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The times

The quality issue

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> "It is essential that discussion about the quality and effectiveness of care are reintroduced into the centre of the debate as they are, in the end, the more important dimensions of NHS performance" (Maxwell, 1984).

While the term quality is not much used explicitly in clinical medicine in general and mental health services in particular, quality is implicit in much that guides us. Indeed it is at the very foundations of our health care practice – the ethical codes with their emphasis on beneficence, non-malevolence, respect for autonomy, justice and fairness.

Nevertheless these ancient codes, however fundamental, have been out-stripped by the great changes in health care and indeed within society itself. Patients, clients, or customers are no longer the passive recipients of professional endeavours, however well intentioned. We are for a variety of reasons required to make the topic of quality, quality of care, explicit.

There are two key issues; the first is "How do we define quality?"; and the second "How can we assure quality?" While the industrial arena might seem far removed from our health care situation, there are valuable lessons to be learnt from today's successful businesses. Tom Peters, leading American management consultant, describes today's winning hand as "Quality and Flexibility" (Peters, 1987). Underpinning his prescriptions for success is a need for a change of attitude in which customer responsiveness is central to the task and partnership is central to the organisation. Peters considers his prescriptions just as valid and relevant for the public sector as the private commercial one.

Quality concepts

A first and critical step is to define what quality is for a particular service. Narrowly interpreted quality means quality of product – broadly interpreted quality means quality of work, quality of service, quality of information, quality of process, quality of people. One health service approach proposes six dimensions to quality: accessibility (in both time and place); acceptibility to users; effectiveness; efficiency; relevance; and equity (Maxwell, 1984). These can be mapped into the three components of the Donobedian triad: Structure (resources), Process and Outcome (Donobedian, 1980). The first two of Maxwell's dimensions focus on patients' perception of *outcome* while the third hinges on professional assessment of the same. Maxwells's efficiency dimension reflects *process* quality, while relevance and equity place a given service in the wider content of equity of provision in relation to scarce health care resources (Donobedian's "*structure*").

A complementary approach recognises three complementary dimensions on quality, namely a patient perspective, a professional perspective and a process perspective (Ovretveit, 1990). Central to the quality philosophy in commercial organisations is customer responsiveness – giving customers what they want. However, in health services the customers (patients) may not know what is in their best interests. It is essential therefore in defining service quality that we include a professional definition of patients' needs.

Third, quality does not mean quality at any cost. In the context of scarce health care resources a service which meets patients' needs at relatively high cost deprives other users or potential users of service resources. A service which has high efficiency saves resources. Efficiency relates to the method and organisation of health care. In contrast to the high priority given to efficiency in commercial organisations, health care services have generally ignored this process quality dimension. Integration of and balance between all three dimensions is essential (Fig. 1).

Quality assurance

However, professional interest in providing a high quality service is no guarantee that an optimal service is provided at minimal costs. Indeed, the only way to ensure continuous improvement in any service is to specify what is expected and to measure performance against those specifications. Quality criteria and suitable measures of performance therefore must be developed to make health care services more responsive to need.

A number of useful operational definitions of quality assurance in health care have been provided.

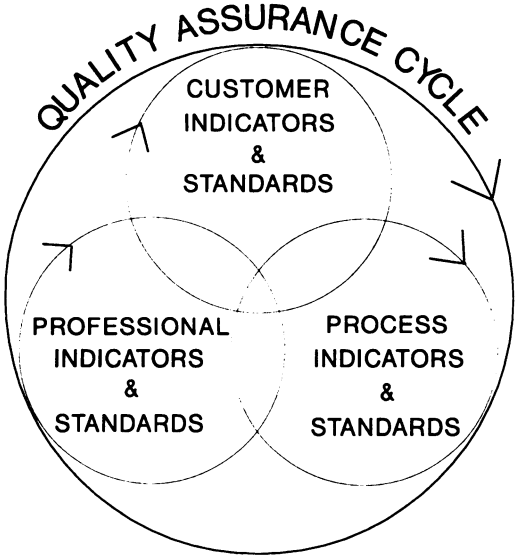

FIG. 1

All have in common a feedback cycle embracing the setting of standards, the monitoring of performance, the comparison of performance in relation to standards and the adjustment of activity to bring performance closer to standards (Wilson, 1989). This principle must be applied systematically throughout the client domain, professional domain (practice standards and effectiveness) and process efficiency.

While service industries and welfare services have adopted many of the quality philosophies and methods developed in manufacturing, there are special problems defining, specifying and measuring mental illness service quality. Outcome evaluation is at a relatively early stage of development and indeed presents methodological difficulties. Nevertheless several schedules for needs assessment and the assessment of unmet need are presently being developed and evaluated (Brewin *et al*, 1987; Jenkins, 1990). This professional dimension to outcome assessment must be complemented by consumer opinion survey.

Given present constraints on outcome evaluation, quality of mental health services will depend greatly on assuring process quality, embracing clinical practice standards and efficiency. Indeed process review, the clinical audit cycle, is pivotal to quality assurance in mental health. The US Joint Commission on Hospital Accreditation emphasises the continuous monitoring and evaluation of high risk, frequently performed diagnostic and therapeutic services as the cornerstone of quality assurance programmes in health care. Such criterion based audit has recently been established within the UK (Shaw, 1990; Stephens & Bennett, 1989).

Qualities of carers

Quality assurance is also about people, about staff attitudes and their approach to work and to one another. Improvement of patient care quality cannot occur without the active involvement and commitment of professional staff. A quality approach, in particular a total quality approach, aims to give staff and management the tools to get to grips with the quality issue. Central is a philosophy of excellence, of doing the right thing, right first time, every time. Staff vision and enthusiasm however must be matched by appropriate education and training.

As Ovretveit has commented, one important question in quality of care and quality of services is how to measure the "intangibles" – such issues as politeness, friendliness and caring itself – one actually destroys the very thing one wants to encourage (Ovretveit, 1990).

Quality of care hinges critically on the quality of the resources made available. The key resource in all health services, particularly those concerned with mental illness, is people. It follows that quality of care is deeply dependent on the qualities of the carers.

Concerning psychiatrists, as Birley has commented, "In addition to clinical skills our psychiatrist would have to become more sophisticated about the problems of management, not only in the organisation of others but in the way he sees himself in the organisation" (Birley, 1973). Birley anticipated by more than a decade the Griffiths' Report on the management difficulties of the NHS when he described doctors as the "natural managers". Not that doctors have any God given right but, as Griffiths points out, our decisions and actions have a major influence on how health care resources are utilised.

It is the opinion of a growing number of medical educationalists and experienced practitioners that the effectiveness of health care delivery and its cost-effectiveness hinge increasingly on effective leadership and responsible management executed by each and every consultant. The more so given the brave new world of the NHS market economy–where volume and cost, by virtue of their measurability, are at risk of driving the system. Neither national experts nor local managers are in a position to assess and control the quality of local practice. As Griffiths has stated, no group is more crucial to the quality process within the NHS than the clinicians who work there. If there is any truth in the foregoing then the quality issue most be placed centre-stage in continuing medical education.

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Do GPs want community mental health facilities?

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Much of a typical general practitioner's time is spent dealing with people who present with "psychological" problems. Of those people who are detected as suffering from a mental health problem, most are then dealt with by the GP without recourse to specialist services. There is a wide variation in referral rate, and a recent review (Wilkinson, 1989) suggests that GPs are most likely to refer a patient to a psychiatrist when he/she has failed to respond to previous GP treatment, an opinion about diagnosis is sought, or there is some specific request either by the patient or another person involved. One of the reasons why GPs are disinclined to refer is their perception of stigma associated with attending a psychiatric clinic, although they do not appear to be unduly perturbed by aspects of the referral process itself, such as a waiting list. Overall, it appears that around 95% of patients in general practice presenting with mental distress are *not* referred to a psychiatrist. As well as being concerned about the stigma associated with traditional psychiatric services, we hypothesise that another concern of GPs may be a lack of liaison and consultation between primary and secondary care services.

There are, perhaps, three possible ways in which GPs and mental health specialists may collaborate: these can be described as the "increased output" model, the "replacement" model, and the "liaison-attachment" model. The increased output model is closest to the traditional service with GPs being encouraged to refer more patients to hospital-based facilities. The replacement model involves major structural change, based on the principle of a community approach to mental health problems with a multi-disciplinary community mental health team which is separate from the "parent" psychiatric hospital. This model envisages the replacement of the GP as a primary provider of mental health care by a community mental health team. The liaison-attachment model involves movement of mental health specialists out of the hospital into general practice settings. This is not simply a change of venue for the out-patient clinics. If properly adopted, it necessitates a real change of working practice for those concerned (Creed & Marks, 1989).

The study

We undertook to investigate GPs' views on services for people with mental health problems. Our interview study involved a sector of Cardiff which has a population of around 100,000 and a variety of types