QUALITY OF CARE IN GENERAL PRACTICE

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INTRODUCTION

As clinicians we want to provide the best quality care for our patients. Those who commission (i.e. use taxpayers money to pay for) healthcare services must also ensure that patients have access good quality care wherever they happen to live.

There is a paradox here, as GPs in the past were paid mainly according to how many patients they have on their “list”. Quantity does not always guarantee quality and therefore quality of care measures have been introduced over the past 20 years to ensure that the quality of services provided by GPs is both high and consistent. General practice has therefore been at the forefront of professions such as law, medicine and politics in subjecting the quality of its output to rigorous external analysis. This can at times feel uncomfortable for GPs, as the quality of their care is now public knowledge and linked to their pay. In addition, construction of publicly available ratings and comparisons can, if mismanaged, result in reductions in professional pride, autonomy and potentially ‘gaming’ of whatever is deemed representative of quality.

NEED TO KNOW

How do we define quality of care?
On the basis of several definitions in the literature, the World Health Organisation (WHO) definition of quality of care is “the extent to which health care services provided to individuals and patient populations improve desired health outcomes. To achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred.”

Safe - Delivering health care that minimizes risks and harm to service users, including avoiding preventable injuries and reducing medical errors.

Effective - Providing services based on scientific knowledge and evidence-based guidelines.

Timely - Reducing delays in providing and receiving health care.

Efficient - Delivering health care in a manner that maximizes resource use and avoids waste.
**Equitable** - Delivering health care that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status.

**People-centred** - Providing care that considers the preferences and aspirations of individual service users

**How do we measure quality of care in general practice?**
There are three main ways in which the quality of GP care is currently measured:

1. The Quality and Outcomes Framework (QOF). A performance related payment system for the quality of services and care provided by GPs.

2. Care Quality Commission (CQC) inspections and ratings.

3. A system of annual appraisal of all GPs linked to revalidation (of their License to Practise).

Through these measures, the quality of practice has arguably been transformed. However, it is also true to suggest that the profession is more managed, has lost elements of autonomy and as a result, motivation. Having a strong sense of professional identity is extremely important in maintaining motivation and resilience. What it means to be a modern professional is nicely addressed in the reference 1 & 2 below.

**The role of the CQC**
The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Their role is to ensure that health and social care services are providing care which is safe, effective, compassionate, and high quality.

CQC inspectors have an important role in regularly visiting every hospital, general practice and care home in England. Visits are detailed and result in an inspection report and overall rating for the practice. In addition to inspecting GP practices, CQC inspectors also inspect out-of-hours services, walk-in centres, minor injury units and urgent care centres.

In inspecting all these services, CQC gather and analyse information through a continual process. Inspections are pre-planned but may take place urgently in response to concerns raised by patients, health services staff, or a range of other individuals.

CQC inspections are conducted by a lead inspector, an independent GP, and an “expert by experience” i.e. a lay user of primary care services. Inspections make use of a variety of data including patient surveys, information from the NHS (such as Quality and Outcome Framework scores), patient opinion feedback, and the findings of the NHS Friends and Family Test. An inspection of a practice will take several hours or even days. Practices are provided with a report which is made public through the CQC website, and with links from the NHS Choices website.
5 Key Questions
The five key questions which form the basis of an inspection are:
1. Are the services safe?
2. Are they effective?
3. Are they caring?
4. Are they responsive to people's needs?
5. Are they well-led?

Population partitioning
In addition to focusing on the five key questions, inspections will focus on some key population groups, where the inspecting team will seek specific information:

1. Older people
2. People with long-term conditions
3. Families, children and young people
4. Working age people (including those recently retired and students)
5. People whose circumstances may make them vulnerable
6. People experiencing poor mental health (including people with dementia)

Following inspection of a service, the inspecting team give one of four ratings:
- Outstanding
- Good
- Requires improvement
- Inadequate

“Outstanding” services are performing exceptionally well. At the other end of the scale, “inadequate” services are performing badly, and, in the most extreme cases, sanctions may be put into place resulting in the immediate closure of the service. Such events are unusual, but CQC inspections are important and have “teeth”.

The overall ambition of the inspection process is to seek to improve standards of care and the quality of services provided to the public.

Patient Experience and CQC inspections
The English National GP Patient Survey is the largest routine survey of patients’ experience of primary care undertaken anywhere in the world. Since its inception in 2008, the survey has been distributed to over 25 million people, and received responses from around 18 million people.

Currently, the GP Patient Survey is distributed to around 2 million people each year, with increased targeting of those practices where patients have lower participation/response rates. The University of Exeter were responsible for designing the survey in conjunction with colleagues from the University of Cambridge and the national survey organisation, Ipsos MORI. The Exeter primary care researchers (APEX) have produced a whole range of papers describing the scientific basis of the survey, its design, and its potential. The GP Patient Survey feeds directly into the NHS Outcomes Framework and is used to form a substantial component of the data used by CQC inspecting teams in their visits to practices.
ACTIVE LEARNING

✓ Obtain a copy of your host practice most recent CQC Inspection report. This will be available here.

✓ Obtain a copy of your practice’s most recent summary in respect of GP Patient Survey data here.

✓ Talk with one of the doctors or practice management staff about the findings of both the inspection and the GPPS summary data.

✓ Is the practice aware of these reports - and have they felt the need to take any specific action in response to the findings of CQC inspectors or GP Patient Survey?

✓ How do you think such quality-assurance data should be presented – does it matter at which level of analysis the data is reported - at the level of individual doctor, practice, or clinical commissioning group/NHS organisation? Check out this reference - how might the findings be applied in practice?

✓ Have a look at your practice’s QOF profile here - pick one area of interest to you and ask your GP teacher or practice manager about what the figures mean.

✓ How does quality of patient experience vary between and within practices? Have a look here.

✓ What do you think quality of care means? In what ways is it similar or different from CQC?

FURTHER LEARNING


The following resources have been developed in conjunction with SAPC Heads of GP Teaching. If you have any queries or questions regarding the resources on offer, please contact Prof. Joe Rosenthal or Prof. Alex Harding, Co-Chairs of SAPC’s Heads of GP Teaching Group.