Improving quality in general practice: qualitative case study of barriers faced by health authorities

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Abstract

Objectives To identify and assess the barriers that health authorities face as they manage quality improvements in general practice in the context of the NHS reforms.
Design Qualitative case study.
Setting Three UK health authorities: a rural health authority in the south west, a deprived inner city health authority in the north east, and an affluent suburban health authority in the south east.
Participants Senior and junior managers.
Main outcome measures Structure of strategic and organisational management, and barriers to the leadership and management of quality improvement in general practice.
Results Seven barriers were identified: absence of an explicit strategic plan for general practice, competing priorities for attention of the health authority, sensitivity of health professionals, lack of information due to poor quality of clinical data, lack of authority to implement change, unclear roles and responsibilities of managers within the organisations, and isolation from other authorities or organisations facing similar challenges.
Conclusions The health authorities faced significant barriers that would impede their ability to fulfil their responsibilities in the new NHS and that would reduce their capacity to contribute to quality improvements in general practice.

Introduction

The responsibilities of health authorities have been the subject of considerable organisational change in the past decade. Health authorities were formed in 1996 by the merger of district health authorities and family health service authorities, and this subsequently assured the strategic function previously fulfilled by regional health authorities. Before this, family health service authorities had been responsible for implementing the new general practitioner contract in 1990 and introducing fundholding in 1991. Under the current government, health authorities have managerial responsibility for abolishing fundholding and introducing primary care groups. Many of the current health authority managers have been involved in all these changes.

Health authorities now have some responsibility for the organisational performance of general practice, but before the recent reforms most focused their resources on terms of service and complaints. They had minimal statutory responsibility to systematically improve quality, particularly quality of clinical care. Like health professionals, health authorities have been set an important challenge. The cultural and organisational barriers to addressing this challenge are being acknowledged within general practice,[1] but those faced by health authorities have received little attention. I aimed to identify these barriers as health authorities attempt to develop a systematic approach to improving the quality of general practice.

Participants and methods

Between June and October 1998 I conducted in-depth case studies in three UK health authorities. I selected a typical case purposeful sample of authorities,[2] guided by geographical distribution, demographic characteristics, and previous research.[3] One authority was responsible for a rural area in the south west, one for a deprived inner city in the north east, and one for an affluent suburban area in the south east.

Box 1—Interviewees in each health authority

Health authority 1	Health authority 2	Health authority 3
Chief executive	Chief executive	Director (5)
Director (1)	Director (3)	Director (6)
Director (2)	Medical adviser	Assistant director (2)
Head of primary care audit and development group (1)	Director (4)	Pharmaceutical adviser
Locality manager (1)	Assistant director (1)	Head of primary care development
Chair of shadow primary care group	Chair of shadow primary care group	Quality assurance manager (1)
	Head of primary care audit and development group (2)	Quality assurance manager (2)
	Locality manager (2)	

In collecting data using qualitative interviews and observational techniques, I aimed to develop an understanding of each authority's organisational culture and operational management of quality improvement in general practice. Anonymity of individuals and organisations was assured. Semistructured interviews were conducted with key informants at different levels of seniority (box 1). The interview schedule (box 2) was derived from a literature review and three pilot interviews, and was applied flexibly to allow each participant to contribute according to their role and responsibilities. Interviewees were asked to recommend others in the same health authority who might contribute to the study. No further interviews were conducted once all available staff had been interviewed and new themes were no longer emerging. Interviews lasted 30-75 minutes, and detailed field notes were kept. Most of the interviews were not audiotaped because this might inhibit openness.

In addition to the interviews, I collected data from the health authorities' annual reports and the director of public health's reports for the current and preceding year, written reports of quality initiatives, a previous survey of health authority quality improvement activity,[3] and the minutes of open health authority meetings from the previous two years. The culture of the authority was inferred by observing the way that individuals and departments related to each other and to their organisation and their attitude to their roles and responsibilities.[4]

I conducted a thematic analysis of the data,[5 6] identifying themes by a process of repeated review of both the interview and the observational data in the field notes and written reports. Then I assessed the reliability of the analysis by triangulating the data collected from different sources—to add weight to common themes and to identify inconsistencies—and by sending the author's interpretation to all participants and asking them to comment on the face validity of the findings.[6]

Box 2—Interview schedule with regard to quality improvement in general practice

- What is your general view about the quality of general practice in your area?
- How can the authority contribute to quality improvement in general practice?
- What mechanisms or approaches are used to improve quality?
- Who are the key people or departments involved?
- What quality improvement initiatives have the authority initiated or supported?
- What or who motivated these initiatives?
- How were they received by the practices?
- Were these initiatives monitored and evaluated?
- What was their impact?
- What are the principal barriers to quality improvement in general practice?
- How could these barriers be overcome?
- What are the opportunity costs of focusing on quality in general practice?
- What impact do you think primary care groups will have on quality improvement?
- Do you use performance indicators or quality indicators?
- What are your future intentions?

Results

The participants described a number of successful organisational processes and specific quality initiatives, but the dominant theme was the barriers faced by health authorities in attempting to facilitate an improvement in the quality of general practice (box 3). I focused only on these barriers; in part they were identified explicitly by the interviewees and in part they were observed during the case studies. Those that were observed during the case studies were tested out by using them in the interviews.

Absence of explicit strategic plan

None of the health authorities had a strategic plan focused primarily on general practice or primary care. Two had locality plans but they concentrated mostly on issues of secondary care and public health as did the annual reports and director of public health reports. All three health authorities expressed a desire to produce such a strategy and had attempted to do so in the previous five years. They failed because of other priorities or because of lack of agreement either within the authority or with the local practitioners about the content. One director of public health considered the heterogeneity of general practice to be incompatible with strategic planning. All three health authorities described multiple disjointed quality initiatives but no overall plan or vision:

"We have a fragmented approach to quality improvement in general practice; there's no sense of direction and no feeling of leadership." (Head of primary care audit and development group (1).)

The NHS Executive was criticised for not providing more direction for the development of general practice, particularly the formation of primary care groups, and for being too oriented to quality improvement in secondary care. One participant felt that the management ethos of the NHS favoured the ability to react quickly over the ability to plan long term:

"The NHS keeps changing, there's no time to plan and evaluate one initiative before another comes along." (Locality manager (2).)

Competing priorities

A sense of frantic activity was apparent in all three health authorities. The junior managers felt overburdened by their workload, much of it created by their senior managers bidding for special one off project funding. Few opportunities arose to stop and take an overview. The establishment of primary care groups was high on the managers' agenda during the study period, but some of the other priorities were dealing with complaints and waiting list initiatives, collecting data for monitoring the performance of the health

Box 3—Barriers to facilitation of quality improvement by health authorities

- Absence of explicit strategic plan
- Competing priorities
- Health professionals' sensitivity
- Poor quality of data
- Lack of authority
- Unclear roles and responsibilities within the organisation
- Organisational isolation

authority, and dealing with health action zone bids and underperforming doctors. As one senior manager said:

"It's all a bit of a muddle. We criticise GPs for being reactive, but in many ways health authority managers are no different. Policy is created on the hoof around here." (Director (3).)

All three health authorities had undergone recent mergers or reorganisations, and felt that coping with the stresses had interfered with their ability to facilitate developments in general practice.

There was little optimism that the clinicians leading primary care groups had either the skills or resources to fulfil their agenda, certainly in a time scale acceptable to the government. There was a feeling that doctors had no perception of the amount of work or level of responsibility expected of them. Some of the managers thought that doctors saw primary care groups as another form of fundholding—an opportunity to influence secondary care rather than improve the quality of their own provider role. At the same time primary care groups seemed to be considered by most of the managers to be just another minor structural change in the health service. One participant described them as:

"Simply a way of unpacking fundholding." (Chief executive (2).)

The managers believed that improving the quality of secondary care was a higher priority than improving the quality of primary care. This reflected the high political profile of hospital care, their purchasing role, which gave them more authority over secondary care, and the greater margin for safety in general practice. They also said that they had an idea of what was happening in the hospital sector because of good quality data, which was absent from general practice.

Health professionals' sensitivity

In two of the three case studies there was little sense of teamwork or effective collaboration between the health authorities and their doctors. Most of the participants in one of the health authorities described considerable friction, and another health authority described an effective working relationship with only a small minority of doctors but a high degree of apathy among the majority. Several criticisms concerned doctors: they were not good team workers; they were too reactive and failed to grasp the "big picture"; they were suspicious of managers' motivations; and they failed to communicate with each other. One chief executive could not understand how doctors could cope with clinical uncertainty but could not accept the uncertainty and risk taking that was part of being a manager.

All three health authorities used several strategies to overcome these problems. They were sensitive about the need to get the best out of the doctors, and they tended to avoid confrontation. They concentrated their efforts only on those doctors who responded positively, they were sensitive to professional autonomy at the level of the doctor-patient relationship, and they avoided issues that would cause dissent, such as performance bench marking:

"The name, blame, and shame culture just doesn't work in general practice." (Chief executive (1).)

The junior managers said they often found it easier to work closely with practice managers and practice nurses, thus bypassing the doctors.

Poor quality data

The lack of information about quality of care in general practice was a major barrier:

"We simply don't know what general practitioners are doing to their patients, we have no notion of what clinical competence is, so how can we monitor and improve it?" (Director (4).)

This did not prevent the health authorities from making judgments about the comparative quality of individual practices but these were made on the basis of criteria such as patient complaints and requests from practices for development funding.

There was thought to be a lack of a national strategy and poor investment in information technology in general practice, and minimal interest among most doctors to improve clinical information. These were the main reasons for almost universal scepticism about measurement of performance and the national performance framework. The national performance framework was described as having considerable perverse incentives and to be:

"A backward step with crude and meaningless measures at a population and personal level." (Director (3).)

It was felt that the national performance framework would be resisted by most doctors and that it represented much work but little benefit to the health authorities. It was seen as a largely political exercise that, if allowed, they would prefer to ignore. Most considered that the underlying principles of the framework were good, but that its success depended upon valid and reliable measures that did not currently exist.

Lack of authority

The feeling was universal that health authorities were in the difficult position of having a great amount of responsibility but minimal authority with respect to general practice. This related in part to the independent contractor status of doctors. One director felt that doctors still treated him as an administrator from the family practitioner committee.

The introduction of fundholding, and in particular multifunds, was thought to have reduced the opportunities for the health authorities to influence general practice, and there was concern that primary care groups would further reduce their authority. One director stated that health authorities can only "tinker around the margins." Some of the participants considered that they would be in a better position to improve the quality of general practice if they employed doctors directly. Health authorities were most influential when they controlled budgets, and one health authority described how it encouraged quality improvement initiatives by linking them to financial incentives.

Unclear roles and responsibilities

Health authority managers identified the lack of clear roles within their organisation as one of the barriers to optimising quality improvement in general practice. There was considerable overlap between directorates, and there were no obvious lines of responsibility. In one health authority this resulted in two senior managers thinking that they were leading on the implementation of clinical governance and in another no one knew who was responsible for considering the implications of the national performance framework. Although some senior managers spoke clearly of their aims and plans,

they failed to convey a clear sense of direction to their juniors. There was a perception among some junior managers that their seniors were motivated more by a desire for personal gain than for corporate gain.

The position of the clinical audit groups that operate within UK health authorities was particularly unclear. In all three case studies, the audit groups had positioned themselves closer to the professionals than the health authority, although to different extents. Also all three tended to focus on willing practices and expressed difficulties engaging poor performers. None of them showed a strategic approach to quality improvement across the whole health authority. Two of the groups considered that their role was unclear and that it might be threatened by the formation of primary care groups.

Organisational isolation

There were few spontaneous references in the interviews to learning from other organisations, such as other health authorities, other emerging primary care groups, academics, or professional bodies. One health authority had tried to promote fellowship by assessment of the Royal College of General Practitioners as a quality initiative and learn from the assessment procedure of training practices, but this was the exception.

Discussion

Health authorities are understudied organisations, despite their central role in the current structure and future development of general practice. By highlighting the barriers that they face when attempting to improve the quality of general practice, an unbalanced impression is given of health service managers. I aimed to highlight problems with the system, not to criticise individuals, and it is noteworthy that similar barriers have been identified in healthcare systems in other countries.[7 8] The negative impression conveyed by my study should be seen in the context of the history, culture, and organisation of the NHS, and it should not detract from the high standard of individual commitment and skills observed during the study.

The overriding impression from my study is one of organisations under siege, barely coping with the multiple demands being made upon them and unable to stand back and take a strategic view of the needs of general practice. Organisational changes, such as fundholding in the early 1990s and primary care groups recently, are more likely to be seen by health authority managers as an administrative burden rather than an opportunity. The barriers and solutions to them may be divided into three distinct but overlapping groups: *(a)* internal issues for the authorities, such as the absence of a strategic plan, lack of clear roles and responsibilities, and organisational isolation, *(b)* issues that are best addressed in conjunction with the NHS Executive and Department of Health, which need to be aware specifically of the implications of overloading health authority managers and devolving responsibility without authority, and *(c)* close cooperation with doctors to build an effective working relationship on the basis of trust and sharing of information.[9 10]

My choice of an in-depth case study design rather than a cross sectional survey may be justified by the sensitive and detailed data collected.[2] Surveys have been conducted to collect technical data from health authorities,[11 12] but are less appropriate when the aim is to study organisational culture and interpersonal issues. Professional managers are good at presenting glossy corporate images that belie the problems of working in an organisation as complex as the NHS. Managing healthcare professionals who value autonomy over accountability causes unique problems.[13] By adopting a qualitative methodology, this complexity can be better understood by probing and cross checking sources of information to an extent not possible with other methods. These benefits need to be balanced against the limitations associated with the small sample size (dictated by the depth of analysis) and therefore the applicability of the results to other health authorities. The disadvantage of a single researcher conducting the interviews and analysing the data, with no audiotaped data for interrater validation,[2] also needs to be considered.

My findings have significant implications for the NHS reforms. Some of those working in and with the NHS regard the proposals as a fundamental change in the culture and organisation of the NHS.[14] My study shows that those who will play a significant part in these changes are sceptical about the process of implementation and about the possible impact on service quality. NHS managers and health professionals need to be aware of, and address, these barriers if the NHS reforms are to have any impact on general practice.

Key messages

- Health authorities fail to take a strategic approach to improving quality in general practice
- Doctors and health authority managers do not work sufficiently closely together to improve the quality of general practice
- Health authority managers seem to lack the authority and organisational structure to maximise the role in general practice expected of them in the NHS reforms

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