profession and the FHSA, and in addition will have or will be prepared to acquire a good working knowledge of the principles of quality assurance including especially performance monitoring.

Defining functions

Like individual practices and the regional postgraduate organisations, each MAAG will need to work out its own development plan so that members and others can see what it is trying to do and how it proposes to get there. Time spent considering the concepts and methods of quality assurance, what the MAAG's

contribution should be, how it should work, what its relationships with the profession and the FHSA should be, and broadly what resources will be needed to do the job, will be repaid in the actual implementation later.

In this book it has been argued throughout that the aim of producing high quality patient care will be best achieved by encouraging every practice to have the internal capacity to manage for quality. Given this, the overall purpose of the MAAG should be to promote and to facilitate this object in every possible way. This may be best achieved by monitoring and asking questions about the arrangements which practices themselves make for assessing and assuring their quality. There should be questions, for example, about the practice's development plan if there is one. Enquiry should be made also about the use of explicit standards and protocols for care, the nature of practice policies for care, the qualifications required and the training arrangements for all staff, and the arrangements which the practice makes for monitoring care given by doctors and other health professionals, including clinical audit. The arrangements which are operated to correct deficiencies in care when they become known should also be examined. The baseline results should provide the basis for feedback to all practices, and should help identify areas where specific help in the form of management expertise or new skills is required. Later the MAAG may want to carry out commissions from either the FHSA or the profession (or perhaps joint commissions from both) on specific aspects of care where prospective performance monitoring might lead to improvement in care.

Modern performance monitoring is heavily dependent on the quality of medical records. In its first reconnaissance every MAAG must aim, therefore, to establish the extent to which the medical records in the contractor practices are capable of yielding data of sufficient quality for performance monitoring purposes.

Improvement or regulation?

It will be important for the MAAG to get its guiding philosophy right from the start. If the broad aim is to secure the continuing improvement of care in the majority of practices then it is the attitude of encouragement which should prevail. This should appeal to every doctor because each practitioner knows where there are aspects of their personal care, or care given by the practice as a whole, which fall short of the optimum.

In adopting this approach it will be necessary to get an early agreement about what is to be done when poor practice is identified through the monitoring process. There it may be a help to recognise that cases of really poor practice are already likely to be well known both to the local medical committee and to the FHSA, and arguably should have been dealt with already by their own machinery quite independently of the MAAG. Nevertheless, where poor practice is identified through performance monitoring (the MAAG) it should be possible to achieve a good result without loss of confidence in the system by doctors generally.

There is clearly an ethical obligation on individual doctors (or anyone else) to report on persistently poor practice which may be harmful to patients. Given this, the MAAG should establish in advance that individual cases of poor practice will be referred either to the local professional committee or group dealing with the matter (in time the GMC) or to the FHSA, depending on whether the problem seems to be essentially clinical/professional or substantially contractual.

If the MAAG is prepared to refer the 'outlier' cases of persistently poor practice in the way described, it will avoid becoming yet another body investigating poor practice. This is important, for the MAAG can then confidently present itself to the profession, FHSA and local community as *the* body which promotes high standards in the majority of practices.

Responsibility for policy and standards

An early policy decision will be required as to where the responsibility is to lie for decisions about the areas of care to be monitored, and against whose standards performance is to be assessed. Should these decisions be made by the FHSA or should they come from the local medical committee or sub faculty of the RCGP? Alternatively, should the MAAG itself have a policy/standards generating function?

There are good reasons why the MAAG should try to limit itself to performance monitoring — at least until it is established.

(i) Policy and standards generation are arguably better left to the contracting authority, individual practices and local professional bodies. For example, it is the FHSA and the practitioners who should decide what standards of access to care should operate in a particular area. And it is for individual practices to decide what

their everyday working clinical standards should be. The task of the MAAG in these two instances would be to find out whether compliance was being achieved by monitoring access in the first case and by monitoring the arrangements which practices make to ensure compliance with their own standards in the second.

(ii) Performance monitoring is technically demanding and complex, and if it is to be done well will absorb all the energies of the MAAG in the formative years. Getting this right should therefore be the MAAG's first priority.

(iii) Participating practitioners are more likely to develop confidence in the MAAG's monitoring system if they see it as carrying out a neutral, technical task rather than as a policy/standards body which is using performance monitoring to justify decisions on standards which it has already taken.

Confidentiality

Both patients and doctors must be assured that the MAAG will operate its performance monitoring procedures in a way which conforms to appropriate professional and managerial standards. There should be an early statement which sets out what the policy will be. This policy should address questions of patient confidentiality, the confidentiality of data concerning individual doctors, and the arrangements for protecting the confidentiality of data in any computer systems used for performance monitoring. It should be disseminated widely and explained thoroughly to all whose performance is to be assessed.

Explanation and advice

If doctors are to have confidence in the performance monitoring system, the MAAG will need to establish good communications with practices. It will need to explain, for instance, clearly and openly what it is trying to do and how it proposes to achieve its purpose. Such explanations are likely to be aided if it has already secured the support of local professional bodies such as the LMC and the sub faculty of the RCGP. Explanations which achieve understanding will need to be made on a face to face basis, as well as by written communication, and may well therefore involve the MAAG and its supporting team of visiting practitioners in a considerable public relations effort.

Inevitably, as monitoring proceeds, doctors carrying out assessments for the MAAG will be asked for opinions or to give advice. The committee should decide how far it is itself going to become a formal agent for facilitation and education, and how far it will confine itself to the kind of informal, practical advice which springs from any on the spot contact in the assessment process, commissioning the regional advisers and other professionals for more specific educational tasks.

IN CONCLUSION

The relationship between general practice and NHS management is undergoing major change as the essentially passive FPCs are replaced by Family Health Service Authorities which are intended to be proactive in securing primary health care of good quality for the communities they serve. This chapter has explored the more important aspects of the relationship, and has indicated how the boundary between FHSAs and their contracting practices may be developed in a positive and constructive way.

The book has attempted to show how the model of managing for quality may offer a promising way forward for individual practices, for general practice education and for FHSAs. To this end, the more that practices can maintain and develop direct responsibility for the range and quality of their services, the more benefit and satisfaction there will be for patients and health professionals alike.

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