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Editorial

A voice for quality

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I am delighted to take up my appointment as editor of *Quality in Primary Care*, which I believe will continue to develop as a key journal for our discipline. Although quality may be difficult to define, it is a concept that we are familiar with and aspire to. Mayur Lakhani, my distinguished predecessor, as chair of the Royal College of General Practitioners, leads an institution that stands for quality as well as caring, and will continue to support the work of the journal through the editorial board. Quality is about the pursuit of excellence. It also refers to a distinctive voice and it is therefore appropriate that I begin by expressing my values and vision as editor.

Theodore Zeldin, an outstanding contemporary historian and philosopher, recently referred in a newspaper editorial to the importance of 'developing new methods of improving personal, professional and cultural relationships' where 'family and friends were the top priority ... a new vision of what should hold society together'. He contrasted this optimism with the observation that, 'We are now divided as much by our education, which makes us into narrow specialists with different mentalities ...'. Zeldin noted that in the modern age we have 'discovered complexity and unpredictability and developed a taste for diversity and for transgressing boundaries. Medicine, despite all its triumphs, is now confronted by the problem of individual variability. The simple formulae we have inherited can no longer work for everyone'.[1]

This view is amply reflected in primary care, a family of specialties that is continuing to expand, change and modernise, and in doing so is facing new and unexpected complexities and challenges. I wish to see a journal that is increasingly multidisciplinary and which reflects the dynamism of today's primary care. A clinical perspective, though important, is not sufficient for us to meet these challenges, and the new complexities will require fresh conceptual frameworks and contributions by friends and allies, whether personal, professional or cultural, from a variety of disciplines to help us understand them.

This complexity is reflected in the myriad of new, emerging and potential primary care organisations, functions and interfaces. General practice continues to be at the centre, but primary care also incorporates others including unscheduled care providers such as triage centres, walk-in centres, emergency care centres, NHS Direct and the emerging emergency care trusts, as well as an increasingly important voluntary sector. Primary care itself is continuing to expand into new areas such as prisons and secure environments, as well as intermediate care and health care that was previously the realm of specialists. The interfaces and differences between traditional general practice, these new organisations and secondary care will become increasingly critical to quality.

There is a risk that we will be divided by these differences, not only organisationally but also professionally. As well as general practitioners, nurses and social workers, there are new primary care professionals from healthcare assistants to physician assistants to practitioners with special interest; with nurse practitioners, emergency care practitioners, community matrons, allied health professionals and complementary therapists also. Rather than being passive recipients of care, patients are increasingly active participants in their own care, whether this means sharing decisions about care with a health practitioner or being responsible for monitoring through the use of telecare. The new systems of care based on emerging technologies including the assistive technologies such as telecare, but also diagnostics and even genomics are likely to lead to dramatic changes in the way primary care is designed and delivered in future. We need to actively address these barriers to stand any chance of improving quality.

Increasing complexity will inevitably lead to an increase in potential barriers to quality improvement and greater possibilities for education.[2] Quality improvement will need to embrace complexity,[3] encompassing not only the many possible interventions capable of improving structure, processes or outcomes of care but also addressing the nature of evidence, the working environment and its determinants, patients and professionals, beliefs and attitudes together with health policy, wider systems of care and the interaction between all these elements.[4]

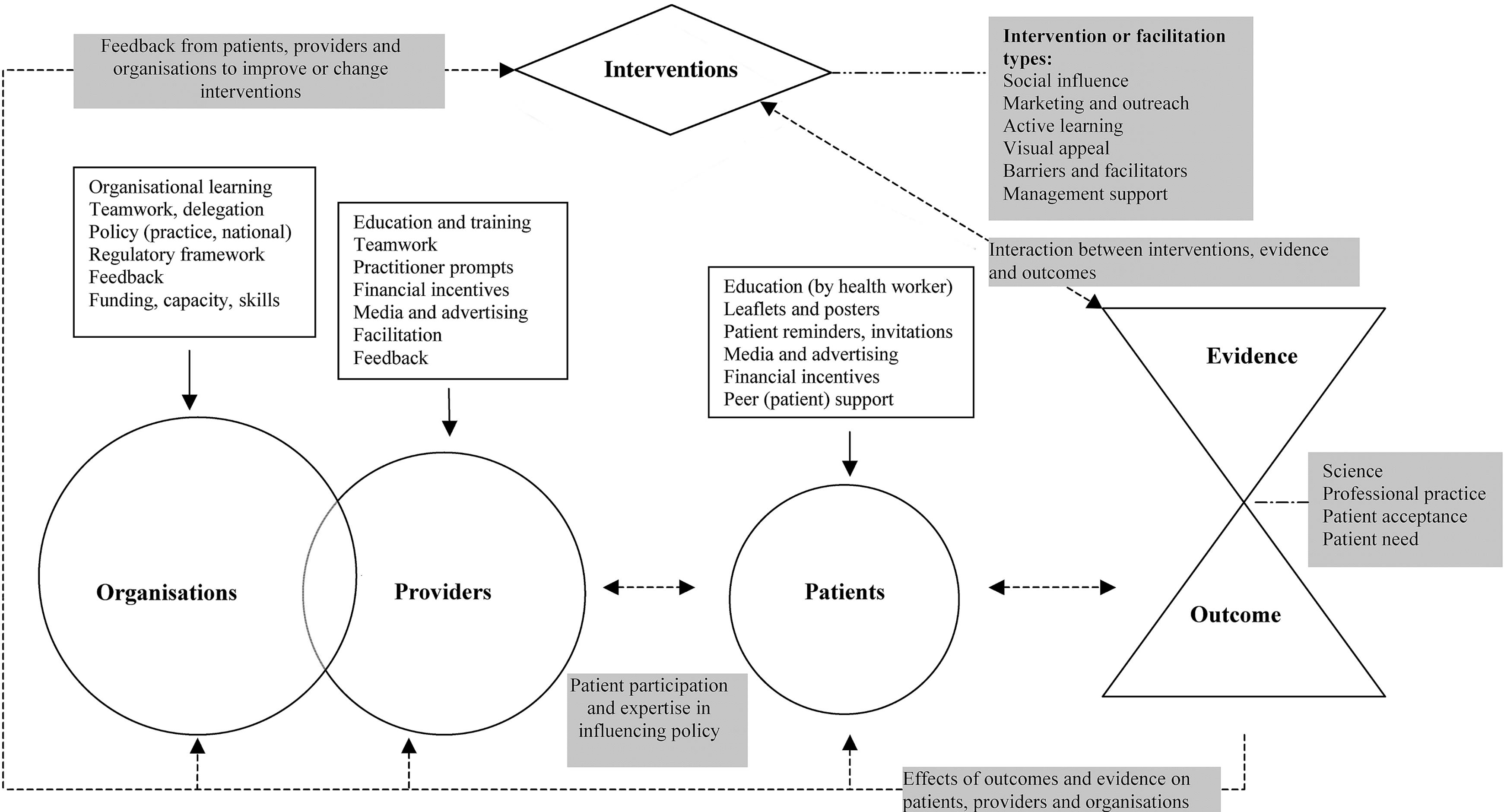

Figure 1 A conceptual framework for quality improvement

To develop the journal for the future I believe that we need to expand to meet the needs of changing primary health care and the individuals contributing to it. This means not only making the journal more attractive and appealing but also developing the content to reflect changes in primary care, inspiring our contributors to innovate and create an even more effective journal that delivers not just 'material to interest educated readers' ... but a journal to excite, educate, catalyse change, and above all to provide a voice for quality among the growing family of primary care.

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