Quality, quality assurance and quality assured practitioners

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The need for consumers to differentiate competing products on the grounds of quality has been around since ancient times and, over the centuries, various bodies have been formed with the aim of ensuring consumer confidence in the quality of the goods and services being traded. The goal of standardising the measurable quality of healthcare also has historical precedence and, in more recent times, the requirement for continuing medical education that has now evolved to continuing professional development, is recognised by healthcare professionals as an essential part of enhancing and maintaining their quality of practice. Physio First has continually expanded on this national requirement by championing evidence-based practice, initially through encouraging members to participate in data collection, and most recently in the option, through the analysis of this collected data, of obtaining the status of Quality Assured Practitioner (QAP).

LEARNING OUTCOMES
1. Explore the concepts of quality.
2. Identify how quality applies with regard to healthcare practitioners.
3. Understand how the Physio First QAP scheme contributes.

Standardisation
The importance of having standardised weights and measures has been recognised since antiquity and naturally occurring objects that were consistent in weight or length were used to benchmark standards. In medieval times, grains of barley were used as a reference and larger weights were defined against this measure. For example, a Pound of Troy was defined as being 5760 grains of barley and that was subdivided into 12 Troy ounces with each ounce further divided into 20 pennyweights. These measures were used in commerce until the 19th century.

The system of imperial measurements evolved from Roman and medieval practice and became increasingly precise through time. Imperial weights and measures have now largely been replaced in the UK by the metric system, which was developed in France in 1795 and imposed on Europe during the Napoleonic era.

With the industrial revolution came the need for standardisation of goods. The British Standards Institute (BSI) was formed in 1901 (www.bsigroup.com). The BSI kitemark was registered in 1903 and was used initially to indicate that products were manufactured to published standards. This enabled consumers to differentiate between competing products on grounds of quality.

The International Standards Organisation (ISO) is an independent non-governmental organisation with a membership of 163 national standards bodies (www.iso.org). It has its headquarters in Geneva and has published more than 21,000 international standards on products, services and systems. ISO was formed in London after the Second World War with the intention of co-ordinating and unifying industrial standards across the world. The purpose was to facilitate international trade as agreed common standards would mean trading partners would have confidence in the quality of the goods and services being traded.

Quality control and quality assurance
A finished product can be tested to ensure it meets expected standards. In some cases the product is physically changed during these tests and thus samples of the product are tested and the results are extrapolated to infer that the rest of the product meets the same specification. The childhood story of the little boy taking a basket of eggs to the market exemplifies this; he has a complaint from a customer that one of his eggs sold the day before was...
“ESTABLISHING A STANDARD ENABLES CONSUMERS TO DIFFERENTIATE BETWEEN COMPETING PRODUCTIONS ON GROUNDS OF QUALITY”

...medical journals through the 1990s and was a contentious subject. In 1994, the Chairman of the Royal College of Obstetricians and Gynaecologists published a letter (Atlay 1994) in which he stated that “provided subscriptions are paid, fellows and members of the college will remain on its register, and there can be no question of preventing them from remaining in practice. The sanction for those who do not take part in the programme is that their names will not appear on the roll of specialists”. To have one’s name on the role of specialists required 200 hours of postgraduate work over a five-year period. This requirement for continuing medical education was seen as enhancing the quality of practice.

Continuing medical education progressed into continuing professional development (CPD) and revalidation. Since 2012, it has been a GMC requirement for doctors to revalidate their licence to practise every five years, a process that positively affirms to the GMC that the individual is up to date on latest medical knowledge, and is fit to practise (www.bma.org.uk). Revalidation involves CPD, quality improvement activities such as clinical audit and case reviews, reflection on significant clinical events that have occurred in practice, feedback from colleagues and patients, and a review of complaints and compliments. Other healthcare professions have followed the lead of the GMC but most have not, as yet, gone as far as requiring this level of revalidation on a regular basis. From a quality assurance perspective this...

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“THE REGULATION OF MEDICAL PRACTITIONERS DATES BACK TO THE 15TH CENTURY”

...the early 20th century when physicians presented a petition to parliament requesting constraints on who was allowed to practise medicine (Raach 1944). Henry VIII introduced the Physicians and Surgeons Act in 1511 which limited medical practice to those who had been examined by the bishop of their diocese, or were graduates of Oxford or Cambridge universities (Warren 2000). The College of Physicians was founded in 1518 and took over the licensing of doctors in London. The Medical Act of 1858 saw the beginning of modern regulation (www.chstm.manchester.ac.uk) with the establishment of the General Medical Council (GMC). The current primary legislation for medical practitioners is the Medical Act 1983 (www.gmc-uk.org).

Until the late 20th century the only requirement to practise was an accredited qualification in medicine and registration with the GMC. The commercially competitive nature of fee-for-service healthcare in the USA led to the ranking of “best hospitals” and “best healthcare plans”, based on various forms of certification (Bashook & Parboosingh 1998). The basis of this certification was contested, leading to uncertainty of how meaningful it was. Continuing medical education was a major topic of discussion in leading...
revalidation requirement is a major change from what went before. Prior to 2012, the requirement for ongoing registration was largely through continuing education; the process now requires evidence of practice quality through peer review in order to maintain registration.

The Health and Care Professions Council (HCPC) is the regulator for many professions involved in delivering many healthcare services, including physiotherapy. Regulation of healthcare practitioners is not comprehensive. For instance, herbal practitioners, somewhat surprisingly, do not come under any regulation.

**Herbal practitioners – an interesting dilemma**

Herbal medicines, i.e. medicinal products manufactured from herbal materials, are fully regulated through the Human Medicines regulations 2012 ([www.legislation.gov.uk](http://www.legislation.gov.uk)) and the Traditional Herbal registration scheme ([www.gov.uk/guidance](http://www.gov.uk/guidance)). The Herbal Medicines Advisory Committee is a government body ([www.gov.uk/government/groups](http://www.gov.uk/government/groups)) that advises on the safety and quality of herbal medicines. In 2014, this committee published a report ([UK Herbal Medicines Advisory Committee 2014](http://www.gov.uk/government/groups)), in which very clear statements were made concerning problems with unregistered herbal practitioners and suggested strongly that these practitioners should be brought under the control of HCPC. In 2015, the Walker report (Walker 2015), commissioned by parliament in 2013, looked at the options associated with the regulation of herbal practitioners and concluded that statutory regulation of herbal practitioners was not feasible. The reasoning articulated in regard to the regulation of herbal practitioners is interesting; the evidence base for efficacy of herbal medical practice is weak and it is thus difficult to differentiate good practice from poor and, consequently, it would not be possible to establish standards for practice, which is a requirement at the heart of regulation. At the centre of this dilemma is the lack of good quality data that measures efficacy and the impact of treatments.

**Regulation of physiotherapists**

As you will be aware, physiotherapists are required to renew their registration every two years and confirm that they continue to meet the HCPC’s standards of proficiency for their profession, meet fitness to practise requirements, and meet the HCPC’s standards for CPD ([www.hcpc-uk.org/registerants/renew](http://www.hcpc-uk.org/registerants/renew)). The CPD activity is audited on a random selection basis. It is expected that registered practitioners’ CPD records will be up to date and available for inspection. The CPD activities are mainly centred on work-based learning, professional activity, formal education and self-directed learning. The implication is that these requirements for ongoing registration as a physiotherapist will ensure that a practitioner will meet the Standards of Proficiency for Physiotherapists as laid down by the HCPC ([http://www.hcpc-uk.org/registerants/assets](http://www.hcpc-uk.org/registerants/assets)).

A significant standard in the context of this article, and specified in the HCPC document, is for physiotherapists to be able to assure the quality of their practice. Included in this standard is the requirement for practitioners to:

- be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care
- be aware of the role of audit and review in quality management, including quality control, quality assurance and the use of appropriate outcome measures.

It might not be obvious to many how this standard will be met through CPD activity alone, or whether the team evaluating CPD records has a requirement that some or all of these standards are mandatory and should be reflected in the CPD records.

**The Data for Impact project and the Physio First QAP scheme**

Since 2005, through funding by the Private Physiotherapy Educational Foundation, we at the University of Brighton (UoB) have worked collaboratively with Physio First in the development and introduction of standardised data collection systems for use by private physiotherapy practitioners. These have had the specific aim of gathering datasets that demonstrate the evidence of effectiveness of practice ([Bryant et al 2016](http://www.hcpc-uk.org/registerants/assets); [Moore et al 2012](http://www.hcpc-uk.org/registerants/assets)). The current Data for Impact (DFI) project is available...
to all Physio First members who, once registered, are provided with continuous access to our online data collection system. In addition to providing a means to enable standardised data collection, we are providing practitioners with individualised reports enabling them to benchmark their practice against the national dataset reports also supplied.

We are also able to offer practitioners the opportunity to be part of the Physio First QAP scheme which was launched last year. This scheme aims to provide individual practitioners with a means of benchmarking their patient outcomes and demonstrating quality. Following the undertaking of complex data analysis, and discussions with Physio First, standard criteria were developed that were statistically derived based on analyses of the national dataset. The current criterion are:
- waiting time
- change in the functional, physical and subjective outcome scores pre/post treatment
- the average number of treatments
- goal achievement at discharge
- outcome of referral on discharge.

Details of the QAP scheme were published in In Touch (2016). The national dataset is downloaded by the UoB three times a year, January, May and September and, in order to be assessed for the QAP scheme, practitioners need to input a minimum of 50 datasets for patients discharged within the last 12 months. To achieve QAP status, a minimum of three of the five criteria listed above must be achieved by the practitioner.

The Dfi project provides opportunities for the profession and individuals to demonstrate, at several levels, the quality of their service provision. At an organisational level, the analysis of the data demonstrates norms for the practice of many hundreds of physiotherapists. For an individual practitioner, gathering sufficient data to generate a personal report is invaluable and provides an incontestable basis for addressing the HCPC Standards of Proficiency for Physiotherapists. Comparing data from one’s own practice with a national dataset allows that individual to take an objective stance in determining the quality of their practice and to identify their own professional development needs.

**Patient reported outcome measures (PROMs)**

A potential problem with practitioner reported data is the possibility of bias in the reporting. Gathering data directly from patients is a means of reducing this bias and achieving a more balanced measure of outcomes. The Dfi project is currently piloting an online patient outcome measure with the purpose of being able to feed back their patients’ responses to practitioners. This will close the loop and provide practitioners with a significantly more robust evidence base for their own practice.

**Challenges of data collection**

In order to extrapolate the conclusions from a sample to the whole population of patients, one has to be confident that the data used is truly representative of the population as a whole. There is always variability between individuals, but if enough data is collected then it becomes possible to derive norms for any particular criterion. One obvious approach to ensuring that the datasets collected are representative of the whole population is to collect data for every single patient. This presents a logistical challenge to the practitioner and, ideally, the data collection should be integrated into practice management systems. Here, an obvious issue with the Dfi project is that the data has to be standardised and all this would need to apply to practice management systems if comparable sets are to be extracted for all practitioners taking part in the study.

**Conclusions**

Quality assurance has progressed from the pragmatic beginnings needed to ensure that the weights and measures used in commerce were consistent and reproducible, to the technically far more complex systems needed to facilitate international trade in goods and services. Assurance of the quality of healthcare practice has developed relatively recently and remains in a state of development, with medical practitioners being required to demonstrate their ongoing fitness to practise in a more rigorous manner than that required for most other healthcare practitioners, for whom the requirement at present remains nested in continuing education activities rather than practice-based evidence.

The Dfi project provides physiotherapists with the opportunity to contribute to a national dataset that demonstrates effectiveness of practice, while simultaneously providing practitioners with the objective evidence needed to verify the quality of their own practice. The development of a patient-reported outcome measure that will integrate with the Dfi project data will further enhance the quality of the data. The ultimate outcome of these activities will be that patient care is enhanced.

**About the authors**

George Olivier is a Principal Lecturer in Pharmaceutical Sciences at the University of Brighton. He lectures in medicinal and pharmaceutical chemistry.
and has an interest in quality issues surrounding the use of plants when used as medicines. He is a pharmacist by training and, for more than 20 years, has been using electronic methods for learning, teaching and assessment involving the online gathering and interpretation of data. George has worked on the DFL project and its predecessors since 2005.

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References


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Physio First. Physio First’s quality assured practitioner scheme is launched. In Touch 2016;157:32-33


Recommended websites

British Medical Association – introduction to revalidation: www.bma.org.uk/advice/employment/revalidation/introduction

British Standards Institute: www.bsigroup.com/en-GB/about-bsi/our history

Centre for the History of Science, Technology and Medicine, University of Manchester: www.chstm.manchester.ac.uk/research/areas/medicalprofession

International Standards Organisation: www.iso.org/about-us

General Medical Council, supporting information for appraisal and revalidation: www.gmc-uk.org/RT_supporting_information_for_appraisal_and_revalidation_DC5485.pdf / 55024594.pdf

General Medical Council, UK primary legislation: www.gmc-uk.org/about/legislation/uk_primary_legislation.asp

HCPC, renewing your registration: www.hcpc-uk.org/registrants/renew


HCPC, what activities count as continuing professional development? www.hcpc-uk.org/registrants/cpd/activities

Herbal Medicines Advisory Committee: www.gov.uk/government/groups/herbal-medicines-advisory-committee


Medicines and Healthcare Products Regulatory Agency: www.gov.uk/guidance/apply-for-a-traditional-herbal-registration-thr