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WORKING GROUP ON PRIMARY AND COMMUNITY CARE PURCHASING

REPORT OF THE SUB-GROUP ON THE PROMOTION OF QUALITY IN PRIMARY CARE

EFFECTIVE PURCHASING OF PRIMARY AND COMMUNITY HEALTH CARE: PROMOTION OF QUALITY IN THE PROVISION OF PRIMARY CARE

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FOREWORD

Recent years have seen the emergence of evidence-based medicine, evidence-based commissioning and, to an extent, evidence-based policy. All GP practices in Trent and their Health Authorities face a range of similar issues. As decisions become more evidence-based, then the scope for sharing that evidence increases.

Following the establishment in Trent of the Working Group on Acute Purchasing, a similar group was set up to consider issues of importance to purchasers and providers of primary and community health care services.

The Department of General Practice at the University of Nottingham and the Nottingham Unit of the Trent Institute facilitate the Working Group on Primary and Community Care Purchasing. The topics for consideration were suggested at an initial meeting in 1996 of representatives from purchasing authorities, from primary and community care and from academic departments. Small groups consider the topics and draft reports are circulated for consultation and presented at subsequent Working Group meetings. Comments and suggestions received at those meetings are incorporated into the final text. The topics are approved by the Purchasing Authorities Chief Executives (PACE) group and the final reports are submitted to them prior to publication.

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EXECUTIVE SUMMARY

In parallel with the work of the Working Group on Acute Purchasing, facilitated by ScHARR, which is looking at the evidence for purchasing certain "high tech" secondary care services, it was decided to bring together a group to look at effective purchasing of primary and community health care services. This document deals with one aspect - that of promoting quality in Primary Care.

The aim of the Sub-Group on the Promotion of Quality in Primary Care was to offer a template for developing a strategy for promoting quality in Primary Care to Health Authorities. It was thought to be especially important, in the context of a Primary Care led NHS, to focus the quality assurance needed in regard to the provider aspect of primary health care. The question of quality in purchasing was not considered as the task was already a large one and the Accountability Framework addresses some issues. Mention should be made of the need to address needs assessment at practice level as this is an area which straddles the purchaser and provider functions in Primary Care.

At the first meeting, the group felt that the ideal methodology of literature search and analysis on specific small topic areas was not applicable to the study of the broad issues in Primary Care and so a mechanism utilising a distillation of current thinking on good practice, as well as literature evidence, if available, was used.

Initial discussions centred around the constituents of primary health care in the context of improvement in quality. A model for exploring how to ensure high quality professional work in high quality organisations, producing the maximum health outcome is outlined.

Next we looked at target setting as a source of motivation. Targets were felt to improve performance in certain situations. However, disadvantages of using targets were also outlined and so care must be taken with appropriate target setting. Performance indicators, on the other hand, were felt to predict the likelihood of good quality care. Very little research has been conducted on the use of such indicators in motivating improvement in the health care sector.

Lastly, we acknowledged that diversity and variation exists in the Primary Care sector. Consequently, in addressing the promotion of quality in this environment we agreed that it

was necessary to view primary health care as heterogeneous, falling into three categories; leading edge, trailing edge and middle ground practices. The need for an ethos of quality improvement for all practices was stressed. It was felt, however, that in recognising this heterogeneity, the promotion of quality should involve different targets, incentives and supports for the three types of practices. Suggestions for each category are outlined.

RECOMMENDATIONS

THE PRIMARY HEALTHCARE TEAM - QUALITY

Standards for Entry and Review of Professionals

1. Health Authorities should apply upward pressure on the professional bodies and the Department of Health to initiate summative assessment, certification and other relevant standards.

2. Health Authorities should encourage relevant bodies to institute compulsory entry standards for practice nurses, practice managers and reception staff.

Clinical Audit

1. Health Authorities should continue to support Primary Care Audit Groups. A useful vehicle could be through the placing of service specifications outlining expectations in such areas as district wide audit, interdisciplinary and inter-practice audit, and outcome orientated audit, while stating the key priorities for the district as a whole or localities within the district.

2. Health Authorities should encourage the Regional Department of Research and Development to support research into audit methodologies.

Education and Training

1. Health Authorities should encourage ongoing development of newly qualified doctors in general practice and established Principals through: a) higher professional training, b) shared posts with academic departments, and c) involvement in the Trent Focus.

2. Health Authorities should promote Membership and Fellowship of the RCGP by Assessment.

3. Health Authorities should exert pressure nationally to establish a training and examination structure for practice nurses.

4. Health Authorities should encourage a 'return to practice' programme for all professional staff.

5. Health Authorities should encourage continuing professional development programmes that are practice based and multi-disciplinary. It is suggested that the practice development plan be used to identify the development areas for all other staff.

Effective Care

1. Health Authorities should ensure that locally sensitive mechanisms are used to implement clinical guidelines. It cannot be overstated that the effort now should be diverted to implementation at practice and individual practitioner level.

THE PRIMARY HEALTHCARE TEAM - PRACTICE QUALITY

Quality Improvement in the Organisation

1. Health Authorities should acknowledge and argue strongly for keeping the good in the old system of general practice in England (generalist, small locally based practice, gatekeeper role), whilst implementing newer thinking (practice contract, cost-effective use of resources, patient satisfaction).

Resource Allocation

1. Health Authorities should define and implement an equitable mechanism of resource allocation to practices.

Standards

1. Health Authorities should support the definition of a quality floor for practitioners and practices. This exercise could usefully be done by a group within the region for the benefit of all districts.

2. Health Authorities should encourage the development of valid performance indicators. Again this exercise should utilise expertise around the region.

Organisational Audit

1. Health Authorities should seek evaluation of various forms of organisational audit, especially in regard to cost.

HETEROGENEITY

1. Health Authorities should evolve a strategy for developing practices by utilising differing incentives, supports etc. for each of the three categories described.

Middleground

- recommend targeting this group of practices for small gains in the big health problem areas e.g. diabetes care, CHD care etc.;
- recommend a dialogue around practices setting their own improvement targets once baseline has been set;
- recommend developing networking between practices.

Trailing edge

- recommend setting a quality floor, as mentioned above, in conjunction with RCGP, LMC, PCAG and other relevant bodies;
- agree method of identification;
- agree package of support over time period;
- agree what will happen when improvement does not occur to the level determined.

Leading edge

- recommend using leading edge practices to test innovations, push out the boundaries in various spheres etc.

OTHER RECOMMENDATIONS

1. Health Authorities should consider the area of quality in purchasing of secondary care services as a next step. Clearly, this task will require that both Health Authorities and GP fundholders agree basic principles. This work may be facilitated initially by a regional group.

2. Health Authorities should address the development of needs assessment at practice level. This will require changing traditional attitudes as well as evolution of techniques suitable to small populations.

1. INTRODUCTION

The Trent Institute for Health Services Research initiated a group in September 1995 to look at priorities for purchasing in Primary and Community Care where benefit would arise from looking critically at the evidence base. A parallel exercise, facilitated by the School of Health and Related Research (ScHARR), in Sheffield, is studying discrete topics of major significance in the field of high cost, low volume interventions. At a preliminary meeting a number of priority topics were identified (Appendix A) and this document deals with one of the topics:- the promotion of quality in the provision of Primary Care.

It was agreed that the target audience for this report was the purchasing authorities' Chief Executives. The aim of this work was to offer a template for developing a strategy for promoting quality in Primary Care in each Health Authority. It was hoped that this document would be a resource to managers and could also form a framework for rational monitoring of districts by the Regional Office.

It was felt that the time was ripe for each Health Authority to put in place a strategy for promoting quality in Primary Care. First of all, Towards a Primary Care Led NHS[1] clearly identifies Primary Care as central to future developments in health care and health improvement. It is important that the provider role within Primary Care is developed and quality assured as well as the purchaser role. Also, "Primary Care - The Future"[2] added to this thrust. Finally, the recent merger of DHAs and FHSAs provides another opportunity to focus on quality in primary health care.

The group agreed with many of the sentiments in "Primary Care - The Future" , in particular, that good Primary Care encompasses a) quality, b) fairness, c) accessibility, d) responsiveness, and e) efficiency[2]. Similarly, it was felt that a good strategy should include: valuing what good quality is already in place, seeking ownership, promoting involvement and consultation and finally, should nurture people.

2. METHODS

At the outset, it was clear that the task was a large one and that the ideal methodology of literature search and analysis (applied already to certain secondary sector decisions) was not easily applicable in the broad environment of Primary Care. Consequently, the Group utilised a methodology which was a distillation of current thinking on good practice as well as literature evidence where available.

The Group has concentrated on quality in the provision of primary health care. It is acknowledged that this may emphasise an artificial divide between the related activities of purchasing by and provision in the Primary Care sector. However, we are mindful that the task is already very sizeable and that the Accountability Framework[3] addresses some of the issues. It is important to identify one area, which spans the purchaser- provider interface, which requires development in the first instance - that is the area of needs assessment at the practice level. This area will need to be revisited in light of the recommendations of the Information Group.

When the Group came to defining primary health care, it took a pragmatic view, defining it as "health services based around general medical services and the wider employed and attached staff", though recognising the narrow and limited nature of this definition.

The Group started by looking at the constituents of quality in primary health care and factors associated with its improvement[4-18]. Next, it looked at target setting as a source of motivation. Lastly, it acknowledged that diversity and variation exists in Primary Care and so explored ways for dealing with heterogeneity.

3. FINDINGS AND CONSENSUS OPINIONS

3.1 Introduction

Initial considerations of the Group centred around: a) the range of services offered, b) resource usage, and c) outcome of care. The Group went on to use these themes when it structured its work from the view point of quality in: a) the practice as an organisation, and b) the professionals working within this structure. One way of representing this conceptually is shown in Fig. 1 where the patient or the population served is the starting point and maximum health outcome is the goal. The intermediate process is that of ensuring that the ingredients are in place to deliver high quality professional care within a high quality organisation. These themes are addressed in the following sections.

It is important to acknowledge the benefits of primary health care as it has evolved through General Practice in this country to date. These are: a) the generalist nature of the clinicians in primary health care teams, b) the particular value of the primary health care team as a small locally based unit, and c) the gatekeeper role to secondary and tertiary care based on establishing patient trust and confidence. These benefits should be maximised in the future while addressing aspects such as: a) effective reactive and proactive care of individual patients, b) cost-effective use of resources within the practice, and c) care which achieves a high level of patient satisfaction[19-22].

Difficult areas which are not amenable to local alteration were noted: a) the problem of flexibility of team mix e.g. it is not possible under current contracts for a practice team to determine its mix of clinicians on the basis of patient demand and the required skills - a retiring doctor cannot, for example, be replaced by two nurses. Practice based contracts would contribute to solving this issue, and b) the traditional position of a doctor-led general practice with ownership and partnership concentrated on one professional group. Yet another issue which will need to be addressed in the future is that of social care provision and funding and how this should be integrated into the development of the Primary Care team.

3.2 The Primary Health Care Team - Professional Quality

Standards for Entry

An agreed, recent standard for entry into General Practice is that of summative assessment following vocational training[23-25]. In due course, it is hoped that this will form part of the process of certification. No specific, compulsory entry standards exist at present in regard to practice nursing or practice management though work on the latter is in progress by the Association of Managers in General Practice. Entry criteria already exist for district nurses and health visitors but no community qualification is required for professionals allied to medicine.

Standards for Review

There are a number of mechanisms for institutional review of individual medical performance. Current or proposed mechanisms are: General Medical Council (GMC) Fitness to Practice scheme, GMC Professional Conduct Committee, Health Authority Disciplinary Procedure and Re-certification. As two of these measures are in the developmental stage, it was thought useful to outline the details.

a) Re-certification is proposed as a standard which will be required by all GPs to remain in post[26-33]. The standards are likely to be mainly educational and to do with clinical audit. GPs will be encouraged to take part in programmes which will ensure that their "re-certification" status is constantly being updated so that there is no mad rush or risk of failure at the end of the time period. At the moment, it appears that the Royal College of General Practitioners (RCGP) and the GMC are designing separate systems. Further information is awaited. Research will be needed to understand if re-certification works.

b) The GMC is designing a system for GPs (and all doctors) in distress under the banner of "Fitness to Practice". A doctor who is perceived to be in distress either through a pattern of events or a single event and who is brought to the GMC's attention will enter a system which includes local mentoring and a two day assessment of knowledge, skills and attitudes. If the doctor fails, support will be

offered to help him/her to improve; if improvement does not occur, that doctor's registration will be under threat.

For nursing staff, mechanisms for review and renewal of registration with the United Kingdom Central Council (UKCC) have been developed (Appendix B). From 1 April 1995, in each three year cycle of registration, each Nurse (practice or community), Midwife and Health Visitor must: a) complete a Notification of Practice form, b) maintain a Personal Professional Profile, and c) undertake a minimum of five days of study or the equivalent in each three year registration period. In addition, nurses who have been out of practice for five years or more will have to undertake an appropriate return to practice programme.

Clinical Audit

Objective evidence of the effectiveness of clinical audit is reasonably strong[34-45]. Subjective and practical experience also suggest it is a very positive force. It was thought important to emphasise the need for effective Primary Care Audit Groups (PCAG) which would offer support and guidance on inter-practice and interface audits as well as promoting multi-disciplinary and unidisciplinary audit, facilitating networking between practices, disseminating good practice etc.[46-50]. While many changes have taken place in the past year, it is noteworthy that many practice nurses, attached nurses and practice managers are not involved in audit.

Methodologies for clinical auditing such as Significant Event Auditing[51-61], auditing outcomes and linking audit results to commissioning are important.

Education and Training

One of the most positive forces in promoting high quality General Practice in the last 20 years has been vocational training (VTS) with Membership of the RCGP as an integral part. Support for new doctors (principals, locums, assistants and those on retainer schemes) should be considered as part of a strategy for maintaining and improving the quality of care in general practice. Consideration should also be given to support for higher professional education which is being developed at present and consists of further education for the two years post VTS.

Membership by Assessment[32] is a mechanism under development by the RCGP aimed at those who have not had the opportunity to sit this examination in the context of vocational training. Fellowship by Assessment of the RCGP is yet a higher educational standard[61].

Structured training and examination, as has been described above, is currently available but is not compulsory for practice nursing.

Continuing Professional Development has now become a desirable though not proven activity. The evidence that does exist is that conventional formats, such as conferences, have little direct impact on improving professional practice. More effective methods are systematic practice-based interventions and outreach visits[62-63].

Effective Care / Guidelines

While there is now considerable evidence on interventions which are effective, the biggest challenge is in ensuring incorporation into clinical practice. Mechanisms which have been found to work are evidence-based guidelines, local ownership, the influence of opinion leaders and computerised based decision support systems[64-74]. Considerable attention must be devoted by Health Authorities to shape this agenda locally.

3.3 The Primary Health Care Team - Practice Quality

Team Working

Resources and their Usage

This is a very wide area with many complex and interlinked variables. The impact of different needs within an area can be accounted for to a certain extent by age, sex and deprivation or social variables. Therefore, a fair system of allocation of resources to meet need at practice level should be established.

At the same time, it was felt that opportunity costs of decisions and the need to use interventions which have been shown to be effective must be part of this debate. Effective mechanisms for implementation remain the major challenge.

However, it was also acknowledged that variation in demand could lead to inefficiencies. Consequently, it was felt that cost alone, however sophisticated, would not be a good measure of resource usage.

Standards

Ideally, a definition of core services, to be delivered by a practice (not an individual), would be a first step in setting quality standards as the diffuse and wide nature of the current GP contract makes the task very difficult. Such core services, then, could be monitored by purchasers and could be the basis of practice accreditation. This argument is further expanded by Dr J. Jones (Appendix C). However, it is possible to set standards based on evidence or, if not available, consensus. The first task would be to define the quality floor, or minimum standard of service. Evidence-based guidelines and audit would set the standards for practices above the quality floor with targets for improvement to be set by such practices themselves. The example of cervical screening was thought to be a helpful illustration with coverage of the eligible population and the inadequate smear rate as quantifiable markers of quality, and a description of the fail-safe mechanism in place, as a further important index of quality.

The importance of involving patients in defining services was noted. There are, however, some limitations to the process of achieving this goal which should be recognised.

Organisational Audit

A number of mechanisms for organisational audit are in place such as King's Fund, ISO 9000, Investors in People etc. However, it is important to remember that the evidence base for these approaches is not strong and in particular there is no evidence that one mechanism is more cost-effective than another.

Practice Management

This area was highlighted, though it was felt that there were more questions than answers. Some questions which need answering within a research context are: a) Is there evidence that improving practice management improves patient care, accessibility, continuity, patient satisfaction, health outcomes and comprehensiveness? b) What are the ingredients for good

practice management - multi-disciplinary team working, practice development planning, user centred orientation, modern IM&T and, staff training? c) What are the more cost-effective ways of delivering these ingredients?

Research & Development

In order to maintain a system of continual improvement in primary health care, it is important to recognise the need for an infrastructure to support a research and development programme. Not all practices will be able or interested in this activity. Consequently, for the minority of practices who are able, important ingredients in ensuring good quality work are: a cohesive team within a practice, research skills, an IM&T infrastructure and a network of collaboration between such practices and academic institutions.

3.4 Targets as a Source of Motivation

This theme, looking at the extent to which targets improve performance, was reviewed by Ruth Elkin and Jane Robinson (Appendix D) and is summarised here. Setting targets is a means of attempting to ensure progress in achieving quality and effectiveness. A target-setting approach was adopted by the government in both its *Health of the Nation* strategy and the 1990 general practitioners' contract. The general practitioners' contract also obliged providers to offer certain services as a means of securing improvements to primary services.

The literature suggests that, since the introduction of the 1990 general practitioners' contract, there have been improvements in performance. However, a number of problems with targets, and with the main services provided by GPs, have been identified:

- Targets tend to focus on those things which are most easily measured;
- Targets may be unrealistic, and may be unattainable for particular, less privileged population groups;
- Targets may foster complacency on the part of providers who have already achieved upper target limits;
- Achieving targets, even in very easily quantifiable areas such as immunisation and cervical cytology, may be contributed to more by efficient computerised recall than target payments;

- National targets may skew local priorities;
- Targets may serve to widen inequalities in health. They can exacerbate the 'inverse care law' by encouraging providers to direct their efforts at the more advantaged sections of society where such efforts are more likely to pay off in terms of overall improvements in the target level achieved;
- The provision of "core" services does not necessarily result in better health outcomes.

In essence then, a target-setting approach to improving the quality of care must be based on the use of appropriate indices.

Performance indicators on the other hand are somewhat different to targets in that they are a selection of measurements used to predict the likelihood of quality in services provided. Indicators can be described as relating to structure, process or outcome. Examples include: a) process indicators such as changes in health-damaging behaviours, increased rates of uptake of services, reductions in inequalities in access to service, and improved client satisfaction, and b) outcome indicators such as improvements in physical, social and psychological health status, improvements in the quality of life and reductions in inequalities in health.

A major limiting factor when trying to assess the extent to which performance indicators act as a source of motivation to individual practitioners is that most of the research described does not have the investigation of motivation as an original objective. Conclusions regarding motivation have generally to be inferred, therefore, from findings provided as answers to other questions. One of the authors of this paper (Robinson) observed in earlier research that performance indicators sometimes have the power to act as a *disincentive* to action by provoking defensive behaviour in practitioners confronted with measures which suggest that their performance compares unfavourably with that of their peers, or at least merits further inquiry[75-76]. Robinson also observed, following publication of the first paper on avoidable deaths which standardised for social variations[77], that a vigorous defence was mounted in the local press of unexplained variations in deaths from 14 diseases of "unnecessary untimely mortality" in one of the Health Authorities concerned.

As far as it has been possible to ascertain, there is little direct research on the motivating or de-motivating influence of adverse audit procedures on practitioners (although there is a vast social science literature on the often strained relationship between researchers and

policy-makers arising from the findings of social research). This is clearly an area which merits further detailed research. It was acknowledged, however, that if outcomes were used without a cost element, the cost-effectiveness balance would be unsettled - very high quality care may require resources beyond the capacity of the health service or society.

3.5 Heterogeneity

The preceding paragraphs, while not exhaustive, set out the general framework for ensuing a quality improvement programme in primary health care. However, a strategy for promoting quality, in this or any sector, must address variation within the primary health care sector. It was felt that a useful way of doing this was to acknowledge three categories of practices. These are trailing edge, leading edge and middleground practices. While the concept of the continual quality improvement should apply to all categories, the expectations of and the support needed will be different in each situation.

Middleground Practices

It is important to recognise and acknowledge that most practices fall into this category - that of offering services within a range of good quality. Though all groups of practices have the potential to improve continually, improvement in this group will bring substantially greater health gain for the population as a whole. Furthermore, this group has not been targeted specifically in the past.

In establishing a quality improvement culture in this sector, it must be borne in mind that there is considerable variation in performance within this group and indeed, within practices, especially large practices. Consequently, there are issues of individual as well as practice improvement. Change management strategies, for this sector in particular, should include valuing professionalism in this group, getting practices to set their own improvement targets thereby stimulating internal change and encouraging networking between practices especially in the light of collective administrative arrangements, such as, locality commissioning, out of hours co-operatives, fundholding consortia etc. It is often forgotten that this group of practices needs varying forms of support, financial or otherwise.

Trailing Edge

While accepting that all practices have strengths and weaknesses, it is clear that a small proportion have multiple problems. A framework for addressing the promotion of quality in these practices should include:

a) A fair and consistent method of identification. This exercise should be underpinned by elucidation of relevant indicators which could include the range of services offered and attainment of minimum standards, use of resources (staff, premises, referrals, prescribing etc.), accreditation/re-accreditation, re-certification, professional development etc.

b) A package of help and support for an agreed period. Clearly this will need to be tailored to the needs of individual practices and should include organisational and professional areas such as staffing, training, teamwork, mentoring and incentives.

c) An end point at which those unwilling or unable to improve are dealt with. It will be important that the exercise is conducted with honesty and integrity and that the consequences of lack of improvement are clear from an early stage. Methods of sanction include resource allocation, GMC's Fitness to Practice scheme, nurse registration, Health Authority disciplinary proceedings and GMC professional conduct committee.

Leading Edge

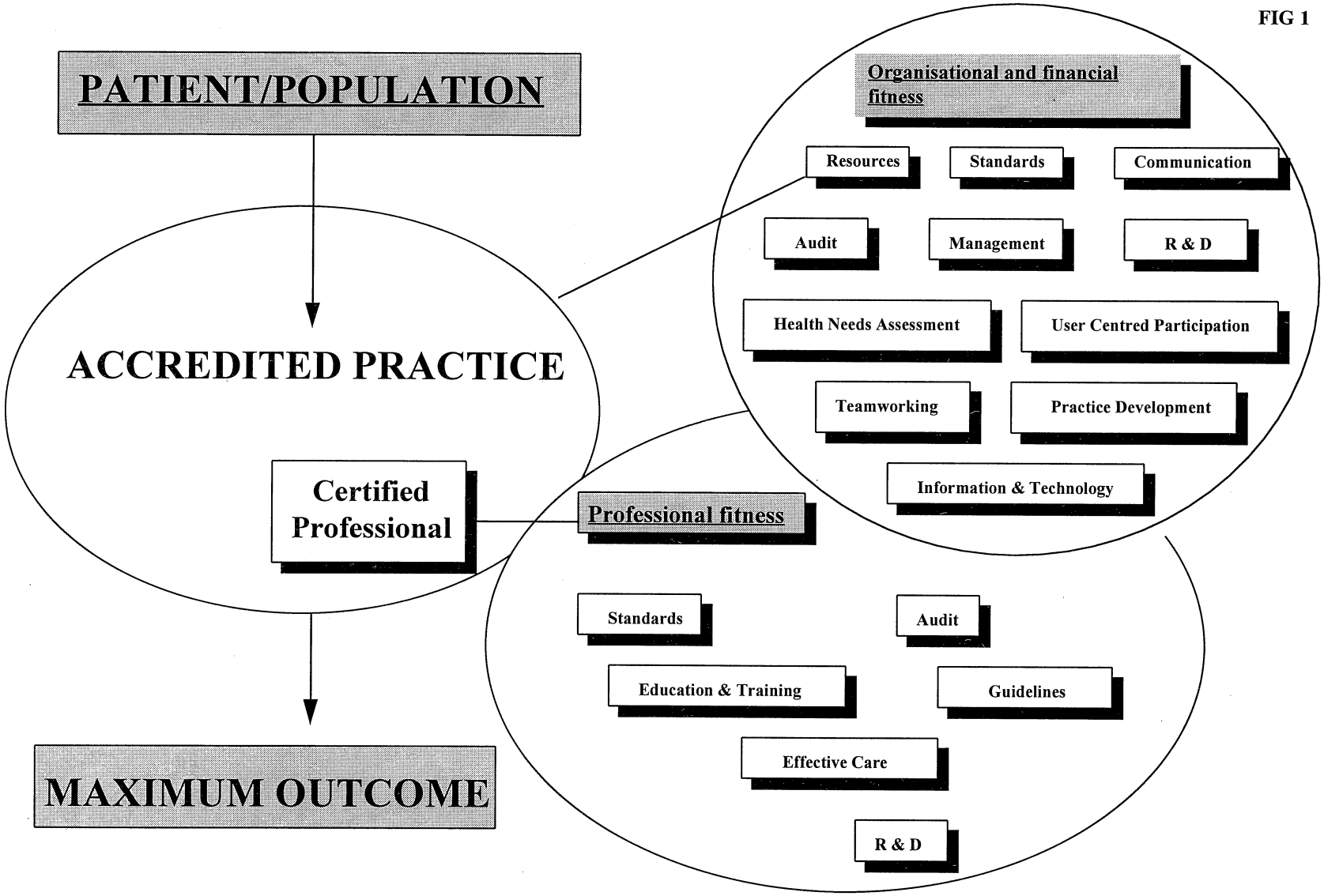
As in any human endeavour, it is important to value and nurture those at the leading edge of practice. In the field of primary health care their main value lies in demonstrating what can be achieved: a) in offering role models, b) as centres of excellence for training doctors and nurses, and c) as agents for cultural change. Issues of workload would need to be addressed if this potential were to be maximised. However, it must be said that an overemphasis on development of leading edge practices can lead to inequality.

Health Authorities may wish to consider a mechanism for recognising leading edge practices which should include practice/ professional involvement in vocational training, in academic

environments and research, in participation in Fellowship by Assessment and in organisational audit (King's Fund, ISO 9000, Investors in People etc.).

In planning to maximise the contribution of leading edge practices, Health Authorities may wish to consider this sector when piloting new initiatives or when initiating policies. Ways of diffusing the experience of leading edge practices include research, clinical audit, continuing professional development, part time clinical/academic posts, practice attachments, nurse attachment, training of all professional groups, and elaborating models of practice population needs assessment appropriate to the Primary Care setting.

FIG 1


PATIENT/POPULATION
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Information & Technology
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Audit
Education & Training
Guidelines
Effective Care
R & D

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Appendix A

OBJECTIVES AND METHODS OF WORKING OF ALL GROUPS

The Working Group identified their objectives and methods of working as follows:

a) Identifying a range of issues to be examined and consult with the Purchasing Authorities Chief Executives (PACE) group before agreeing a final list;

b) Setting up sub-groups to examine each issue within a defined timescale, the review would include:

- a definition of the problems for purchasers and their significance;
- the definition of the work of the Group, including the possibility of choosing an example service in the area to act as a paradigm;
- a review of available evidence on options and effectiveness in the area;
- the costs of the options;
- areas for future research.

c) Resourcing the sub-groups with library and literature search facilities;

d) Receive a report back from each working party and prepare a consensus report on the issue;

e) Consult key stakeholders concerning that report, including the PACE group and the Regional R&D Committee;

f) Publish the report through the Trent Institute, disseminating the findings appropriately.

Proposed Issues to be Addressed

The Group met in September 1995 and proposed the following areas as significant issues for most Districts. The approval of the PACE group was sought for this list:

a) Management of demand at the interface between Primary and Secondary Care;

b) Movement of services from secondary to Primary Care;

c) Promotion of quality in Primary Care;

d) Information for health needs assessment and resource allocation;

e) Staffing, service and unit size.

Other topics were identified as being important, but were left for the second round of this exercise:

a) Dissemination strategies in Primary Care;
b) Control of demand;
c) Roles of carers and link workers;
d) Needs based postgraduate education;
e) Care for the house-bound;
f) Assessing functional status and quality of life;
g) Effectiveness of non-drug interventions, including counselling;
h) Interventions in back pain;
i) Barriers to research in Primary Care;
j) Use of complementary therapies;
k) Transfer of services to Primary Care - does effectiveness follow into the new location?;
l) Purchasing for outcomes;
m) Role of the community hospitals;
n) Community mental health services;
o) Rural deprivation;
p) Measuring cost-effectiveness in Primary Care;
q) Asthma, wound care and implementation of guidelines.

Appendix B

SUB-GROUP ON THE PROMOTION OF QUALITY IN PRIMARY CARE

Professional Development & Maintenance of Registration for the Nursing Profession

It has been recognised for many years that in order to cope with constant changes in role and practice, it is vital for the nurse to continue to develop his or her knowledge and competence throughout their career. It goes without saying that many nurses did this without any formal requirement being placed upon them, driven only by their 'professional imperative' and their conscientious care of the patient.

Alongside the requirement for quality standards and indicators in health care itself has developed a more formalised requirement to undertake this professional updating and development which has been linked to renewal of registration with the United Kingdom Central Council (UKCC). This is the body responsible for maintaining the register of Trained Nurses, Midwives and Health Visitors throughout the United Kingdom. From 1 April 1995, in each three year cycle of registration, each Nurse, Midwife and Health Visitor must:

1. Complete a Notification of Practice form

This will enable the UKCC to identify:

a) the number and type of qualifications being used in practice;
b) the number of people in specific areas of practice;
c) the number of people in specific employment sectors e.g. Mental Health Nursing.

2. Maintain a Personal Professional Profile

This is an on-going record of all aspects of training, professional development and reflective practice, maintained throughout the career. The UKCC will undertake to audit a percentage of these profiles each year.

3. Undertake a Return to Practice programme

Where a nurse has been working for less than 100 working days or 750 hours in the previous five years, it is considered to be a break in practice. Return to Practice programmes can vary in length and content and should be designed to equip the nurse to return as a competent and confident practitioner.

4 Undertake a minimum of five days of study or the equivalent in each three year registration period

It is important to reaffirm that this last requirement is a minimum, and does not necessarily imply a formal training course. The "equivalent" may mean for example, private study and research, work shadowing, attendance at conferences and so on. The only stipulation at present is that the study must be relevant to the area in which the nurse is currently working.

There are some other regulations concerning nurses who hold and use more than one registerable qualification, and those in management, teaching or other non-clinical roles but the above are the essential requirements.

I feel that it is important to emphasise that this process has only just begun, and it will be 2001 before all nurses are covered by the requirements. Also, the requirements, known as PREP - Post Registration Education and Practice, are fairly crude and currently not subject to formal audit other than a series of pilot studies to be completed between 1 April 1995 and 31 March 2001. These aim to identify and monitor the effectiveness of the system. Another criticism of the system refers to the fact that, for audit purposes, the UKCC will 'call in' a sample of portfolios for scrutiny and checking that the requirements are being met, which will inhibit practitioners from reflecting on their practice for fear of revealing error or 'less than optimum' practice for which registration may be refused. Many practitioners would say that stringent regulations should govern 'fitness to practice', while others maintain that professional practitioners should not have to be 'driven to the trough' of training/ development in this way.

It is of course, very difficult to assess and measure the impact on the quality of care of patients that these measures will have, and there is perhaps a much more important debate co-existing with the above, namely the implementation of clinical supervision in nursing

practice which will arguably have a much more direct impact on the delivery of quality care than these minimum standards.

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Professional Development Adviser
April 1996

Appendix C

SUB-GROUP ON THE PROMOTION OF QUALITY IN PRIMARY CARE

CORE SERVICES

Introduction

The current GP contract does not specifically define the content of 'general medical services' provided by GPs to their patients as independent contractors with a Health Authority. Medical services provided by GPs can be considered to fall into 3 categories:

- general medical services;
- other NHS medical activities;
- non-NHS activities.

There is also the recognition that not all these services need to be provided by the GP personally, but that some medical services may be appropriately delegated to make best use of the skill-mix within individual practice teams, i.e. organised by the GP.

General medical services should now be defined as a range of services which GPs provide. The concept of a core content of general medical services is being taken forward actively, however, considerable debate surrounds the actual content. Quality as an element of the definition of a core range of services has not been addressed, although elements such as targets for cervical cytology provide an example of how this might be taken forward.

By defining 'core', a practical mechanism is developed by which 'non-core' services can be identified and contracted for with a GP separately, and usually attracting appropriate remuneration. With the probable future introduction of the ability of health authorities to contract with GPs to provide secondary care sector services, the urgency to define the core content of a GPs workload is increasing.

Core Content of General Medical Services

It is generally accepted that a reactive service to patients on an individual GP's list, who are ill, or who believe themselves to be ill, including the reactive management of patients with

chronic diseases, can be classified as core general medical services. This generally encompasses history taking, examination, investigation, diagnosis, prescribing and appropriate referral, as well as some certification.

It is also recognised that the content of core services, even as defined above, will change over time and sufficient flexibility in either national or local definitions of core services will need to be maintained.

Non-core General Medical Services

These are mainly preventative and proactive medical services, e.g., child health surveillance, cervical cytology, health promotion, chronic disease management, immunisation. In some cases, services may be provided not only to the GPs own patients, but may also be offered to patients of other GPs, or patients specifically registered for that particular service, e.g. contraception, maternity services.

Minor surgery is often included within the list of non-core general medical services as not all GPs would elect to provide this service, however, does not necessarily classify as preventative.

Other Services provided by GPs

Audit is also considered separately as an activity outside core services, although it is anticipated that this will be undertaken by the majority of GPs as part of their ongoing continuing medical education and professional development.

Some GPs provide optional services which have been negotiated nationally:

Vocational training of GPs

- trainer;
- course organiser;
- regional advisor.

Undergraduate medical student teaching

- tutor;
- part-time lecturer;
- academic appointments;
- nursing homes;
- academic general practice.

NHS Non-General Medical Services

These would be optional and undertaken according to locally negotiated contracts for specific services. These would most appropriately cover services currently provided in Secondary Care but which could move to Primary Care settings.

Questions are still raised concerning the involvement of GPs in commissioning and purchasing of health care. These are non-medical services provided by GPs on behalf of their patients.

Private Services

These may fall into two sections, the first encompassing nationally agreed fee systems, e.g. police surgeon, and the second individually negotiated private services, e.g. reports for solicitors.

Issues of Defining Core Services

Many GPs would regard activities such as contraceptive services, child health surveillance and maternity services to be integral to a family doctor service, as well as the reactive function, described above, for individuals who are, or perceive themselves to be, ill.

Whilst the driving force for the recognition of 'core' services has been the desire by GPs to identify workload and its appropriate remuneration. It also allows for the ability to plan effective delivery of services of a given quality and effectiveness.

Currently the GMSC is aiming to define, at a national level, those core services which practices provide according to the GP terms of services, thus enabling better negotiation of local contracts to provide non-core services.

The GMSC approach has also identified that a national framework should be provided within which there is room for local flexibility. The national negotiations are seen as appropriate for situations where there is little scope for local variation in what is expected of the doctor providing the service. Local negotiations are seen as appropriate for service shifts involving many or all of the practices within a locality, in which a contract must take account of local circumstances. In addition, local negotiation with individual practices to provide a specialised service may also be appropriate.

The GMSC has recently produced a document called **"Defining Core General Medical Services"**.

This defined the advantages and disadvantages of defining core services from the GPs perspective.

Advantages

- protects core services;
- defines basic range of services;
- allows GPs to choose which non-core services to provide;
- identifies new work;
- ensures new work is properly remunerated;
- prevents imposition of new, unpaid, work;
- enhances GPs' incomes where non-core services are provided.

Risks

- risks more intrusive management control;
- lessens clinical freedom to decide what services patients should receive;
- risks losing non-core work to other providers through competitive tendering;
- involves negotiation of contracts for all non-core services.

Within this paper are defined the following:

Work considered 'core' or remunerated through intended average net:

- responding to problems presented by, or on behalf of, a practice patient;
- proactive services normally provided by every GP; e.g., health promotion;
- services provided voluntarily within practice but not necessarily by all GPs; e.g., contraception;
- additional services requiring extra training, skills or experience; e.g. minor surgery;
- organising patient services; e.g. out-of-hours, chronic disease management;
- organising the practice team; e.g. recruitment, employment.

Work excluded from 'core' which is remunerated outside intended average net:

- work separately remunerated or undertaken without payment; commissioning, audit, R&D;
- usually associated with secondary care; nursing homes, residential homes, complex care needs;
- work which should be subject to an explicit contract; phlebotomy, pre-operative assessment;
- prescribing where GPs do not have the specialist skills to accept full clinical responsibility; cytotoxic therapy;
- mental health care for which GPs do not have specialist knowledge to accept full responsibility; mentally ill patients under supervision orders;
- activities related to research;
- work that some GPs may wish to undertake requiring specialised training; endoscopy, colposcopy, etc.;
- shared care arrangement with other providers; glaucoma, anticoagulant therapy;
- organisation of services provided by other health professionals; physiotherapy;
- non-NHS professional services with national agreements; prison service;
- individually negotiated private services; sports medical.

A Purchaser's Perspective

A practice population has a right to expect a range of services to be provided locally by the practice team. These would include:

- responding to problems presented by, or on behalf of, a practice patient;
- proactive services normally provided by every GP; e.g., health promotion;
- services provided voluntarily within practice but not necessarily by all GPs; e.g., contraception;
- additional services requiring extra training, skills or experience; e.g. minor surgery, etc.

These should be provided to a given level of quality before further contracts should be placed for non-core medical services.

In addition, the practice team has an obligation to keep up-to-date hence a commitment to:

- audit;
- continuing medical education, etc.

Maintaining the practice organisation is also essential:

- recruitment and selection;
- health and safety;
- complaints procedures, etc.

Providing input into commissioning might also now be considered a routine part of a practice's commitment.

The flexibility provided by non-core, locally negotiated contracts, responding to local needs may evolve to a locally negotiated core, as increasing numbers of GPs provide these services.

Summary

As a summary, the following situation could be envisaged. Much of the ability to deliver these services would probably necessitate a move towards practice-based contracts with General Practice rather than individual GPs.

Nationally Negotiated Core Services, with given minimum quality standards and locally negotiated quality standards

Nationally Negotiated Non-Core Services, with given minimum quality standards and locally negotiated quality standards

Locally Negotiated Core Services, with quality standards

Locally Negotiated Non-Core Services, with quality standards

Appendix D

SUB-GROUP ON THE PROMOTION OF QUALITY IN PRIMARY CARE

PERFORMANCE INDICATORS AS A SOURCE OF MOTIVATION

Ruth Elkin and Jane Robinson, Department of Nursing and Midwifery Studies

Summary

This paper starts by looking very briefly at a number of broad indicators of effectiveness and quality in Primary Care. It then discusses the extent to which targets, or performance indicators, improve performance. What this paper does *not* discuss is what indicators are *appropriate* measures of quality in Primary Care.

Setting targets is a means of attempting to ensure progress in achieving quality and effectiveness. A target-setting approach was adopted by the government in both its *Health of the Nation* strategy and the 1990 general practitioners' contract. The general practice contract also obliged providers to offer certain "core" services as a means of securing improvements to primary services.

The literature suggests that since the introduction of the 1990 general practitioners' contract there have been improvements in performance. However, a number of problems with targets, and with the core services provided by GPs, have been identified:

- Targets tend to focus on those things which are most easily measured;
- Targets may be unrealistic, and may be unattainable for particular, less privileged population groups;
- Targets may foster complacency on the part of providers who have already achieved upper target limits;
- National targets may skew local priorities;
- Targets may serve to widen inequalities in health. They can exacerbate the 'inverse care law' by encouraging providers to direct their efforts at the more advantaged sections of society where such efforts are more likely to pay off in terms of overall improvements in the target level achieved;

- The provision of "core" services does not necessarily result in better health outcomes.

The paper concludes that a target-setting approach to improving the quality of care must be based on the use of appropriate indicators.

PERFORMANCE INDICATORS AS A SOURCE OF MOTIVATION

This paper begins by looking very briefly at a number of broad indicators of effectiveness and quality in Primary Care. It then discusses the extent to which performance indicators, or targets, act as incentives to improve performance.

Indicators of quality and effectiveness

There are a number of possible indicators of quality and effectiveness in Primary Care. These include:

Outcome indicators

- improvements in physical, social and psychological health status;
- improvements in the quality of life;
- reductions in inequalities in health.

Process indicators

- changes in health-damaging behaviours;
- increased rates of uptake of services;
- reductions in inequalities in access to services;
- improved client satisfaction.

TARGET SETTING

a) The *Health of the Nation*[1]

One way of attempting to ensure progress in achieving quality and effectiveness in Primary Care is to set targets. This was the approach adopted in the government's *Health of the Nation* strategy (DoH 1991, DoH 1992). However, there are problems with targets. These have been summarised by Smith (1991). Smith argues, first, that targets may lead to a spurious priority being given to that which is easily measurable. Second, he suggests that targets may be unrealistic and dismissed as unattainable. Third, Smith suggests that targets may represent an over-simple description of policy.

A 'spurious emphasis on the measurable'? :Quantitative versus qualitative targets.

The government's *Health of the Nation* Green Paper recognised that for a number of health care interventions, it is not always possible to find an appropriate indicator of progress:

- An indicator for an improvement in coronary heart disease might be a decline in the death rate from that disease. In many cases appropriate indicators of progress are much less obvious - the sorts of things which may easily be measured may not be measures of genuine success (DoH 1991: 33, 5.23).

Despite its recognition of this problem, it is undeniably the case that the government's own *Health of the Nation* targets focus only on those things which are most easily measured. A number of commentators have been critical of the way in which the *Health of the Nation* targets rely almost exclusively on rates of illness and death as indicators, to the neglect of indicators of the 'quality of life'. The RCN have suggested a number of 'quality of life' targets. For example, alongside the *Health of the Nation* cancer targets, which are exclusively about reducing premature illness and death, the RCN suggests that targets could have been set which were related to pain control and the delivery of care at a patient's home (RCN 1991: 8).

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[1] This section draws on Robinson J and Elkan R (in press) *Health Needs Assessment - theory and practice*, Chapter 4, Edinburgh, Churchill Livingstone

Targets: unrealistic and unattainable?

The government was aware that targets must be attainable. The *Health of the Nation* Green Paper states that:

- a target which is beyond realistic expectations may ... be a disincentive to action (DoH 1991:33, 5.22);
- (Targets) must be sufficiently challenging, yet not so daunting that they become a disincentive to achievement (DoH 1991:v).

Far from being unrealistic and unattainable, it has been suggested that targets might foster complacency. Akehurst et al (1991: 23) point to the fact that when performance indicators were introduced into the secondary care sector of the NHS they did not encourage those districts and units which were performing well to improve. Similar misgivings have been expressed in relation to some of the targets set in the primary health care sector as part of the 1990 general practitioners' contract. As we shall see below, there is a danger that performance indicators in the form of cervical screening targets may foster complacency in those general practices which are performing well. However, it has also been suggested that in relation to particular social groups, targets may indeed be unattainable and might act as a disincentive (see below).

A further criticism levelled against the *Health of the Nation* targets is that national targets may skew local priorities. National targets may serve to divert attention and resources away from the most pressing local needs. Local circumstances may suggest different priorities than those set as national targets, and therefore, as a number of commentators have pointed out, there is a real danger that the pursuit of targets may neither maximise health gains nor use resources in the most cost-effective manner. In any particular locality, greater health gains and a more efficient use of resources could be achieved by concentrating on other priorities. (Akehurst et al 1991, Godfrey 1993, David 1994)

Furthermore, as Akehurst et al (1991) argue, if too much emphasis is placed on the achievement of targets, there is the danger that agencies will engage in activities where targets can be met easily, rather than those where the most health gains are to be made.

Targets: an over-simple description of policy?

'Health' is not solely the responsibility of health care professionals. The achievement of health targets is dependent not only on the curative and health promotion activities pursued in the health care sector but requires also wider government policies to combat the adverse effect on health of such factors as growing poverty, unemployment, homelessness, road traffic accidents and environmental hazards (Radical Statistics Health Group 1991:12, David 1994). The *Health of the Nation* targets have thus been subject to the charge that they place an undue burden of responsibility on health care professionals to counteract the effects of social ills. As we shall see below, there is some evidence that the pursuit of the targets set out in the 1990 general practitioners' contract have failed to overcome the effects of poverty and deprivation.

Targets and equity

The *Health of the Nation* targets are concerned with the goal of improving the nation's health but they are not concerned with the goal of promoting equity between different groups in society. The failure to include the promotion of greater equity as an explicit objective of the *Health of the Nation* strategy has been criticised in many quarters (Akehurst et al 1991; Radical Statistics Health Group 1991; RCN 1991). This criticism has been articulated by the RCN:

- There is clear research evidence which shows inequalities in health still exist. This is true in terms of access to the health service, use of health services and outcome of treatment. Targets must take into account the evidence that some types of preventable disease occur more frequently in some groups in society. Reducing the total incidence of a disease in the nation may be welcome but attempts should also be made to reduce the health differentials between groups (RCN 1991:9).

Both the RCN and the Radical Statistics Health Group have expressed the worry that the needs of people whose circumstances make it difficult for them to respond to health promotion and other health care initiatives may be neglected in favour of the more advantaged in society. There is the real danger that in trying to achieve both the *Health of the Nation* targets, and the targets set out in the 1990 general practice contract (see below), health promotion and preventive efforts will be directed at the more advantaged sections of

society where it is known that such efforts are more likely to pay off. The failure to pursue the objective of reducing inequalities in health means that any overall reduction in, for example, rates of heart disease, may well mask widening differentials between different social groups.

b) Target setting and general practice contracts

The 1990 general practice contract

The introduction of the 1990 general practitioners' contract signified a concern on the part of government to ensure that GPs delivered a more cost-effective service. The objective of the 1990 general practitioners' contract was to identify a number of "core services" to be provided by all practices, and to reward performance by financial incentives. Core services include:

1) Health checks within 28 days of joining a GP's list for all new patients.
2) Health checks for all patients aged 16 to 74 who have not seen their general practitioner in the last 3 years or have not had a health check in the last 12 months.
3) An annual consultation and a domiciliary visit for all patients aged over 75 years.
4) Cervical cytology every five and a half years for women aged 25 to 64 years of age.
5) Immunisation and vaccination services for children.
6) Health promotion clinics.

In addition, GPs can provide child health surveillance and minor surgery for additional fees (Scott and Maynard 1991). Other changes in the new contract include a 'deprivation supplement' which is calculated on the basis of the Jarman index.

As part of the new contract targets have been set in relation to cervical screening and childhood immunisation. Cervical screening targets have been set at 80% and 50%. Immunisation targets have been set at 90% (query 95%?) and 70%. A threefold differential in the level of fees received by practices achieving the higher target, the lower target and no target respectively has been introduced.

The general practice contract and cost-effectiveness

A discussion paper by two 'York economists', Scott and Maynard (1991), has looked at the question of whether the 1990 GP contract is likely to lead to more cost-effective Primary Care. This paper does not deal directly with the question of whether or not financial incentives are successful as a means of encouraging providers to meet targets or provide particular 'core' services. Rather, the paper questions the cost-effectiveness of the targets and the core services themselves.

Scott and Maynard argue that too little attention has been devoted to the *outcomes* of the services provided by GPs, that is, too little attention has been devoted to the question of whether the provision of the core services set out in the contract results in improvements in health status. Attention has been focused instead on the *process,* that is, on the establishment of a strong link between GP income and the level of service provided. But improving the process is no guarantee of a better outcome. Scott and Maynard acknowledge the difficulty of measuring which interventions produce the best outcomes. But in the light of such information as currently exists about effectiveness, they are highly critical of many of the core services set out in the contract. For example, in relation to health checks Scott and Maynard conclude:

- Examining the contractual obligations for health checks, it can be seen that the evidence points to the fact that such activities provide little or not benefit to the patient in terms of reducing mortality and morbidity, and incur substantial costs (Scott and Maynard 1991, p58).

Scott and Maynard argue that priorities within general practice are now determined partly by the relative profit each service generates, rather than the relative improvements in health status each generates. The contract has, of course, assumed that these two are linked, but Scott and Maynard stress that such a link cannot be assumed. They believe the proposals have been adopted with "scant regard to their relative costs and their relative effectiveness in terms of improvements in health status" (Scott and Maynard 1991, p10).

The effects of target payments

Childhood immunisation: Do target payments increase uptake?

The system of target-linked payments introduced in the 1990 general practitioners' contract was based on the assumption that financial incentives would have an effect on performance in general practice. However, Maurice Lynch (1994, 1995) has questioned whether payment really does improve performance. On the basis of a study carried out in the early 1990s Lynch has suggested that there exists no straightforward and direct relationship between financial incentives and the uptake of childhood immunisation services (Lynch 1995). Lynch concludes that it is socio-economic factors which have the most important effect on the ability of general practices to achieve high immunisation targets. Lynch's study is discussed in more detail in the next section.

Lynch's study of the effects of practice and patient population characteristics on the uptake of childhood immunisation: Aim and design of study

Lynch's study relied on data on primary immunisation uptake rates during the financial year 1991-2 in 208 practices in the Greater Glasgow Health Board (92% of all practices). The aim of Lynch's study was to examine the effects of a range of factors on general practices' performance in meeting childhood immunisation targets. The factors which the study looked at were grouped into "practice characteristics" and "patient population characteristics". "Practice characteristics" comprised:

1) the size of the list;
2) whether or not the practices were single-handed;
3) the number of general practitioners in the practice;
4) the number of children eligible for immunisation;
5) the number of practice nurses;
6) whether or not the practice provided child health surveillance.

(Information on the number of health visitors attached to the practice was not available).

"Patient population characteristics" were captured through the use of three indicators:

1) the 'notional' standardised mortality ratio (SMR) for the practice population (which served as a proxy for health status);
2) the percentage of patients attracting deprivation payments based on the Jarman score (which served as an indication of socio-economic status);
3) the neighbourhood type of each practice location.

The study adopted both a latitudinal and a longitudinal approach. First, the practices were separated into three groups according to the target level achieved at 1st October 1991 - high-target (uptake rates of 90% or more), low-target (uptake rates between 70% and 89%), or neither; and the relationships between the factors outlined above and the level of target achievement was examined. Second, in order to ascertain whether the same relationships held over time, the practices were grouped according to performance concerning the high target only over four consecutive quarters of the financial year.

Findings

The study found that 75% of the practices qualified for a high-target payment in the last quarter of the 1991-2 financial year, but only 53% achieved this in all four quarters of the year. Four factors were significant in differentiating the practices grouped according to the targets achieved at 1st October 1991. These were the notional SMR, the percentage of patients attracting deprivation payments, the type of neighbourhood, and the provision of child health surveillance. A disproportionately large number of practices reaching the high target were located in the more affluent areas where SMRs were comparatively low, while a disproportional high number of practices achieving the low target or no target were located in the more deprived areas with higher SMRs. Similar results were obtained when the performance of practices achieving the high target over four consecutive quarters was examined.

Apart from the provision of child health surveillance, which, as Lynch suggests, places providers in a good position to take advantage of opportunistic contacts to carry out immunisations, none of the other "practice characteristics" was significant. There was no evidence that the target level achieved was significantly affected by the workload or the organisation of the general practices, or by the number of practice nurses employed. (It

should be noted, however, that there were non-statistically significant differences between the three groups [high, low and no-target achievers] in relation to such factors as the number of practice nurses employed, and whether the practice was single-handed).

Lynch concludes that practices serving populations living in socially deprived areas and with poorer health are less likely to achieve the high target for childhood immunisation. This reinforces the conclusion from a wealth of other studies - not all specifically concerned with childhood immunisation - that the 'inverse care law' (Hart 1971) is still very much in evidence (Griffiths et al 1994, Balajaran et al 1987, Gillam 1992, Haynes 1991, Reading et al 1994).

On the basis of her study, Lynch questions the appropriateness of applying a global measure of performance to general practices operating under very different conditions. She believes that the evidence of her own study "does not provide a great deal of support for such a measure". She concludes that:

- there may be a case for recognition, beyond the deprivation-related payments, that in the case of some practices the effect of exogenous constraints cannot be offset by financial incentives, despite the importance of such incentives (Lynch 1995, p208).

Immunisation uptake as a performance measure in general practice

Jones and Moon (1991) have also questioned the appropriateness of applying a global measure of performance to general practices operating under different conditions. In a study which looked at the uptake of immunisation against pertussis, Jones and Moon have drawn attention to the shortcomings of performance indicators themselves.

Jones and Moon take exception to the use of crude uptake rates (i.e., the numbers of children who are immunised expressed as a percentage of the total target population) as performance indicators. First, Jones and Moon suggest that such rates are taken to imply more than they actually do imply. Rates express quantitative outcomes but they are taken to imply quality. Second, Jones and Moon suggest that even if rates are not taken to imply quality, they are not a valid and reliable measure of quantitative performance. This is because first, rates describe only an overall performance irrespective of certain 'patient characteristics', which are known to be associated with low uptake (for example, local

authority housing tenure is associated with poor uptake). And secondly, crude rates obscure the possibility that practices do not perform equally well for all patients. A reasonable rate can be achieved by providing an excellent service to some patients and an "abominable" service to others.

On the basis of their own study, which was based on 126 practices in the south of England, Jones and Moon suggest that it may well be that some practices which do not achieve a high performance as measured by crude rates are in fact models of good practice with very effective means of reaching low-uptake groups, but this is masked by the failure to employ a measure which takes into account the characteristics of the practice population.

Jones and Moon conclude that:

> "...some practices perform excellently but still do not reach performance targets. The implication is that these practices will, despite their best efforts, not qualify for target payments. The fear is that without some acknowledgement for their effort they will either artificially manipulate their list to exclude "problem" patients[2] or they will stop trying to attain high uptake" (Jones and Moon 1991, p30).

Cervical screening: Do targets increase uptake?

A study by Reid et al (1991) has looked at the question of whether changes in the cervical screening service since the introduction of the 1990 general practitioners' contract have increased uptake rates. The study was based on 30, 071 women aged 21-60 who were on the lists of 26 general practice partnerships in the Perth and Kinross Unit, Tayside. The computerised records of cervical screening both before and after the introduction of the new contract were analysed.

The study found that rates of uptake did increase after the introduction of the new contract. However, already by 1989 Perth and Kinross Unit had completed a computerised cervical screening call programme which had produced an increase from 71% to 78% in the mean percentage of women who had had a smear test in the previous 5.5 years. Six months after the introduction of the contract, coverage was increased to 85%. The authors concluded that the performance related payment system had brought about "a further sustained increase in population coverage for cervical screening in a small Scottish unit with a stable

population, well motivated general practitioners, and a fully integrated computerised call and recall system.. " (Reid et al 1991, p447) (The authors do not elaborate on why the GPs were "well motivated". They simply state this as a 'fact').

The authors propose that the current targets should be modified. They propose a more graduated system starting at a lower target of around 30% and proceeding in 10% increments up to 100% coverage. This, they suggest, would encourage those practices achieving relatively poor coverage to continue to participate in the programme and would also give further incentive to practices currently achieving the high target to achieve complete population coverage.

A further interesting finding of this study was that there had been a definite shift away from the use of well woman clinics. 2.7% of smears were taken in well woman clinics in 1990 compared with 5.6% in 1988. As the authors themselves note, one of the principles of the new contract was to improve choice for the patient. The authors raise the question of whether the move away from well woman clinics has been a matter of genuine choice, or whether there is any truth in the suggestion, raised in the media, that women might be removed from a GP's list if they decline to have their smear taken within the practice. The authors conclude that:

- The viability of our well woman clinics is now in doubt and it would be a great pity if the wider facilities offered by these clinics were to be lost as result of the changes to the general practitioner contract (Reid et al 1991, p449).

Two commentators have made useful observations concerning Reid et al's findings. Smail (1991) points out that what is not at all clear from the evidence presented by Reid et al is the extent to which the improvements in population coverage can be attributed to the new contract, and the extent to which other factors are important. Smail believes that it was the improvement in the call system in Perth which had the more significant impact. (There is, of course, no way of knowing whether, or to what level, improvements in coverage as a result of the call system would have continued in the absence of the 1990 reforms). A working group convened in Smail's own area of the country (South Glamorgan), where coverage was 82% by 1991, concluded that the most important contributory factors were improvements in the call-recall system, improved training for practice nurses, and the provision of a "sensitive, flexible and timely" service (Smail and Smail 1989). Finally, Smail is

in full agreement with Reid et al's call for a graduated system of targets and payments which he believes would reward those practices with high proportions of working class, immigrant, or mobile populations.

A second commentator, Roworth (1991) is also in agreement that the upper target should be higher than 80%. He points out that the many practices in his own area (Fife) which have achieved this target have little incentive to screen the remaining eligible women. In common with Smail, he suggests that women who are reluctant to attend for screening are likely to represent a sub-group at relatively high-risk of developing cervical cancer. A further issue raised by Roworth is the screening interval. He argues that the present payment system, based on five yearly screening, acts as a disincentive to three yearly screening. Until payment is based on three yearly screening, he maintains, cervical screening programmes will not be as effective as they could be.

Health checks and the inverse care law

A study by Griffith et al (1994) provides evidence that those who are most likely to need a health check are least likely to attend. This study did not attempt to assess the effectiveness of health checks. Its main aim was simply to describe the differences between attendees and non-attendees at health checks to which patients registering with a general practitioner in east London had been invited. The study found that non-attendees were significantly more likely than attendees to be of lower social class, unemployed, of African origin and to be heavy smokers. Women who did not attend were less likely to have had a cervical smear within the last three years, and they were more likely to be single parents. The authors conclude that inviting all new patients to a health check appears to result in poor targeting of health promotion resources and may widen inequalities in health. They suggest that specific targeting is needed to improve uptake in deprived areas. They point to the benefits of such schemes as the use of advocates for ethnic minorities which encourage attendance and improve the interpretation of patients' needs and beliefs. Finally they call for adequate resources to allow for opportunistic health advice when patients with risk factors attend the practice.

Targets and nursing staff

The GP contract places great emphasis on health promotion and disease prevention. Following its introduction there was a large increase in the numbers of practice nurses employed and a concomitant increase in the number of health promotion clinics (David 1994). However, both doctors and nurses have expressed doubts about the effectiveness of these changes and their ability to overcome the inverse care law. David (1994) cites a survey which found that nearly 80% of practice nurses felt that people who least needed services were the ones who attended clinics (Cancer Research Campaign 1994).

Finally, it has been reported in the literature that some health visitors feel they have been de-skilled by the introduction of target payments to GPs. Some health visitors feel their role in immunisation has been marginalised to chasing up defaulters to ensure maximum payments for GPs (Bedford 1990, Health Visitor 1990). It appears in this respect that there has been little progress in research on the contribution to quality of the respective objectives and outcomes for individual primary health care team members since Donabedian wrote:

- When more than one practitioner are involved in the provision of care, we are confronted with the problem of assessing the separate and joint contributions of each. As care becomes more highly organised, attributes such as "continuity", "co-ordination", and, even, "teamhood" become important constituents of the concept of quality. But these attributes are difficult to define and even more difficult to measure, so that their contribution to quality has remained largely untested (Donabedian 1976, quoted in Rinke (ed.) 1987, p5).

Conclusion and directions for further research

The literature suggests that targets *may* act as an incentive to improve overall performance, although they are not the only factor contributing to improved performance. The extent to which targets may act as a *disincentive* by provoking defensive explanations for low positions in league tables requires further research. The most serious drawback of targets is that they provide little incentive to direct resources at those in greatest need. They are therefore ill-suited to combating the 'inverse care law'.

The greatest challenge in setting targets is to ensure that appropriate indicators are chosen.

As the government itself is aware, the difficulty in adopting a target-setting approach lies in the fact that targets must be measurable in order that progress in achieving them can be monitored, yet those things which are easily measured may not be adequate measures of the quality and effectiveness of care.

There is clearly a need for further research into what are the most appropriate indicators of quality and effectiveness in Primary Care, and the feasibility of employing such indicators constructively in order to help practitioners to monitor the services delivered, and then to act on the findings.

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