

Churchill Fellowship Report 2000

Systems of Quality Assurance for General Practitioners

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Executive Summary

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Project Description:

Quality Assurance for General Practitioners is a relatively new initiative in Australia – participation in the Royal Australian College of General practitioners (RACGP) Quality Assurance and Continuing Education (QA&CE) Program has been a requirement for vocationally recognised GPs since only 1987. In 2000, almost 18 000 GPs were required to participate in the Program.

The QA&CE Program is revised every three years and attempts to incorporate research evidence regarding the most effective quality assurance and educational strategies. The great bulk of this evidence comes from overseas (particularly Europe) where quality assurance in medicine has a long history. I am particularly interested in investigating other countries experiences with clinical audit, as this is a method which is receiving increasing emphasis in the RACGP Program, but about which there is limited expertise and experience (particularly long-term experience) in Australia.

Study questions included:

- What quality assurance systems are used?
- How is effectiveness of Quality assurance systems evaluated?
- What research is being conducted to evaluate the effectiveness of clinical audit?
- Is any research being conducted which links quality assurance with improved community health?
- How are GPs encouraged to take part in QA?

Lessons learned from project:

Many of the difficulties in implementing quality assurance programs in health care which are experienced in Australia are issues world-wide. For instance, all countries visited as part of this program had problems encouraging participation of GPs in quality assurance initiatives and all had some level of mandatory participation. In addition, evaluating the effectiveness of quality assurance systems remains problematic in all organisations visited.

My main recommendations for the future direction of quality assurance in general practice in Australia are outlined below:

- We must encourage more interdisciplinary cooperation to truly achieve quality health care for the community. Isolated efforts from individual professions is inadequate.
- A multi-strategy approach to improving quality in general practice is necessary. Whilst Clinical Audit is a useful tool, it is only one of many and should not receive undue emphasis.
- The quality-assurance community must continue to lobby for more funding to conduct rigorous research in to the efficacy of quality assurance methods and programs in the Australian context.
- The use of available technologies should be encouraged and increased. This will allow much easier access to data about quality of care as well as improving communication with and between GPs, and streamlining administrative activities.

Programme

My programme of study was as follows:

UK

- Royal College of General Practitioners, London
- Oxford Medical Audit Advisory Group, Oxford
- Clinical Governance Research and Development Unit (formerly Eli Lilly Clinical Audit Centre), University of Leicester
- National Institute for Clinical Excellence (incorporating the National Centre for Clinical Audit), London

Netherlands

- Quality of care Research Centre, University of Nijmegen, Maastricht
- Dutch College of General practitioners, Utrecht

Sweden

- University of Stockholm, Department of Family Medicine

USA

- American Academy of Family Physicians, Kansas City, Missouri
- Alliance for Continuing Medical Education, Birmingham, Alabama

Background

Why is quality assurance in health care important?

Issues of quality in health care have come to prominence in the last 20 years, largely due to mounting evidence of sub-optimal quality of care and government and consumer expectations of greater accountability from the health system and doctors. Donabedian (1988) writes that a major aspect of assuring quality in health care is performance monitoring which he defines as a fine tuning process to achieve a targeted level of quality. He describes the steps involved in performance monitoring:

- collection of information about the processes and outcomes of care
- analysis of the information to detect patterns of good or questionable practice
- explanation of practice
- action to correct questionable practice and
- continuous performance monitoring, with particular attention to problems identifies and addressed, to make sure the problems have been corrected and that other problems do not go undetected.

What is Clinical Audit?

The steps described by Donabedian form the basis of most quality assurance in health care, including clinical audit. Clinical audit, which is sometimes called medical audit or practice audit, is now being used as a quality assurance measure by a wide variety of medical organisations through out the world.

The Royal College of Physicians (1989, p. 195) defines medical audit as “a mechanism for assessing and improving the quality of patient care, enhancing medical education and identifying ways of improving the efficiency of clinical care” whilst the RACGP (1998, p.11) defines clinical audit as “... series of planned activities based on performance review and enhancement with the aim of continually improving patient care.”

Marinker (1990) builds on these definitions, stating that clinical audit is "...the attempt to improve the quality of medical care by measuring the performance of those providing care, by considering the performance in relation to desired standards and by improving on this performance." This definition is perhaps the most comprehensive because it notes the importance of knowing what constitutes good practice in order to detect good or questionable care. Most clinical audit models today include a step which involves establishing standards of good medical practice in the area being examined.

The Royal Australian College of General Practitioners (RACGP) uses clinical audit as a major part of its Quality Assurance and Continuing Education (QA&CE) Program. Since 1993 it has been mandatory for recognised GPs to participate in at least one Clinical Audit per three year cycle of the RACGP's Quality Assurance Program, in order to maintain vocational registration with the Health Insurance Commission.

United Kingdom

Britain's National Health System (NHS) is very different from Australia's system of health care and it is extremely difficult for an 'outsider' to develop a firm understanding of it in a short time. In addition, the NHS is currently undergoing a major process of change both in terms of overall structure and quality assurance procedures. This was reflected in the fact that two of the organisations I visited during my fellowship had recently undergone changes in name and goals.

One of the major differences between the UK and Australian health system is that in the UK there is considerably more interaction between different health professionals involved in primary health care – such as GPs, nurses, physiotherapists, pharmacists and so on. Primary Care Groups (PGCs) coordinate local education and quality assurance activities for health professionals in their constituency.

In 1999 plans for increased funding of the NHS were announced. This extra funding was linked to several challenges to the health community to “modernise” the health service. New NHS quality programs have been introduced – the National Institute of Clinical Excellence (NICE), the Commission for Health Improvement (CHI) and the local Clinical Governance program. Whilst the development of these programs has generally been greeted enthusiastically by the health-quality community, there is a common complaint of inadequate funding to successfully meet the goals.

One of my first challenges was to understand the concept of clinical governance, particularly how it impacts on clinical audit and quality assurance in general. I spoke about this issue with all the organisations that I visited and the concept still seems somewhat vague and undefined even though it is now in the process of implementation. It seems Clinical Governance is largely a new name for established concepts such as commitment to high standards, reflective practice, risk management and personal and team development. There are many definitions

of clinical governance and how it will affect primary care. Among the definitions that seemed to be most useful and appropriate were:

- “The development of a framework so that high quality can be demonstrated and safeguarded, and monitoring systems designed to improve quality”
- “a mechanism for ensuring clinical accountability”
- “an improvement of clinical care through audit and analysis”
- “Clinical governance is about responsibility and quality”

The tasks of clinical governance are to protect patients, develop people and develop teams and systems. The main difference between clinical governance and the previous systems is that it encompasses both quality improvement and *accountability*. Once quality has been defined, PCGs are accountable for ensuring that its constituent health care individuals and teams are providing it. It also stresses the involvement of patients as equal partners in defining the quality of care they receive. Health authorities and the CHI will be required to monitor the quality of care provided by PCGs. Reporting mechanisms and performance management criteria are not yet fully developed.

The Clinical Governance Research and Development Unit (formerly Eli Lilly Clinical Audit Centre)
Department of General Practice and Primary Health Care
University of Leicester

The Clinical Governance Research and Development Unit was formed in response to the NHS Clinical Governance initiative. Whilst it is recognised that there is continuing need to research audit methodologies additional innovatory activities are required to assess the introduction and continuing development of clinical governance. The centre is funded primarily by the Leicestershire Health Authority and the NHS with substantial support from Eli Lilly.

During my visit to the unit I met with Research Fellows Stuart Reddish and Sarah Redsell and Research Assistants Carolyn Preston, Kate Windridge and Linda Jones.

The centre provides a resource to Primary Care Groups and Health Authorities and offers information on:

- research into effective methods of implementing change in professional behaviour and performance;
- the determination of methods for the professional development of individuals, teams and Primary Care Groups;
- evidence based protocols for systematic audits for use by the Primary Care Team;
- the development and evaluation of ways of involving patients in clinical governance;
- the most feasible and effective approaches to clinical governance.

They have developed a model of clinical governance that brings together the activities of defining, accounting for and improving quality at the level of the individual health professional, the primary health care team and the PCG as a whole. The basis tenets of this model are outlined below:

- To account for and improve quality, a group must first define quality in respect of any particular professional activity;
- Quality also involves the elimination of inequalities in access to effective care;
- Quality is part of a process of improvement rather than an end point, with the patient or user having a greater, or even predominant role in defining and judging quality;
- Groups must establish systems for accountability that ensure poor performance, however identified, is reported and corrected;
- The system for accountability must also include rules about the need for confidentiality and the point at which it becomes permissible, or even obligatory, to break confidentiality to protect patients;
- Although clinical audit is likely to be the principal tool for monitoring the quality of clinical care, for maximum impact it needs to be used in conjunction with a wide variety of methods for implementing change

- Methods of identifying obstacles to change at the individual, team and organisational level are needed, to enable informed choices of the most effective implementation methods
- Primary Care Groups that value people will have a system of clinical governance that includes means of identifying and supporting colleagues who experience problems
- Clinical governors need to select quality improvement methods that promote collaboration, communication and joint decision making
- Implementing clinical governance is likely to be a staged process, as Primary Care Groups progress towards becoming Primary Care Trust.

They have considerable funding to conduct high quality, robust research into clinical audit. Current projects include a randomised trial of the effectiveness of prioritised audit criteria; a randomised controlled trial of audit and feedback and educational outreach in improving community nursing practice and health care outcomes for the management of continence; a controlled trial of a method to promote multidisciplinary audit in hospital teams; an observational study of the factors related to carrying out successful audit in general practice and the development and validation of a standardised outcome instrument for patient evaluation of the quality of care in general practice.

They also have a well-established program of secondments to the centre, where a member of a primary care team is seconded for one day a week for up to a year to work with centre members on developing audit protocols on topics of relevance to their practice.

National Institute for Clinical Excellence (incorporating the National Centre for Clinical Audit)

London

The role of the National Institute for Clinical Excellence (NICE) is to provide both health professionals and the public with authoritative and reliable guidance on current best practice. This guidance covers individual health technologies such as procedures and diagnostic techniques and the clinical management of specific conditions. I met with Project Officer Shahira Patel to discuss current developments in the organisation.

The primary focus of clinical audit team at present is the establishment of a number of funded collaborating centres. Proposals are currently invited from medical colleges, professional associations and universities who wish to be involved in these centres. Each centre will bring together a wide range of high-quality professional, patient, academic and managerial skills for NHS guidelines and audits. The responsibilities of the collaborating centres will be to provide clinical practice guidelines; national audit and implementation tools to support guidelines; educational and information services to support audits; data sets collected from audits which will provide baseline and outcome data. This is a very large-scale project which should see the best data produced to date on the efficacy of clinical audit, and has considerable government commitment.

The institute also publishes a National Index of Clinical Improvement projects on its website, to encourage contact between those who are planning an audit and those who already have relevant experience.

The Royal College of General Practitioners

London

The Royal College of General Practitioners (RCGP) is the academic organisation for general practitioners in the UK. It aims to encourage and maintain the highest standards of general practice and act as an advocate for GPs on education, standards and training issues. The RCGP is a relatively young organisation (being founded in 1952) which deals with roughly the same number of GPs (about 18 000) as does the RACGP. This is because all registered GPs in Australia must complete the QA Program of the RACGP, whilst involvement in the RCGP is a purely voluntary activity for College members.

I met with Education Officer Georgina Cooper to discuss quality assurance initiatives of the college. There is currently no QA requirement for continued membership of the college although a system of Accredited Professional Development is about to be introduced. This will be a purely voluntary system for members of the RCGP to demonstrate their commitment to lifelong learning. Hence, the RCGP is perceived to have less of a 'policing' role than the RACGP, as involvement is voluntary and they have no role in continuing registration. Whilst the RCGP does develop some Clinical Audit activities and practice guidelines, these are not seen as its major role.

The RCGP is encouraging its members to become more hands-on in their use of information technology and hosts a discussion forum on its website which provides opportunities for GPs to network and share ideas. This is particularly useful for solo practitioners and those in rural areas and would be a useful tool for the RACGP to encourage more contribution and feedback from its members.

Oxfordshire Multidisciplinary Clinical Audit Advisory Group

Oxford

The Oxfordshire MAAG is one of a number of audit advisory groups throughout Britain which promote quality improvements in care by supporting and advising primary health care groups in their audit and educational activities. I met with Sue Trinder and Angie Eachus who are both audit facilitators.

The broad aims of the Oxfordshire MAAG is to:

- increase participation in clinical audit and quality improvement activities
- provide a central reference point for all agencies involved in quality improvement

- provide training for PCGs in skills relevant to clinical audit, quality improvement and clinical effectiveness
- increase effective use of computers and appropriate information technology
- collect audit data from PCGs and produce comparative data

They offer a wide selection of very professional clinical audits free of charge as well as assisting local medical staff to develop their own audits.

They develop guidelines and hold practice based educational meetings for GPs and other health professionals.

Oxfordshire MAAG has been working since 1990 to help general practices improve the quality of care they provide through promoting clinical audit as a key part of quality improvement. There are a number of areas important for clinical governance that the MAAG is helping practices and PCGs with:

evidence-based clinical audit of coronary heart disease, diabetes, hypertension and asthma; making better use of information technology in practice - computer templates, Read codes; making collection of clinical data easier - using MIQUEST; implementation of National Service Frameworks for mental health and CHD in primary care; developing evidence-based practice and clinical effectiveness and using patient satisfaction surveys to access patient views on services

The MAAG has been involved in a national pilot of the use of MIQUEST software to collect comparable data from different practice systems. Participation in national data collections will continue in the future, but the MAAG is now concentrating on using MIQUEST to support its regular audits within Oxfordshire. Local Primary Care Groups are also expressing an interest and the Oxford City PCG has asked for it to be used for data collection on drug misuse in the city.

They also offer training in several areas:

- “Finding the Evidence” workshops to learn skills in electronic searching. These are held in conjunction with the medical library services.
- Clinical Effectiveness meeting (1 hour) in GPs own practice where quality improvement issues are discussed.
- Mini-CASP meetings based in GPs own practice (CASP stands for critical appraisal skills program). This consists of a highly interactive hour going through a published paper on a topic relevant to primary care to assess its relevance, validity and what it actually shows.

Lessons learned from UK visits:

- we need to take a more multidisciplinary approach to improving quality in health care, rather than having professional groups working in isolation from each other
- patients should be involved as equal partners in the quality improvement process
- the introduction of clinical governance in the UK should be closely monitored – effective components could then be introduced in Australia
- it is essential that more funding is made available for rigorous outcome studies of quality improvement strategies
- GPs in Australia must continue to be encouraged to make use of technology in their practices, and to learn to use this technology for quality improvement purposes.

The Netherlands

Quality of care Research Centre, University of Nijmegen, Maasstricht

The Netherlands is arguably at the forefront of quality assurance in health care. The key tool used are practice guidelines – systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Variations in the content and quality of clinical practice, delays in implementing research findings and failures to abandon outmoded practice are issues in Australia as well as abroad. Guidelines are seen as a tool for making care more consistent and efficient and for closing the gap between what clinicians do and what scientific evidence supports. They also make it more likely that patients will be cared for in the same manner regardless of where or by whom they are treated.

Much research is being conducted into the implementation of guidelines in the Netherlands. Unfortunately, I was unable to meet with one of ‘gurus’ of quality assurance in medicine, Professor Richard Grol, but I was able to meet with two of his research assistants, Irene van der Veld and Bastian Haagsma. The particular focus of their current research is the determinants of behavioural change, both in individuals and institutions, in order to gain a better understanding of what influences the uptake of new evidence. They are also conducting very thorough evaluations of the effectiveness of guidelines. Controlled multi-centre trials are being run to evaluate the cost effectiveness of specific guidelines and economic analyses of implementation strategies. Studies have found similar barriers to implementation as we have in Australia – lack of time in practice to implement guidelines, especially in preventative care, and poor understanding of the rationale behind guidelines.

Clinical Audit is used as one means of implementation of practice guidelines. Whilst studies of Clinical Audit in the Netherlands have been quite rigorous, they too have found inconsistent results in terms of improved practice. However, guidelines and clinical audit are intrinsically linked - guidelines are an essential element of full cycle clinical audit, as we cannot assess quality of care unless we can explicitly define good care.

Dutch College of General Practitioners

The Dutch College of General Practitioners has produced clinical guidelines since 1987, issuing more than 70 clinical guidelines at a rate of 8-10 topics a year. A rigorous procedure involves an analysis of the scientific literature, combined with consensus discussions on content among ordinary general practitioners and experts. The systematic implementation programme that follows clinical guideline development uses various methods, such as specific educational packages for local continuing medical education and small group peer review, telephone cards for use in practices, facilitators to introduce clinical guidelines directly to practice teams, and publication of clinical guidelines in consumer journals. More than 80% of Dutch family physicians are aware of clinical guidelines within a few months of publication, and an average of 70% of the recommendations are followed. Updating of the clinical guidelines has recently begun, as well as collaboration with other medical specialty societies to develop guidelines for the primary-secondary care interface. Clinical guidelines figure prominently in Dutch health policy.

One example of an integrated strategy for implementing guidelines relates to the national guidelines for cervical screening in family practice in the Netherlands. The strategy focuses on barriers to implementation found in earlier studies, such as a critical attitude to prevention in GPs, extra workload and need to organise the practice differently. At National level guidelines were generated and supported by educational packages as well as financial resources. At regional and local level, education was provided to groups of doctors and nurses and regional arrangements for coordinating the screening program between community services and general practices were put in place. At practice level, outreach visits by trained facilitators were used to educate and motivate professionals to participate in the program. Over the two-year course of the study cervical screening rates and follow up increased significantly. This suggests that a coordinated, integrated approach to guideline implementation is more likely to work.

Lessons learned from Netherlands visits:

- systematic, multi-strategy implementation programs encourage the uptake of practice guidelines.

- guidelines need to be thoroughly evaluated after their introduction, and any necessary modifications made.
- studies of the effectiveness of Clinical Audit are still inconclusive.

Sweden

Department of General Practice and Primary Care Health University, Linköping

I met with Anna Strang and Uren Andersson who are researchers with the department of General Practice and Primary care. Unfortunately, I was unable to meet with many of the staff of the department as it was summer and almost everyone was on holidays. Their area of interest is improving clinical decision making through access to guidelines via the world-wide web. The web has been chosen as the medium for communication because it is cheap, stable, easy to use and is easily accessed through ordinary computer networks.

They note that technology can be used to improve individual care, but it must be introduced very systematically. Negative attitudes to IT and cost factors can be issues in some practices.

Experts committees have produced decision trees to aid treatment decision for a number of common health conditions. An interactive version of these were then uploaded to the web and a representative sample of GPs recruited to the study to use the instrument during consultations. A matched control group was also selected. Data collection is currently under way.

Lessons learned:

- be aware of new and novel ways to bring practice guidelines to the health care community.

U.S.A

Alliance for Continuing Medical Education

The Alliance for CME is an association for those with an interest in CME. The most similar organisation in Australia is probably the Australian Association for Medical Education. However, the Alliance for CME is only concerned with continuing professional education (as opposed to initial undergraduate education) and has a wider range of facilities and services. The organisation aims to provide educational opportunities, professional development, information exchange and supportive services to improve the CME activities offered to doctors, thus improving the performance of health care providers and health care outcomes. It is a small organisation with a membership of just over 2 200, 23% of whom are GPs. The organisation receives no government funding, rather it is entirely supported by membership fees.

I met with Ms Mandy Stone, Assistant Director of Professional Development, and Mr Jay Brown, Project Manager.

The most impressive aspect of the ACME's activities is, in my opinion, the educational tools developed to teach those involved in CME best educational practice. For instance, they produce a number of written materials: CME handbook; The Informatics Manual – a comprehensive manual which gives information about educational program design, development and delivery using a variety of electronic technology; Evaluating Educational Outcomes is – this provides methodology, design, proven practical procedures and examples of evaluation tools.

In addition, technology is used to reach as wide an audience as possible.

An annual CME basics workshop is audio and video taped and used to produce a four-hour webcast program called the 'Virtual Basics Institute' which can be used as 'just in time' basic training for newcomers to the field of CME. In addition, last year the Alliance launched a CD-rom educational activity called "CME Best Practices:

Proven Pathway to Successful Collaboration” which gives providers of medical education in-depth information about policies, procedures, regulations and standards governing commercial support of CME. There are also discussion forums on the Alliance’s web-site.

Another method used to encourage quality educational activities are annual awards for outstanding CME activities.

American Academy of Family Physicians

The AAFA is a national association of family doctors with over 89 000 members. It provides advocacy and representation for the discipline of family medicine as well as promoting high standards and providing CME activities. Members of the Academy must complete minimum mandatory CME. However, this is not linked their continued registration as a family physician as it is in Australia. The Academy is not responsible for postgraduate training and certification of family physicians. It therefore avoids the problems associated with the perceived ‘policing’ role of the RACGP.

CME requirements are quite similar to those of the RACGP – 150 hours of approved CME every three years. However, members must complete both prescribed and elective areas of CME whereas in Australia GPs are free to choose any area of medicine in which to undertake CME. There is, however, no requirement to participate in clinical audit – the Academy consider that not enough rigorous data has been produced to prove the efficacy of the method.

Several areas which are eligible for CME points in Australia do not attract points in the US: patient record review; peer review, community public educational activities and activities produced by pharmaceutical companies.

AAFP accredits CME points to educational activities. Volunteer physician reviewers review and approve activities based on very similar criteria to which the RACGP uses. However, there is a considerable charge (US \$250) for having activities reviewed. This process, which is undertaken by the RACGP in Australia, is free to providers of medical education.

In terms of CME, the AAFP is because of its size able to offer a far greater range than the RACGP is able to. In addition, they offer a range of learning activities on-line, which the RACGP is yet to do. On-line activities include lectures from the annual scientific assembly, clinical quizzes and cases, all of which are evaluated by means of an on-line interactive post-test. Members can also gain access to their CME records on-line to check their progress towards meeting the requirements and can access information about administrative procedures and full details of requirements from the web-site.

Lessons learned from US visits:

- Increase use of available technology to reach wider audience, both for educational activities and administrative tasks.
- Develop methods to recognise good practice in CME.
- Improve access to training in CME methods and practices.

Conclusions and Recommendations

Over the course of my visits to the organisations discussed I was exposed to a huge amount of information as well as a variety of approaches and attitudes towards quality assurance in general practice. However, throughout the program there were themes which were repeatedly apparent. These make up the basis of my recommendations for the future directions for quality assurance in general practice in Australia.

1. Encourage interdisciplinary cooperation to achieve quality in health care.

Quality health care for the community cannot be achieved by one group of health professionals alone. Whilst GPs are central in providing primary health care, other health professions such as pharmacists, physiotherapists and so on, also play an important role. The UK provides a firm example of how health professions can work together in Primary Health care teams, and take joint accountability for the quality of services delivered. One way of increasing this cooperation in Australia could be to introduce more common educational activities and collaborative quality assurance activities between the professions.

2. Take a multiple strategy approach to achieving quality of care.

Whilst the organisations visited continue to use clinical audit as a method of measuring and working towards quality of care, they have broadened they are attempting to devise other strategies as they realise that clinical audit is not the most suitable method for everyone. Therefore, it is important that we treat Clinical Audit as one of many useful tools in quality assurance.

3. Increase rigorous research into efficacy of quality assurance methods and systems.

The health quality community needs to continue to lobby for increased funding to conduct rigorous research into the efficacy of quality assurance methods, such as clinical audit and practice guidelines, in the Australian context. The UK, Sweden and the Netherlands enjoy considerable funding for this purpose and it is imperative that firm evidence of the efficacy of quality assurance methods is established before they are widely disseminated to the health community.

4. Encourage increased use of information technology

Many of the organisations visited make greater use of existing technologies than is currently being widely used in Australia. This ranges from using computerised systems to gather data to assess current quality of care, using information technology as a means of providing continuing education (particularly useful for rural and remote GPs) and for streamlining administrative procedures.

How can I put this to practice in Australia?

I plan to share this information with colleagues in the workplace and with committees and meetings in which I am involved. On a personal level I am preparing a proposal for PhD study assessing the effectiveness of various quality assurance methodologies used in Australia, and I can then disseminate this information through publication of articles in professional journals. I am also currently studying multimedia development part-time so that I can contribute to on-line/CD-rom educational activities for rural health practitioners.