IMPROVING THE QUALITY OF CARE IN GENERAL PRACTICE

Report of an independent inquiry commissioned by
The King’s Fund
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The views expressed in this report are those of the independent panel and do not necessarily represent the views of The King’s Fund
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<td>A&amp;E</td>
<td>accident and emergency</td>
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<td>ACG</td>
<td>adjusted clinical groups</td>
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<td>ACS</td>
<td>ambulatory care sensitive</td>
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<td>APMS</td>
<td>Alternative Provider Medical Services</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>BME</td>
<td>black and minority ethnic</td>
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<td>CHD</td>
<td>coronary heart disease</td>
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<td>CHF</td>
<td>coronary heart failure</td>
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<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>DES</td>
<td>directed enhanced services</td>
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<td>EOLC</td>
<td>end-of-life care</td>
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<td>FTE</td>
<td>full-time equivalent</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<td>General Medical Services</td>
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<td>general practitioners</td>
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<td>GPAQ</td>
<td>General Practice Assessment Questionnaire</td>
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<td>GP’s Experiences Questionnaire</td>
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<td>General Practice Extraction Service</td>
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<td>GPwSI</td>
<td>GPs with a special interest</td>
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<td>HES</td>
<td>Hospital Episode Statistics</td>
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<td>HQIP</td>
<td>Healthcare Quality Improvement Partnership</td>
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<td>ICO</td>
<td>integrated care organisation</td>
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<td>IPQ</td>
<td>Improving Practice Questionnaire</td>
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<td>LES</td>
<td>local enhanced services</td>
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<td>MAAG</td>
<td>Medical Audit Advisory Group</td>
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<td>MMR</td>
<td>measles, mumps and rubella</td>
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<td>NCAPOP</td>
<td>National Clinical Audit and Patient Outcomes Programme</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>NES</td>
<td>national enhanced services</td>
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<td>NETS</td>
<td>North East Transformation System</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>National Patient Safety Agency</td>
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<td>PCT</td>
<td>primary care trust</td>
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<td>Primary Care Trigger Tool</td>
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<td>Plan/Do/Study/Act</td>
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<td>PMS</td>
<td>Personal Medical Services</td>
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<td>PROM</td>
<td>patient-reported outcome measure</td>
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<td>Quality Improvement Support Team</td>
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<td>Quality Outcomes Framework</td>
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<td>Royal College of General Practitioners</td>
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<td>SEA</td>
<td>significant event audit</td>
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<td>SHA</td>
<td>strategic health authority</td>
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<tr>
<td>TIA</td>
<td>transient ischaemic attack</td>
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Preface

I am delighted to submit this report to The King’s Fund on behalf of my colleagues on the independent panel of the inquiry. It represents over 18 months of work since I took over as Chair from Niall Dickson. It has been a hugely interesting, challenging, and, I hope, valuable exercise. I pay tribute to the insight, intelligence and hard work of my colleagues. It is their work; I merely tried to keep order and move us on to deal with an agenda which, at times, threatened to overwhelm us. I also pay tribute to Niall in conceiving the idea of the inquiry and the incredibly able and hard-working team from The King’s Fund who supported us throughout.

Producing a report of the quality of care in general practice is no easy job. There were problems to solve at the beginning – what does quality mean? – at the end – what are we offering which adds value? – and all the way along, as we wrestled with these and other questions. We went about our task by first commissioning research in a number of areas which constituted aspects or domains of quality, as conventionally understood. We exposed our thinking to the challenge of distinguished experts and commentators. And we sought the views of practitioners and the wider public.

This is not the place to offer a résumé of the inquiry, or even our key findings. They are clearly set out in the following pages. What my colleagues and I are anxious to say here is that the study of quality in general practice is an underdeveloped area. Many reasons might be offered. One which comes through clearly is that, for many in general practice, it is not an area of health care greatly given to self-reflection and self-challenge. One of our hopes is that this inquiry will bring home the importance of greater self-examination. The ways of doing so and accumulating the range of evidence (hard and soft) necessary to know how you are doing, formed an important part of the inquiry. The benefits in terms of improving the service offered to patients cannot be overstated.

Perhaps one other theme should be mentioned – the notion of general practice as a team effort. This is how health care will increasingly be delivered. And ‘teams’ refer to those working within general practice and those working in general practice alongside others, whether in health care or in other public services. Teams also include patients as active participants in decisions about their care. Quality extends to the way in which all types of team work for the benefit of patients and the wider public.

The timing of this inquiry could not be more propitious. We are about to embark on a radical overhaul of the way in which the NHS is organised and delivers its services. General practice (not GPs alone, but all those involved in primary health care) is at centre stage in the present government’s vision. General practitioners are to take on a central role in commissioning health care. Quality must be the watchword in their role as commissioners just as in their role as providers. Our hope is that this inquiry will provide a guide as to how to ensure that quality is at the heart of the service that general practice offers to patients of the future.

Sir Ian Kennedy
Chair, independent panel
Foreword

Good primary care is the bedrock of a cost-effective health care system, according to Barbara Starfield’s research. Her work also suggests that the NHS has a stronger primary care orientation than the health care systems of most other countries. Surveys show that public satisfaction with the NHS is higher than it has ever been and that general practitioners and other primary care staff enjoy high levels of trust and confidence from patients. Against this background, why did The King’s Fund establish an inquiry into the quality of general practice in England?

Although the majority of patient contacts in the NHS take place in general practice, many of the initiatives to measure and improve quality had been focused on the acute sector. There was relatively little information on the quality of general practice and no comprehensive overview. While the introduction of a pay-for-performance element into the GP contract in 2004 – the Quality and Outcomes Framework – generated the first national data on the quality of care, it was narrow in scope. The King’s Fund commissioned the inquiry to take a broader look at the current state of quality in general practice, to make recommendations about how quality could be improved, and to suggest ways in which general practice needs to change in future.

The Inquiry was launched and initially chaired by my predecessor, Niall Dickson. We are very grateful to Sir Ian Kennedy for taking up the chair and guiding the panel’s deliberations over the past year and to the other members of the panel who contributed so generously of their time and brought a depth of experience, intellectual rigour and expertise from within and outside general practice. This report demonstrates the careful consideration given to these issues by the panel and by The King’s Fund staff who supported them. We are enormously grateful for all their work.

The evidence brought together in this report shows that while standards of general practice are generally high, there are no grounds for complacency. On many of the available indicators, there are variations in performance, suggesting that more needs to be done to realise Nye Bevan’s vision that the NHS should ‘universalise the best’.

The panel quite rightly emphasises the role that practices themselves have in tackling variations in the quality of general practice and in creating an environment for quality improvement. General practice commissioning consortia are well placed to play a part in this process so long as the NHS Commissioning Board works with and through consortia to improve the quality of primary medical care provision.

It is not clear whether action by general practice will be sufficient. Like other professions, general practice includes conservatives as well as innovators. At a time when the coalition government is increasing the role of choice and competition in the NHS, the stimulus provided by new market entrants may prove to be just as important, perhaps more so, than the drive to improve quality that comes from within.

This report also underlines the importance of general practice adapting to meet the needs of an ageing population in which there is an increased prevalence of chronic disease. Despite the undoubted strengths of the current model of general practice based on
small practices that are often highly valued by patients, a case can be made for practices to collaborate in federations to reduce the risk of isolation and offer a wider range of services. The model of post-industrial care advocated in this report envisages much greater emphasis on teamwork, closer integration between GPs and specialists, and a new deal with patients. Innovative practices in many parts of the country are already evolving in this direction, and the financial pressures on the NHS will accelerate these developments.

At the Fund we will be looking at how through our own work we can reflect the research, leadership development and improvement requirements which this report identifies. Henry Ford once famously said that in developing the motor car there was a choice between producing a faster horse and doing something quite different. Ford’s pioneering example of disruptive innovation has since been emulated in many other sectors, including banking, telecommunications and the airline industry. Health care has evolved more gradually and the time is now surely right to explore how the real strengths of general practice can be built on in the challenging times that lie ahead. The gauntlet thrown down by this report is to accelerate the pace of improvement in general practice and to develop a system that is fit for the future.

Chris Ham
Chief Executive
The evolving role and nature of general practice in England

- The range of activities provided in general practice has increased. General practice plays an increasingly important role in co-ordinating care provided in other settings.

- There is a trend towards larger practices and federated models of working. Between 2004 and 2009, the number of single-handed GP practitioners fell from 1,949 to 1,266.

- The availability of general practitioners is inequitable, ranging by PCT from fewer than 50 to more than 80 per 100,000 population.

- Nurses play a greater role in general practice than in the past. The number of whole-time equivalent nurses employed in general practice increased by 37 per cent between 1999 and 2006 to 14,616. However, the number subsequently dropped to 13,582 by 2009.

- There are projected shortages in the general practice workforce due to an ageing workforce and changing working patterns.

- Contractual arrangements in general practice are now more diverse. The number of salaried GPs employed in practices has risen significantly – from 786 in 1999 to 7,310 in 2009.

- The ageing population and increasing number of people living with co-morbidities requires general practice to work in partnership with patients and to support self-management in order to improve the quality of care.

- Patients today expect a more responsive service. Patients want to play a much more active role in decision-making about their care.

- Technology is available that could transform the way patients interact with general practice. However, general practice has been slow to adopt it.

- GPs will have a key role to play in the reformed NHS, as commissioners as well as providers of care. They will need new skills, and will need to make greater use of information, engage with local authorities and other public services, be more open and transparent, and be more widely accountable.

- General practice will become increasingly involved in, and responsible for, the health of local populations. This includes those who are most in need of care but currently do not receive it.

Defining and measuring the quality of general practice

- Quality is complex and multidimensional. No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality in general practice.
Clinical outcomes are the ultimate measure of quality, but good outcomes can be achieved only if there is agreement on what they are, and if appropriate structures and processes for achieving them are in place.

Nationally available data sets provide a rich source of material for measuring quality in general practice, but they have significant gaps. Other methods of harnessing information from data held within general practices are needed to supplement national quantitative indicators.

Not all aspects of general practice lend themselves to quantitative assessment. More diverse and creative approaches to assessment and improvement of quality are needed, including the use of practice audit, peer review and qualitative research methods.

Standards are required to ensure the quality and completeness of data recorded and reported by general practice.

Standardised methods for defining and applying indicators are also needed, to ensure comparability between indicators in different areas or reported by different agencies.

Audit and quality assurance at local or practice level is underdeveloped, but can play a significant role in ensuring that general practice delivers safe, high-quality care.

Other data users, such as regulators, need to agree a standard set of indicators and not seek to request additional data returns directly from general practice.

Greater transparency of information on quality is both welcome and proper, but the presentation of information needs to be tailored so that it can be used by clinicians for peer review, by patients for choice, and by those concerned with accountability.

There are many different sources of information about quality in general practice. There is an urgent need for these to be rationalised in order to avoid duplication.

The current state of quality in English general practice

Core services provided within general practice

**Diagnosis** A variety of factors can lead to delays and errors in diagnosis, but there is not enough evidence to ascertain the scale of such problems in general practice. Retrospective audit and significant event audit is essential in order to assess and improve the quality of diagnosis.

**Referral** There are wide variations in the rate of referrals between practices. The evidence suggests that a significant proportion of referrals made in general practice may not be clinically necessary. However, the appropriateness of a referral is specific to the context, and it may be difficult to decrease unnecessary referrals without also decreasing necessary referrals. There is scope for improvement in the quality of other aspects of referral:
- ensuring that timely referrals are made (especially in cancer care)
- the quality of referral letters
- getting patients to the right destination
- involving patients in decisions about referral options.

**Prescribing** Variation in the level of prescribing between general practices is common and widely reported. Much of the practice-level variation in prescribing results from differences in the clinical case-mix of patients and socio-economic
factors. There are opportunities for quality improvement to address inefficient or inappropriate prescribing – for example, through
- reducing medication errors
- improving adherence to what is prescribed
- standardising prescribing practices for certain treatments, such as the prescription of low-cost statins, potentially saving the NHS £200 million.

- **Acute illness** Appropriate and effective diagnosis and management of acute illnesses form a key aspect of high-quality care. The evidence suggests that GPs are more likely to make a misdiagnosis of acute illness compared to non-acute illness. More needs to be done to monitor the quality of acute care – for example, through peer-reviewed audit of referral letters and case notes, and to reach out to those patients whose acute illness is not being managed.

- **Long-term conditions** Improvements in care for patients with long-term conditions have been made over the years, particularly for those with diabetes, but the evidence suggests that recommended care is not reliably delivered to all patients – especially to those with multiple long-term conditions. There is significant scope for primary and community care providers to undertake more proactive preventative activities that can lead to earlier diagnosis and treatment, and the prevention of unscheduled hospital admissions.

- **Health promotion** There is a need to target childhood immunisations at those groups where uptake is low. Most general practices meet targets related to smoking cessation advice, but there is evidence that a more proactive approach to supporting patients may help people to quit smoking. Approaches to the management of people with obesity are inconsistent, and obesity is often seen as a lifestyle issue rather than as a priority for general practice. More evidence is needed for appropriate interventions in general practice.

### The non-clinical aspects of general practice

- **Access** Most people, most of the time, report good access to care. However, there are wide variations across all dimensions of access. Since people’s preferences about access to general practice vary, retaining a set of measures to examine the broad picture appears reasonable. General practice needs to reach out to all those in their local community who need care but who are not currently receiving care.

- **Continuity of care** Enabling patients to see the same doctor and other clinical staff with whom they build a relationship over time is regarded as a priority by GPs and patients alike. There is evidence to show that in recent years it has been more difficult for patients to see a preferred GP, raising concerns about continuity of care.

  There is a need to improve co-ordination of care – particularly for those patients with complex and long-term care needs. Greater priority needs to be given to continuity of care and care co-ordination, and innovative ways need to be found to assess the quality of such care in practices, and between practices and others providing public services.

- **Engagement and involvement of patients** Patients report high levels of confidence and trust in general practice, but patients’ experiences of involvement in decisions about their care and treatment vary. Overall, patients and carers remain poorly engaged in making decisions about their own health. More effort and attention in general practice needs to be placed on enabling patients to be engaged in decision-making, and in supporting people to care for themselves.
As GP commissioning is implemented, involving patients and the public in making decisions about services and in evaluating the success of the services provided will be a key to delivering high-quality services.

General practice as part of a wider system of care

- **End-of-life care** There is confusion about the roles and responsibilities of general practice and other care providers in providing end-of-life care. Evidence suggests that there are problems with out-of-hours care and meeting a patient’s preferred place of care, and that GPs lack confidence in communicating prognosis and discussing care planning with patients and their families. General practice needs to be encouraged to support the co-ordination of health and social care to people at the end-of-life and to promote continuity of care.

- **Maternity care** There has been a dramatic decline in the role of GPs and general practice in maternity care, both in terms of involvement and skills. There is a need to re-skill GPs in maternity care and to develop a shared care approach with midwives (except for intrapartum care).

- **Health inequalities** Practice-level variations in achievement of quality targets in general practice tend to show that, although the differences are small, poor-performing practices are in areas of the highest deprivation. GPs working in such areas are faced with a challenging case-mix of patients and high levels of demand. Practices in deprived areas might benefit from additional support and investment.

  There is evidence of inequalities in provision of general practice care for patient sub-groups. GP commissioning consortia will have a key role to play in assessing the needs of local populations and in tackling health inequalities. There needs to be a greater focus on health inclusion and reaching out to those in local communities who remain unregistered with general practice and lack access to care.

**Overall**

- The majority of care provided by general practice is good. However, there are wide variations in performance and gaps in the quality of care that suggest there is significant scope and opportunity for improvement.

- In judging comparative performance based on rates of variation, it is important to determine whether such differences can be justified; for example, more data needs to be adjusted to take account of differences in case-mix.

- More needs to be done to make those working in general practice aware of variations in quality, and to understand how much of this variation is unjustified.

- More needs to be done to ensure that where unacceptable variations exist, these are addressed so that a better and more consistent standard of care can be delivered to patients. Practices that perform poorly compared to others will need to be challenged to improve and, where appropriate, supported to do so.

- There is considerable scope for improvement in ensuring that all patients receive all their recommended care as defined in clinical best-practice guidance; for example, in the prescribing of low-cost statins and in delivering care to people with long-term chronic illness.

- Significant potential exists for reducing the number of emergency hospital admissions for conditions that could have been managed in primary care.
There are wide variations in patient experiences in terms of access to care, continuity of care, and patient engagement. Patients remain poorly engaged in making decisions about their own health and more could be done to support patients to make choices, to be engaged in decision-making, and to care for themselves.

There is considerable scope to improve the quality of care co-ordination for patients with long-term chronic and mental illnesses, for those at the end of life, and in maternity care. Links between general practice and other services need to be strengthened in areas where patients with complex problems receive care from multiple providers.

Developing an environment for quality improvement

Many general practices are engaged in quality improvement initiatives and are proactive in seeking to deliver improvements in care. However, quality improvement is not yet routinely embedded as a way of working. Practices need to be supported in creating an environment within which quality improvement can flourish.

GPs are often unaware of the variations in quality that exist within and between their practices and those of their peers. Making clinicians aware of such variations is a first step to encouraging them to explore the reasons for variable performance, and to act accordingly.

Practices need to use data and information tools to provide clinicians with the information they need to identify and prioritise areas for quality improvement.

Strong clinical leadership is essential to foster a clear vision and set of common values through which effective collaboration and teamworking can operate.

People working in general practice need training and support in order to acquire the necessary skills to implement quality improvement.

Protected time and incentives, both financial and non-financial, are required for individuals to think about, train for, and reflect on the quality of care.

Excellence needs to be recognised and rewarded. High-performing practices need to use their skills to support those that are weaker, and should ultimately be given the ability to expand and/or take over failing practices.

Developing an environment for quality improvement also requires action to be taken at many different levels. Policy-makers, regulators, commissioners and the professional bodies all have roles to play in creating a better environment that supports general practice in its quest for quality.

There is an opportunity for GP commissioning consortia to be provided with the levers to drive improvements and challenge poor practice. Member practices need a system of rewards and penalties that is genuinely influential and that focuses on local priorities.

GP commissioning will make general practices accountable for the quality of care they provide and responsible to take action where such quality is sub-optimal.

An open culture needs to be developed that balances GP consortia’s ability to challenge as well as support practices. General practice is more likely to become engaged in driving improvements in care where there is transparency in the sharing of data at a local level with patients, the public and professional peers.

Fundamentally, general practice must own the quality agenda and take on professional leadership for quality improvement.
The future of general practice

- Generalism lies at the heart of the future of the NHS, and the system needs to value this. Instead of general practitioners developing more specialist knowledge, general practice needs to make specialist support available during the consultation process, during care planning, and in ongoing care to support patients to manage their own illness.

- General practice needs to see itself at the hub of a wider system of care, and must take responsibility for co-ordination and signposting to services beyond health care – in particular, social care, housing and benefits.

- General practice needs to move from being the gatekeeper to specialist care to being the navigator that helps steer patients to the most appropriate care and support.

- Delivering high-quality care requires effective teamworking within general practice. The skill-mix in general practice will need to evolve, to include a wider range of professionals working within and alongside it. The GP should no longer be expected to operate as the sole reactive care giver, but should be empowered to take on a more expert advisory role, working closely with other professionals.

- Delivering high-quality care also requires new models of shared care to be developed with other care providers, including those working in the community, in hospitals, and in care and well-being services. Multi-specialty local clinical partnerships need to develop that integrate services across boundaries. Such models of care will need to articulate the roles and responsibilities of general practice clearly to ensure that care for patients is well co-ordinated.

- As referrers – and, in future, as commissioners of care – general practice will have a responsibility to ensure that the services to which they refer patients provide high-quality care (as well as care that gives value for money).

- These new responsibilities will require those in general practice to work with their partners within GP commissioning consortia, local authorities and wider public services to improve the health of the population and to reduce health inequalities. General practice needs to be far more proactive in preventing ill health and taking a population-based approach to care.

- In the transition of commissioning from PCTs to GP consortia, the Department of Health and the NHS Information Centre must ensure that information flows, and indicators derived from them, are appropriately and speedily realigned to consortia boundaries.

- General practice needs to strike a new deal with patients, in which patients are active participants in decisions about their care and the services they receive. This is important as effective engagement with patients is intrinsic to quality improvement.

- Overall, general practice needs to deliver ‘post-industrial’ care in which measuring performance, improving care standards, and transparent reporting are key features of the way care is provided. To achieve this, general practice will need to operate at a scale commensurate with the demands placed upon it.

- There is an urgent need to accelerate the work to establish federations of practices, and to bring isolated practices more formally into larger provider organisations or networks. The advent of GP commissioning will make this a necessity.
Conclusions

- General practice has evolved significantly from its origins. Many practices have been at the vanguard of innovation and quality improvement. However, if general practice is to meet its new responsibilities and maintain its international reputation for excellence, it needs to adapt significantly.

- The transition will not be easy. Those leading practice organisations and GP consortia have the opportunity to build on the strong values and professional ethos to be found in general practice.

- General practice will need to have a relentless focus on improving the quality of care given to patients, supported by the proactive use of data and information to do so.

- Quality improvement needs to balance and combine external scrutiny and regulation with locally driven, peer-led and user-centred approaches. The key to achieving this balance is transparency. Reporting on quality – to patients, between peers, to other care partners, and to commissioners and regulators – can help create a ‘virtuous circle’ of quality improvement.

- GP commissioning could provide a new platform through which improvements in the quality of care of general practice can be driven.
Introduction

In April 2009 The King’s Fund commissioned an independent inquiry panel to undertake a review of the quality of general practice in England, and to make recommendations as to how general practice can be supported to improve quality. The key aims of the inquiry were:

- to examine the current state of quality of care in general practice across key ‘dimensions’ of care and to identify opportunities for quality improvement
- to consider the current availability and use of data and information in supporting quality improvement in general practice, and to explain how data can contribute to quality improvement in the future
- to produce practical ideas and recommendations on how to promote quality improvement in general practice
- to set out the challenges for general practice in meeting the quality agenda and present a commentary on how the existing model of general practice may need to be adapted in the future.

This report summarises the findings of the inquiry’s deliberations. It aims to support further efforts by those working with and in general practice to improve the quality of care. In particular, it proposes specific ways to support and encourage general practice to make better use of available data sets and information, in order to improve the quality of care. Its findings will be relevant for policy-makers, regulators and commissioners of general practice services. It makes some suggestions as to how these actors can constructively engage with, and support, those working in general practice in their quest to improve quality.

The inquiry has been conducted in a rapidly evolving political and policy environment. The developments outlined in the coalition government’s 2010 White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010a) are radical and far-reaching, and include fundamental changes to the role of general practice. The devolution of commissioning to general practice consortia will require a more transparent and systematic approach to how quality of care in general practice is monitored, managed and reported – one that goes well beyond the Quality Outcomes Framework (QOF) and existing patient experience surveys. The report is therefore also forward-looking, in that it suggests not only quality of care in general practice can continue to be improved but also how the model of general practice needs to change in future.

About the inquiry

Since April 2009, the inquiry has collected and examined evidence on the quality of care and services provided by general practitioners (GPs) and other health professionals working in general practice (see the box opposite). The inquiry panel selected a number of aspects (‘dimensions’) of general practice. These dimensions spanned different elements of what general practice does on a day-to-day basis (such as diagnosis and referral, and prescribing) as well as some of the ‘enablers’ of high-quality care (such as
clinical leadership and the commissioning of general practice services). It also considered a number of areas in which the role of general practice is less well defined, and indeed is contested (such as maternity and end-of-life care).

The dimensions of care examined in the GP inquiry

The inquiry commissioned 10 research projects covering the following themes:

- the management of acute illness (both minor and serious)
- the quality of diagnosis and referral
- prescribing and prescriptions management
- the management of people with long-term conditions, including mental health problems
- health promotion and ill-health prevention
- access to care
- continuity of care and how well general practice is integrated into the rest of the health care system
- patient engagement and involvement
- end-of-life care
- tackling inequalities in general practice.

The inquiry also commissioned four discussion papers on:

- the quality of the therapeutic relationship
- improving the quality of commissioning general practice services
- the quality of maternity care in general practice
- clinical leadership.

The majority of these papers are available on The King’s Fund’s website at: www.kingsfund.org.uk/current_projects/gp_inquiry/index.html.

The inquiry was conducted in four phases:

- research
- validation
- integration
- approaches to quality improvement.

Each of these is described below.

Phase 1: Research

To inform its work, the inquiry commissioned a series of research papers and discussion papers on key dimensions of care. Each paper examined the following issues.

- What does high-quality care look like?
- What is the role of general practice in the delivery of high-quality care?
- What is currently known about quality of care, and how does this vary between practices?
- What measures of quality are currently being used, or could potentially be used, to assess each dimension – and for what purpose?
- What does the evidence tell us about the future challenges of general practice in delivering high-quality care?
In commissioning the research papers, the inquiry asked the authors to suggest measures that might capture ‘quality’, as defined in their reports. As a result of the suggestions put forward by the research teams, the inquiry compiled about 200 different measures, ranging from the readily quantifiable to the unmeasured and aspirational. The suggested measures included those that were:

- derived from routinely available data sets, such as QOF and the General Practice Patient Survey
- derivable from locally available data or data in GP systems
- based on audit within general practice
- measures of good practice, process or structure suitable for accreditation
- areas that are critical to high-quality care and where further development of measures is required.

Researchers at The King’s Fund analysed routinely available data to illustrate how data can be used to compare performance between practices, and to identify variations in the quality of care where these exist. A selection of this data is presented in Chapter 4.

Phase 2: Validation

The inquiry was committed to testing the findings of the research with GPs, other frontline general practice professionals, managers, patients and the public. In February and March 2010, The King’s Fund held a series of engagement seminars with audiences of up to 40 people. At these events, the report authors shared the key messages emerging from their research and used the audience feedback to revise their papers where necessary.

The inquiry also engaged people in its work through The King’s Fund website. People were invited to submit comments via email to the inquiry team. More than 500 individuals and/or groups directly signed up for updates with the inquiry.

Research reports and discussion papers were published online from June 2010 onwards, with further feedback invited through online discussion. The King’s Fund also ran an online survey, between December 2009 and March 2010, to gather the views of those working in general practice (Goodwin et al 2010b). In all, we estimate that more than 1,500 individuals contributed advice or commentary to the inquiry.

Finally, the panel held a stakeholder dinner in September 2010 at which the emerging findings and recommendations were discussed and debated. This feedback and information fed into the panel’s deliberations, and has been considered in preparing this final report.

Phase 3: Integration

The integration phase involved reviewing the current availability and use of quality measures and indicators, in order to identify gaps where key dimensions of quality were not being measured. To assist with this, The King’s Fund carried out research that mapped current and planned initiatives for developing and using quality indicators in general practice (see Chapter 3).

In March 2010, the inquiry convened an ‘indicator group’. This group of experts had two purposes: to review the quality measures and indicators recommended by the 10 research reports, and to advise the inquiry on whether any of these could be usefully developed into indicators for the purpose of informing quality improvement in general practice.

The inquiry considered that rather than working to produce a comprehensive basket of indicators, it would be preferable to suggest measures of quality. This was particularly
the case for aspects of care that are currently considered difficult to quantify. These could then act as useful markers, or proxies, of quality in a local practice, and/or could be developed into ways of gathering data and information to support quality improvement through self-reflection, audit and peer review.

To guide the work of the indicator group, the inquiry panel developed a set of criteria for judging the usefulness of the indicators. They were interested in indicators that:

- promote quality improvement in general practice – in other words, that are intended for use within general practices for self-evaluation, rather than for assessing performance or for setting external targets
- general practice can use – in other words, that make sense to GPs and health professionals in general practice as measures that can be used to ensure that patients are receiving a good service and to drive further improvement
- are not confined to routinely available national data sets, but include measures that could be derived through local audit and review in general practice
- raise the bar of quality – in other words, supporting high-quality performance beyond minimum standards
- go beyond those currently available, and that capture some of the hard-to-measure aspects of good-quality care in general practice.

Phase 4: Approaches to quality improvement

The inquiry commissioned a further discussion paper examining quality improvement in general practice (Dawda et al 2010). This paper sought to examine the barriers to, and factors promoting, improvement and was used as the basis for discussion at an expert seminar held in July 2010. The seminar discussed different approaches to quality improvement, and the barriers to, and factors that promote, improvement in general practice.

About this report

The inquiry panel met 14 times over a 24-month period. Meetings were held at The King’s Fund and attended by key staff involved in supporting the inquiry. These meetings involved the panel:

- clarifying the remit and scope of the inquiry
- agreeing the dimensions of care to be examined
- determining the remit for the commissioned research
- reviewing the reports
- listening to direct feedback from the research teams
- considering additional evidence and feedback
- reviewing and discussing drafts of this report.

This report reflects the lively discussions and deliberations held within the meetings described above, and sets out the conclusions and recommendations agreed by the panel.

Having considered the scope and remit of the inquiry, in this Introduction, we move on to the report findings. Chapter 2 looks at the evolving nature and role of general practice and its growing range of responsibilities. This is followed by an overview of current approaches to the measurement of quality in general practice, set out in Chapter 3.

In Chapter 4, we assess the quality of general practice, drawing heavily on the findings of the research papers and analysis of routine data. In Chapter 5 we go on to discuss how different approaches to quality improvement within a general practice context might be
promoted and applied, and how external organisations can support quality improvement in general practice.

Chapter 6 considers how general practice needs to evolve as part of the wider health system to meet the aspiration of delivering a higher quality of care, and reflects on whether recent NHS reforms will support this.

Our concluding comments are presented in Chapter 7.