

# Fit for the future – The evolution of general practice

March 2010



# Foreword

When patients talk about 'their' GP it's with a sense of belonging. Family doctors also think of the people they care for as 'their' patients. It's a system that lets GPs develop a long-term knowledge of the person in front of them, a relationship where the patient is more than a collection of symptoms and is treated as a whole person whose background is known and understood. GPs know about the social and physical aspects of their patients' lives. GPs also know when to seek specialist help and how to explain the system to a patient. These are the enduring values and ethos of general practice. Together they make the UK system of general practice unique. This was confirmed in the Commonwealth Fund policy study of 2009, which highlighted the importance of primary care in producing better outcomes for patients at lower costs.<sup>1</sup>

GPs want to coordinate patient care, not see coordination made more difficult through the fragmentation that results from the introduction of many different providers of care. NHS GPs are independent contractors, the majority of whom work under a nationally agreed contract, though some work under local contracts. This model of care has a track record of giving value for money and providing a good deal for patients. It isn't perfect, but improvements are happening all the time and GPs are working to deliver better and more convenient services for their patients. Improvement is hampered sometimes by a lack of long-term investment, for instance in GP premises. On the other hand, GPs have led the way for the whole NHS in a number of areas, such as in the use of information technology, at the same time as acting as guardians of confidential patient details to protect their patients' privacy.

The range of services GPs provide has increased dramatically, including the provision of extended diagnostic and monitoring services, minor surgery, and a growing range of health promotion activities. GP practices are beginning to work in different ways, joining with others to form federations, seeking economies of scale while preserving individual practice autonomy. Others are developing their internal structures to respond to the changing expectations of patients. Through their involvement in local commissioning GPs are using their knowledge of their patients to ensure care is delivered where it is needed. Strong links with secondary care are vital and GPs want to ensure close liaison between primary and secondary care on a whole range of issues. Patients have an important role to play and contribution to make in determining improvements and future developments, and the BMA General Practitioners Committee (GPC) would like to see a patient participation group in every practice.

These days, general practice is so much more than just family doctors. An enormous contribution is made by nurses and other highly-trained staff. The wider practice team is managing increasingly complex patient and public requirements. GPs have told us that these vital teams are being put at risk by developments in primary care. It is vital that these teams are maintained and strengthened.

This document has been developed by the UK General Practitioners Committee of the BMA as a distillation of views about the ways in which general practice is moving forward and evolving. It puts forward some suggestions for changes and improvements in the future, and highlights our concerns about a number of developments. Modern general practice has built on its strengths, and is ready to adapt for the future. GPs will take up the challenge as they always do, and the ideas set out in this document will help them to do it.



Dr Laurence Buckman  
Chairman of the BMA General Practitioners Committee



# Quality

UK general practice is recognised throughout the world as one of the most cost-effective, high quality means to deliver care. Despite changing political imperatives, general practice is still a fundamental part of healthcare, at its heart is a relationship between the GP and patient based on mutual trust and personal attention to the individual.

Because continuity is very important to the majority of patients, GPs need to ensure that they are able to see their first, or at least second, choice of doctor in the practice wherever possible. During a GP consultation patients may present with an enormous and diverse range of conditions. At present, the length of a consultation with a GP is 10 minutes. Most patients would value a longer consultation length and we would like to work towards this. This will mean an expansion of the general practice workforce. We believe that any proposals to cut the current consultation length are unacceptable both to patients and GPs, and will be completely counter-productive.

The key features that make general practice such a good service are that it involves:

- a personal service based on continuity of provision of care by practices with registered lists of patients
- long-term trusting relationships between patients and GPs
- a whole-person approach to patient care delivered by highly-trained clinical generalists. This central high level of care will be increasingly important as the population ages and medicine becomes more complex, while fewer hospital beds are available and there is more care in the community
- the provision of a broad range of comprehensive services
- coordination of patients' care throughout their treatment – this is of particular importance to patients with a chronic or long-term condition
- not only do GPs manage the primary/secondary care interface, but many patients expect GPs to be able to signpost them to carer support and social care.

Highly-trained GPs play a key role in deciding with the patient whether further referral to a specialist is needed. This is a central and special role which helps to ensure the best value for money for the NHS. In this role GPs coordinate and manage the interface between primary care and the rest of the NHS and this should not be weakened by the introduction of untested systems that might fragment or lose this vital aspect of general practice.

GPs are open to change provided it is based on experience and evidence. General practice has evolved hugely in recent decades in response to evidence-based initiatives, significantly improving public health in the process. For instance, since 2004 under the unique Quality and Outcomes Framework (QOF), GPs have been systematically contacting and monitoring their registered patients with raised blood pressure, heart problems and other common illnesses. This rigorous checking has led to many thousands of patients avoiding serious adverse events such as heart attacks<sup>2</sup> and the QOF is recognised internationally to have improved the quality of healthcare in the UK. No other healthcare system has embraced evidence-based medicine so comprehensively.

Practices have performed outstandingly against QOF targets, in excess of all expectations. QOF has delivered national standards of care to the entire UK population and has ensured that care is provided to a defined high standard. Introducing local variations or local QOFs would be detrimental to this especially as local priorities can be addressed using local enhanced services (a different means to allow GPs to deliver additional care). The GPC is committed to promoting these principles of high quality and evidence-based care, and preserving consistency for patients across the country.

This role of general practice in promoting public health should be more widely recognised and enhanced. This has occurred not only through the QOF, but also through immunisation programmes (for instance, against cervical cancer and seasonal flu). Many health problems in society are the result of modern lifestyle choices, and it would be unrealistic to expect general practice alone to solve them. GPs should, however, be fully involved in the development of programmes to improve these modern health problems, especially as they are often the 'safety net' for the chronically ill and most vulnerable in society. Governments should invest more to help family doctors improve health outcomes for the most disadvantaged.

Governments always rightly want to maximise better care, better patient experience, and better value for money in general practice. GPs already provide excellent quality and value for money and readily support a better experience for patients. The 2009 GP patient survey revealed that 84 per cent of patients are satisfied with the access offered by their GP.<sup>3</sup> We believe that responding to the needs and views of patients, measured locally, is the best way to achieve this. Talking face to face with patients is far better and more cost-effective than blanket national surveys. There is no need for a national survey to discover that the majority of patients want a choice of reliable, good quality, familiar services close to where they live. The original QOF patient experience indicator did actually promote true consultation with local practice populations, affecting change accordingly. We would support a return to that sort of method of seeking patients' views. The nature and history of general practice means that there will never be complete standardisation of size, premises, or services provided. Different practice models can all achieve high quality care – small as well as large. Practices need Primary Care Organisations (PCOs) to engage with them constructively so they can work in partnership with patients and local communities. Much work has already been done on how to improve quality in general practice, and GPs have shown that they are ready and willing to adapt and change in response to this. Practices should work with their patient participation groups, perhaps with the help of validated surveys, to respond to what patients need.

The GPC will always champion clinical excellence and patients' medical needs above consumer and political whim. However, to address the needs of particular groups such as long-distance commuters, the GPC would consider appropriate innovations, such as some groups of patients being able to register with more than one practice, providing the complex issues surrounding such changes could be resolved. We do not believe patients would want their GPs not to visit when clinically necessary and any changes in this area should take into account the needs of all patients to avoid any unintended consequences. The public has huge expectations of what general practice can deliver. As the health economy becomes more competitive, and politicians place a greater emphasis on patient choice, the GPC acknowledges that it is more important than ever for GPs to discuss with patients their expectations and respond wherever possible to their wishes.

## Recommendations

- There should be a requirement to consider, through appropriate piloting prior to introduction, how changes would help improve public health and address health inequalities.
- Practices should be supported to become more responsive to patients both in terms of access and other services. Information and support should be given to improve management structure and clinical teams and PCOs should consider how best they can support the practice overall to develop services in response to patient need.
- Practices should develop patient participation groups using the BMA guidance <http://www.bma.org.uk/patients-public/ppgintro.jsp> and aim to ensure that patients involved are representative of their practice population.
- Patient participation groups may be linked to other groups in the area to enable patients to be more fully involved in commissioning and planning discussions, and decision-making.
- Patients could have the opportunity to register at more than one practice if they commute, as long as issues relating to continuity of care, home visiting, communication between practices, and funding can be resolved. Employers should be responsible for ensuring employees know their rights and are able to get time off to visit their GP if needed. Employees should be supported in any rehabilitation and return to work if possible.

# The changing NHS

In England the Government has already brought the market into the NHS, including into general practice. Its aim is to bring in more providers of care to introduce competition, and so in theory force up standards and quality. Unfortunately the introduction of plurality of providers is not proven to improve the quality of patient care. The independent contractor status of existing GPs continues to show value for money and is rated very highly by patients.<sup>4</sup>

Initial reports suggest that many of the contracts for the new GP-led health centres and polyclinics introduced by former health minister Lord Darzi in his Next Stage Review have in fact been awarded to consortia of local GPs. However, many of these have entered the process reluctantly, purely in order to protect the interests of their patients, to prevent practices from being destabilised, and to preserve the service, value and ethos of traditional general practice. As predicted, in many cases patients are not choosing to register at GP-led health centres and their value for money is now questionable. The role of GPs in the market has become increasingly ambiguous. Putting GPs in a given area in a position where they are forced to compete with local GP colleagues is not necessarily a good thing for patients or tax payers. It threatens the morale of GPs and reduces the success of collaborative working.

No doubt the NHS can be made more efficient, but the introduction of a market, aimed solely in some cases at maximising profits, is not the right way to achieve this. Because of their status as independent contractors, GPs are expected to act as a small business yet because they are governed largely by national initiatives they cannot operate as a commercial business would, for example by raising prices to cover increased costs.

For the moment the commercialisation agenda is operating in England only. There are many aspects of the way health and social care operates in Scotland, Wales and Northern Ireland that should be implemented across the UK as a whole. These include free personal care for those in need, the end of commercialisation, and free prescriptions to replace the complex, unfair and illogical charging system operating in England.

While the 21st century NHS probably cannot totally exclude some market-based activities, this must be restricted to avoid long-term damage. Once structures are dismantled it is often impossible to rebuild them. There is also a clear difference between a commercial enterprise with disinterested shareholders whose key aim is making profit, and shareholders who are actively delivering a service, who have a personal, professional and financial investment in the practice and in the area and a firm commitment to local health services. All new contracts open to commercial bidders are offered under a new kind of contract – Alternative Provider Medical Services (APMS) – that do not tend to be long term. Commercial providers – being larger – are often more willing to take the risk of a short-term contract. They often do not have the expense of an NHS pension scheme and may employ staff on less favourable terms. This in turn leads to demotivation and disengagement of staff who are unlikely to remain in post for long periods of time as is the case in many existing practices, and the loss of the very goodwill on which the NHS has always relied.

Initially, patients may not immediately see much difference in the service they are offered, as in theory the service should be at least as good irrespective of who is ultimately responsible (public limited company, limited liability partnership, charity, community interest company, or social enterprise scheme – it could be any one of these). Over a longer period, the impact on both primary and secondary care in a given area could produce a very different outcome. There are of course some areas which are under-doctored. But the solution to this is not necessarily to open the market to all bidders – running the risk that vulnerable patients could face a high turnover of doctors and no continuity. Instead, incentives could be offered to local GPs to make a real investment in these areas to recognise the difficulties of practising there, and to ensure that patients get true continuity and stability into the future.

All major political parties have committed themselves to further commercialisation and competition in the NHS. However, restrictions could be placed on this and nothing further should now be introduced without prior testing. Unfettered competition can only ultimately lead to greater fragmentation, with services disconnected from the patients they should be serving. But we cannot turn back the clock – some degree of commercialisation now seems inevitable as structures are being established that will be difficult to reverse. We remain convinced that the current direction of travel is as yet unproven to produce a better quality of care for patients and could be more costly in the longer term. There is a real danger that the personalised, continuing and holistic care offered by GPs directly responsible for providing the service could be lost.

### Recommendations

- NHS general practice should involve the same standards in all four countries, ie free personal care, no commercialisation agenda, free prescriptions and a UK QOF.
- A full analysis should be undertaken within the next two years to establish the value for money of all practices commissioned as a result of the Next Stage Review.
- Providers of primary care operating in more than one PCO should produce public annual reports covering all practices, which should include independently assessed measures of clinical quality, as well as costs per registered patient.
- Long-term contracts are best for patient care. Primary care providers from outside a PCO area should be invited to bid for general practice services only after existing practices within the area have been given an opportunity to expand their service or develop new services within the area as preferred providers.
- APMS contracts should only be used if the PCO is unable to find anyone else to take on a national or personal medical services (PMS) contract. Any competition should be on the basis of a level playing field including APMS providers offering the same standards as PMS/GMS practices including offering an NHS pension and model terms and conditions of employment or its equivalent.
- Contract holders should have day-to-day involvement in the running of any practice.

# Commissioning

GPs are on the front line of patient care. They know their patients and their health needs. They also know about available services locally. GPs coordinate the care a patient receives and help patients exercise choice. They act as the entry point and guardian of further NHS services. In recent years, GPs have had the ability to commission local health services working with the local PCO. This is done through a system called Practice Based Commissioning (PBC) in England – not in the devolved nations. Effective commissioning through PBC can bring efficiencies and potentially free up resources that can then be used for service innovations such as clinics closer to patients' homes, thus creating a wider range of services responsive to the needs of local people. Moving services closer to homes must not however be at the expense of destabilising essential local hospital services or impairing the quality of service offered, so dialogue with secondary care clinicians is essential.

The advantages for patients of a robust and multi-faceted primary care sector are numerous. Services in the community, and the personal overall care provided by general practice have demonstrable benefits to patients. These are associated with higher patient satisfaction, healthier patient populations, reduced prescription of drugs, lower hospitalisation rates, reduced adverse effects of social inequality and lower overall health service expenditure.<sup>5</sup>

Commissioning in itself does imply the presence of some form of market in the NHS. GPs are central to PBC. All GP practices are however involved in commissioning in terms of referrals, admissions to hospital, and prescribing. Practices should be allowed to commission without undue interference to the extent that is possible for them, with GPs essentially acting as the clinical advocates of patients. Ultimately, PBC is likely to give way to locality based commissioning covering a larger area. The development of commissioning groups, with a number of GP practices acting together in a locality, should be considered.

Effective commissioning requires locality health needs' assessments, close working with the Director of Public Health and team, and good management support from PCOs, as well as adequate funding, and timely, good quality data from secondary care. Commissioning needs better coordination and effective working between PCOs and practices. Collaboration with secondary care is absolutely vital as consultants have an important role in commissioning. Competition between primary and secondary care can reduce this collaboration and there is evidence that the current system of payment by results (PbR) is leading hospital management to prevent consultants and GPs working together to develop new services in the community. Service reconfiguration must take place in an environment of cooperation. It should be evidence-led with outcome assessment mechanisms, and must enhance the standard of care.

Budgets for commissioning should remain entirely separate from any GP contract funding. Essential/personal medical services to patients should not be affected by the finances of the practice commissioning budget. Linking GP pay and/or profit to commissioning budgets would also be wrong as it would create a perverse and unethical incentive in commissioning services. One potential unintended consequence is that there would be a risk of widening health inequalities through differing levels of health provision. Commissioning budget deficits should not be subsidised by the practice budget, nor practice contracts terminated because of commissioning failings. Hard budgets are not supported by the whole profession and would require substantial management support and information, together with training, if they are to function effectively.

Some PCOs have recently developed incentive schemes aimed at referral rates or costs from primary to secondary care. These either encourage GPs to analyse and understand their practice referral patterns, promote the use of alternative referral pathways to hospital services, or encourage GPs to reduce their level or cost of referrals as an outcome in itself. These schemes have become more widespread in the

context of a reported 15 per cent rise in referrals from general practice for the first quarter of the last financial year (08/09). We believe that financial incentives from PCOs to maintain or reduce referral rates provide the sort of perverse incentive already mentioned.<sup>6</sup> It may also to some degree reflect issues such as coding of referrals, which currently can be of poor quality; re-referral requirements in secondary care; and possibly reduced hospital waiting times as a consequence of the PbR payment mechanisms for hospital episodes. GPs should only refer patients to the service most appropriate for their condition, whether this is in hospital or closer to home. All referral analysis and demand management schemes must only explore or promote suitable alternative pathways of care that are acceptable to the patient. There must be no incentivised target-based element. It is not acceptable for practices to receive funding or payments that provide specific financial rewards for reducing referral numbers or costs.

### Recommendations

- Management resources should be made available to all GPs involved in commissioning, in addition to the resources available for PBC in England.
- The commissioning budget should remain completely separate from any funding for the GP contract, to ensure a distance between clinical decision-making, funding, and management processes.
- The operation of commissioning – including PBC – should never adversely affect patient care, for instance by creating perverse incentives for practices that can only lead to health inequalities.
- Referral management schemes must be handled carefully to ensure that they do not provide similar perverse incentives.
- There should be close professional collaboration between primary and secondary care both in commissioning care and in any proposed reconfiguration of services.

# Out of hours

Out of hours (OOH) means the period outside normal operating times of practices – usually before 8am and after 6.30pm in the week, as well as on weekends, and public holidays, though many practices now have extended opening for routine care during these times. OOH services deal with emergencies as well as urgent unscheduled care, and may deal with these either directly or by referral.

Since responsibility for providing the majority of OOH services passed from GPs to PCOs in 2004, there has been a marked variation in the quality of these services. This has been coupled with significant variation in the funding of OOH services across the UK, with widespread underfunding. Some areas have tried to cut costs by employing fewer doctors. While an appropriate skill mix is vital for the NHS, there are some times when only a doctor will do and in this context where only a qualified GP will do. The provision of care by the most highly qualified and appropriate professionals reduces onward referral, increases safety and saves the NHS money. NHS investment in this sector, in particular to deliver these outcomes, would save money overall. GPs have general clinical diagnostic skills to diagnose a wide range of problems, including those that do not present in a textbook fashion. Ideally, they should also have some knowledge of the local area they are serving. While many GPs do continue to work in the OOH period under the employment of PCOs, this is not always the norm.

Within any discussion about the provision of OOH GP services, it is important to remember that not all GPs have opted out of providing OOH care directly. Some 10-15 per cent of GPs still do so and the overall trend here is increasing direct provision.

The priority for all OOH commissioners and providers must be to offer patients a high quality service that is safe, clinically appropriate, and delivered by suitably trained clinicians. The provision of such a service is most likely to be effective where the PCO commissions OOH care with the involvement of local GPs. However, the responsibility for commissioning OOH services must remain with the PCO, otherwise there is a risk that GPs may become the providers of last resort were a commissioned service to fail. The new GP contract was predicated on removing direct obligation for OOH/24-hour provision, and has positively transformed the lives of many GPs, allowing a safer and more manageable workload, while also increasing the attraction of general practice as a positive career choice. While many GPs are still very much involved in the provision of OOH services, they are no longer and nor should they be the providers of last resort. This is not an acceptable option under the current model of independent contractor general practice. Effective and responsive commissioning sees GPs, or PBC groups, working with PCOs to ensure that safe, quality care is available to patients in the OOH period.

Essential to high quality OOH care is the availability of adequate funds from PCOs to provide these services. The OOH needs of patients vary across the country, but the funding must match the clinical demands of the local population.

It is absolutely vital that patients know how their local OOH service operates and who to contact, as there is often confusion about this. There are now so many other options available to patients (NHS Direct and walk-in-centres, the internet etc) and patients need to know exactly who is providing this service and how to access further help if they need it.

## Recommendations

- Practices and PBC groups should be involved in the commissioning of OOH services but GPs should not be the providers of last resort.
- PCOs should make available adequate funding to provide a safe, high quality OOH service.
- PCOs must ensure that OOH organisations have enough trained staff available to see that patients can access appropriate advice and diagnosis during the OOH period.

# How GPs work

A new contract for General Medical Services (GMS) was agreed in 2003. This is a national, UK contract centrally negotiated to ensure uniformity in NHS care across the UK, and to uphold some guiding principles for the provision of primary care by GPs. The continued existence of a nationally negotiated contract is a key principle and the GPC will protect that national contract for independent contractor GPs. Any changes that are made to it should be based on the following principles:

- it should be a formally negotiated agreement between the GPC/BMA and UK governments
- it should provide fairer funding for practices
- it should provide financial stability for practices
- it should provide new funding for additional work.

While the GPC stands by the guiding principles that are the foundation of this contract, these have not been maintained or properly implemented. Rapid attrition of these principles by the Government since the contract's introduction has damaged GP morale and made the profession suspicious. The GPC cannot negotiate directly on behalf of holders of different types of primary care contract – Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) but instead seeks to represent doctors working under these contractual models in local negotiations through Local Medical Committees (LMCs). Of course, there is a difference between PMS and APMS contracts in the sense that there is a read across from nGMS to PMS in implementation and in national guidance, while no such read across exists for APMS. The different types of contract are confusing and should ideally be reduced. The PMS contract was introduced before the new GMS contract and circumstances have since changed. GPs on PMS contracts should be able to return to GMS without damaging the financial stability of their practices. APMS contracts, introduced to allow private providers in to primary care, should not be necessary.

Funding for practices (and ultimately for GP pay) is very complex. A substantial part of practice income is based on a Global Sum, an overall amount of money calculated using a formula which takes into account the characteristics and associated workload of registered patients. In practice there is a wide disparity between the amounts given to practices with similar patient populations – because much of the original contract funding was based on historical funding ie what levels of funding had been provided under previous contracts. In addition the funding allocation formula is applied to all Global Sum funding and does not sufficiently recognise the core costs of managing a practice. A further large part of practice income comes through the QOF (see above), and there are other income streams. Practices need to cover the expenses of running the practice before the GPs can be paid. While it is true the GP income went up initially as a result of the new contract, for the past few years it has reduced. The results of the GP Earnings and Expenses Enquiry for 2007-08 show that the average gross earnings of GMS contract holders fell by 0.6 per cent when compared with 2006-07. Average expenses rose by 1.3 per cent with the result that average net income fell by 3.1 per cent – a reduction of over 7 per cent in real terms as measured by RPI inflation.<sup>7</sup> The expenses to earnings ratio rose again in 2007-08 to reach 56.7 per cent. We anticipate on the basis of conservative estimates of movements in expenses and increases in total gross earnings, which mirror nGMS that net incomes fell further in 2008-09 taking the cumulative fall since 2005-06 to a little under 10 per cent.<sup>8</sup> In addition, investment in general practice as a proportion of total NHS expenditure has fallen from 9.1 per cent in 2003-04, just before the new GMS contract, to 8.4 per cent in 2008-09. A mechanism to ensure fairness in future needs to be developed.

The GPC firmly believes that annual increases to contractual funding should be determined by the Doctors and Dentists Review Body, one of a number of such bodies to make independent recommendations on public sector pay. This should not be the subject of Government interference. Practices need long-term financial security to plan future work and developments.

GP practices have historically worked as independent small businesses contracted to work for the NHS. Recently other options have started to emerge, and different models of delivering care considered. The RCGP has put forward the concept of 'practice federations' grouping practices to work together.<sup>9</sup> This development is a natural step in the direction that many practices are already moving. The model can offer advantages to clinicians and benefits to patients. This should not undermine existing services either in primary or secondary care. PCO support is crucial to its success, and any federation will require guidance on legal, commercial, financial and clinical issues. As the model is advanced, discussion will be needed on whether it is appropriate for all parts of the country and all types of practice. Primary care federations may also face a conflict of interest if they both commission and provide a service. Clinical and corporate governance structures are needed to avoid this.

Increasing numbers of GPs are working as sessional or salaried GPs, or locums. This can be through choice, because this way of working offers greater flexibility; it can also be through a lack of available GP partnerships. It is partly a result of the huge changes taking place in the medical workforce. Salaried GPs employed by practices should be employed on terms at least as good as the BMA model salaried GP contract, as there is no nationally negotiated contractual framework. Practices should consider offering partnerships to salaried GPs within their practice for many reasons including maintaining independent contractor status for UK general practice.

In addition to this, more work is needed on the financial aspects of appointing a partner as opposed to employing a salaried GP. Some work has already been undertaken in Wales that begins to demonstrate that employing a partner is not always a more expensive option. This should be explored further for the rest of the UK.<sup>10</sup>

## Recommendations

- The GMS contract should remain nationally negotiated, as this offers the best value for money and greatest consistency for patients, as well as the best way to stem the tide of commercialisation/fragmentation. It also reduces the cost and bureaucracy involved in local negotiation. Some local flexibility is appropriate, but should not lead to a new postcode lottery in standards of healthcare and services to patients.
- The funding for GMS contracts should be further reviewed aiming to level up the distribution of funds to practices. We recommend that additional support should be given by means of dedicated funding to practices that are expanding.
- Practice federations may offer benefits to patients and GPs. The RCGP model and other alternatives should be explored and assessed further. Working in federations should not be compulsory and GPs should be able to maintain their independence if they wish.
- All PMS practices should be able to revert to a GMS contract if they wish to do so, with practice funding protected and with an aim to converge the two contracts.
- APMS contracts should not be used where they are detrimental to existing services, or where they threaten to undermine the cornerstone principles of general practice.
- All salaried doctors, working in GMS, PMS or APMS should be offered terms and conditions equivalent to the BMA model salaried GP contract.
- Practices should consider offering salaried GPs the option of becoming a partner in the practice.

# The quality and outcomes framework

The Quality and Outcomes Framework in the national GP contract (QOF) is unique. It is recognised internationally and many countries have shown interest in it as a system that has demonstrably improved the quality of healthcare in the UK. It reflects a shift in healthcare workload towards primary care, in particular the monitoring of patients with chronic conditions. There is increasing evidence that the QOF is beginning to reduce the incidence of chronic disease and has led to long-term improvements in morbidity and mortality rates for the UK population.<sup>11, 12</sup> The QOF is evidence based and must continue to be so. Political imperatives that have little evidence to back them up must be addressed through other means, for instance by introducing enhanced services. The clinical indicators were chosen because there is evidence that intervention in primary care is effective, and the system has been designed so that the recording of data intrudes as little as possible on the consultation. The QOF also provides an excellent basis for the collection of data in primary care. In summary, the QOF has given patients something they never had before – the expectation that they will receive the same standard of care in any locality, which diminishes the risk of a postcode lottery.

To maintain GPs' confidence in the QOF, a clinical evidence base, rather than cost reduction measures or political imperatives should remain the primary criterion when indicators are being reviewed, now that the National Institute for Health and Clinical Excellence is overseeing the review process.

The GPC supports incorporating patient feedback into the QOF process but does not believe that PROMS (Patient Reported Outcome Measures) or indeed the national GP Patient Survey, should be a major source of evidence. There is currently insufficient evidence to suggest that attaching incentives to PROMs benefits patient care. Evaluation should be independent or quality will not improve further.

QOF must continue to be UK-wide. It has delivered high quality care to a defined standard through the four countries of the UK. There is no postcode lottery according to where you live. While prevalence of chronic conditions may vary in the four countries, the main disease areas are those that cause the most deaths and hospital admissions. QOF has delivered national standards of care to the entire UK population.

The GPC does not support local QOFs. It would be more appropriate to deliver local health priorities via Local Enhanced Services. The introduction of local QOFs would devalue the power of the QOF as a public health tool. The introduction of the QOF has reduced healthcare inequalities. Fragmentation of the national QOF into a set of local priorities would be detrimental to the reduced gap in health inequalities.

QOF income funds workload as well as outcome. Evidence presented to the QOF expert panel showed that rewarding proper processes was an effective way of ensuring a good outcome. The funding of process will be a measurable proxy to outcome in many instances, for example, measured blood pressure. Practices cannot afford to gamble expenditure on staff and resources in the hope of hitting a target at the end of the year.

The GPC supports piloting new indicators before introduction. Changes to QOF should be as infrequent as possible, to allow enough time for process to be introduced into practice.

A significant proportion of GP funding goes into the QOF, and the GPC believes it would be preferable for some of this to be invested in basic practice income to ensure that all practices receive a reasonable amount according to the number of patients for whom they are responsible. Practices have performed outstandingly against QOF targets, in excess of Government expectations. This makes the funding in QOF larger than in other incentive schemes. The funding should be moved in such a way that it does not create a major redistribution, therefore it would need to be strictly according to the number of patients served by a practice and not be the usual allocation formula.

## Recommendations

- The QOF must continue to be evidence based.
- Neither PROMS nor the GP Patient Survey should be included in the QOF as their effectiveness as a reliable indicator of quality in primary care has yet to be evaluated.
- There must be no local QOF – it must remain a national UK framework. QOF should continue to recognise the importance of funding processes as well as outcome in delivering high quality care to patients.
- All new QOF indicators must be fully evaluated in a pilot process before adoption.
- QOF should only be reviewed every two years unless there is a significant change to clinical evidence.
- Consideration could be given to moving a proportion of funding from QOF to basic practice funding via the Global Sum. Some funding must be based on patient numbers and not allocated via the Global Sum formula.

# Workforce

The GPC recognises the enormous contribution made to general practice by other healthcare professionals, and support staff, in particular since the introduction of the new GP contract. This section focuses on the medical element of the primary care workforce but acknowledges that this could not operate successfully without close cooperation with colleagues.

The primary care workforce is changing – and so are the needs of practices and their patients. There are far more women GPs and many GPs are seeking to work less than full time to allow for other responsibilities or activities such as involvement in commissioning, appraisal, teaching etc.

There are far fewer partnerships available. The GPC continues to believe that the partnership model of independent practice is the most effective way of delivering care. All GPs should have the opportunity to pursue this as a career if they wish. It should not be the case that the only vacancy available is as a salaried GP, but some GPs may prefer to pursue a career as a salaried GP for a variety of reasons. The appointment of partners must be fair and transparent.

The result of the shortage of partnerships and the change in demographics is that the number of salaried, sessional and locum GPs has increased dramatically. This should certainly be a career option for GPs but not the option of last resort for those who cannot get partnerships. It is difficult to get an accurate and up to date picture of the increase in numbers of non-partner GPs – official statistics are often published very late. One figure suggests that there has been a 600 per cent increase in the number of sessional and salaried GPs since the new GP contract was introduced. There are no official figures on the number of locum GPs in the UK but it seems likely that these numbers are also increasing. The needs of this growing group of GPs must be addressed and in particular they must be employed on appropriate contracts that reflect their experience and skills. The GPC is working to ensure that the concerns that salaried GPs have expressed about their representation will be addressed to mitigate any professional disunity.

There is evidence that the partnership model remains the preferred career option for the majority of doctors. There is certainly value to the NHS in promoting this model for the sake of continuity and the evidence of commitment to a practice and a community. The NHS could consider specifically rewarding the creation of partnerships – putting in more control mechanisms similar to the old Medical Practices Committee might be a first step.

The GP workforce needs to be managed better at national level, to avoid the shortage of GPs (partners and otherwise) in more unpopular areas. The return of something similar to the former Medical Practices Committee may be an option (a Government committee that ruled on how many GPs could work in an area, based on population numbers and need). This might also help GPs expand their choice of partnership/salaried posts, and develop their skills after some time in practice.

Another possibility is to introduce incentives to encourage practices to offer partnerships – especially in under-doctored or deprived areas. These might take the form of a 'golden hello' as previously existed, and should last for a number of years to encourage retention.

One of the casualties of recent years has been the end of central funding for the GP retainer scheme (to allow qualified GPs taking a full or partial career break to stay in the workforce) and also the Flexible Career Scheme. Both successfully ensured trained GPs remained up to date and available to the NHS.

Some newer GPs and GP trainees currently feel disenfranchised. It is vital that these doctors have a say in the future of general practice. GP training itself must meet the current demands of modern primary care and be flexible enough to respond to future changes. The UK must produce enough GPs to meet the increase in demand for primary care, the increased complexity of the co-morbidities of our ageing population and the management of more long-term conditions closer to home, and also to address the coming retirements of a generation of existing GPs.

GP trainees spend much of their time preparing for and taking exams. Some feel that more hands-on experience would be better – perhaps through an extended training year, allowing in addition more training in areas of special interest or medical leadership. This could follow the model currently operating in Wales and if so would not be part of the general career structure.

There are plans to extend GP training from three to five years. This proposal is supported by the GPC and provided that the training is properly structured and funded could improve the confidence and experience of trainees by giving them the opportunity to develop areas of special interest, and gain expertise in the leadership and other skills that will fit them for partnership in general practice. These plans are not yet finalised so it is not clear which of a number of options for the extension of training will be suggested. However, any proposal must ensure the benefits of any extension are apparent for both trainees and patients, that the extra time is not used to prop up hospital rotas, that GP premises are funded to accommodate this, and that there are arrangements in place to cover the initial period where few GPs will qualify. Those who do qualify immediately before this should not be seen as 'second class'.

There must be clarity over terms and conditions for GP trainees, which would be facilitated by a single contract throughout their five-year training. Pilots are currently being undertaken to establish which body should most appropriately hold this single contract. The PCT holding the contract is one of the options that will be under consideration.

The increased burden this extension of training would place on GP trainers is obvious, and measures need to be put in place to address this. These could include organising training practices differently, with the trainer/s having an overview of training within an individual practice, but taking more trainees than currently. It is probably not practical simply to recruit hundreds more GP trainers, so alternative means will need to be found in addition to some expansion of trainer numbers.

Careers in general practice must remain attractive enough to encourage the highest quality candidates. There should be competitive rewards during training. The GP trainee pay supplement has been cut year on year. This erosion of pay has adversely affected trainee morale and recruitment and should stop. Furthermore, any future changes to pay should not penalise those already recruited to training programmes.

GPs should have the opportunity for varied careers post-qualification, and it should be recognised that more qualified GPs may lead to increased competition for both salaried posts and partnerships.

## Recommendations

- A national scheme to incentivise the expansion of partnerships should be introduced. This should include nationally allocated funding for at least five years especially in under-doctored areas.
- Practices should be encouraged to include in salaried GP contracts incremental payments to reflect skills and experience.
- The GP workforce must be planned to ensure the right number of GPs are trained, with the right skills, and to allow a proper choice of career path.
- A career development fund should be established to support additional postgraduate training after 10 years of practice.
- Ring-fenced funding for the GP Retainer and Flexible Careers schemes should be re-established as evidence suggests without this these will not happen.
- GP trainees should have a single contract throughout their training, held by a single body depending on the outcome of piloting.
- The extension of GP training should be supported. Training should be general practice based and fully funded through new national resources, recognising that there are a number of options currently on the table for the length of any such extension to training.
- GP trainers should be allowed time and resources to reflect increasing demands on trainers and training practices. There should be no financial detriment to practices in taking on this work .
- All GPs should be entitled to protected learning time and opportunities to further their career development; this time should be recognised in future workload surveys to remain comparable with consultants.

# Premises

The increasing range and level of services offered by many practices today means that premises are often bursting at the seams. GPs who are keen to develop them and offer even better services cannot do so because there is no funding. Many premises were built some time ago and their specifications are not suited to modern primary care. In particular, they are not energy efficient and do not meet modern requirements for reducing carbon emissions. Lack of funding – and sometimes practical constraints like space – have meant that some premises are no longer fit for purpose. The Government has been willing to invest in new buildings to accommodate polyclinics and under PFI schemes, but not to develop existing practices that could offer more local services. Not all practices have been able to address the needs of patients with disabilities as they would have wished.

Everyone would agree that modern purpose built premises, fit to deliver a high standard of healthcare, would be the ideal. Practices need to ask themselves these questions:

- does every doctor need their own consulting room?
- can the practice make better use of its physical assets?
- should property ownership and partnership in general practice be linked, as is traditional?
- would retiring GPs be willing to retain their premises share, to act as a pension supplement?

GPs' personal involvement in their practice is one of the reasons for the success of the 'traditional' arrangements – projects are easier to initiate and GPs have ownership of them. GPs recognise that their premises have a big impact especially in smaller communities. Practices also play a central role in moving care closer to home. High quality GP premises are critical for practices to facilitate these developments, which are of health and economic value.

PCO officials need to develop further expertise in premises development, as they are responsible for funding in addition to decisions on development. If this expertise is not present, for once it might be appropriate to use external consultants or develop regional expertise that could be shared between primary, secondary and possibly social care. Practices too need to develop their expertise – possibly the increasing development of practice federations will empower practices to achieve more in this area. GPs should show their renowned leadership and entrepreneurial spirit – long-term investment in premises would be helped by funding stability and may be helped by pump-priming and early incentives. Federations may also be helpful in allowing practices to share certain facilities while retaining their operational autonomy.

GPs themselves take the risk of investment in premises. Any reluctance in recent years has been largely due to uncertainty in contractual arrangements and the resulting unwillingness to take this financial risk. Without investment, GPs cannot develop their practices. It is better in the long run for patients if GPs are in control of these developments – not the case in third party development premises, or PFI initiatives.

The estimated value of GP premises in the UK is about £4 billion. The new GMS contract originally provided for but failed to deliver £300 million in recurrent funding for the development of GP premises. This should have delivered about £2 billion for new premises, or replaced about 40 per cent of existing premises. Some sort of supportive funding is clearly needed though other factors also come into play, for instance a valuation process for notional rent and to encourage partnership buy-in for a realistic return would make GPs more likely to invest.

## Recommendations

- Investment should be made in existing practices rather than putting money into PFI initiatives or GP-led health centres.
- Practices need support to allow them to develop premises fit for modern general practice.
- PFI projects should be replaced by a new scheme to support sustainable practice developments, with a realistic valuation process.
- A 'green practice' fund should be established if it is expected that practices will make their buildings more energy efficient.

# Information technology

General practice has the highest level of computer use and literacy in the NHS, and is at least as good as in any other country's primary care system (for example, less than a third of US primary care is computerised).

Modern healthcare relies upon high quality information technology (IT) systems supporting decision-making, reducing errors (especially in prescribing), supporting business processes, improving patient responsiveness, enhancing audit and research, and enabling sharing of appropriate information. To achieve this IT must be modern, fit for its purpose and properly funded. GPs have shown that given the resources they can lead the way in improving services for patients.

IT will continue to develop to help patients and practices. It will enable new ways of making appointments, ordering and processing prescriptions, contacting and consulting with clinicians. Developers and policy makers must ensure that such developments do not have a negative effect on health inequalities, widening the gap between those with computer access and those without.

Further development with general practice IT will require continual improvement in data quality, and the progression towards paperless practices. This will require appropriate safeguards for privacy, and provision and support of hardware and software solutions including those for scanning and mobile devices. The GPC will be working with the Royal College of GPs and the Departments of Health on this over the next year or so.

The continual innovation and development of general practice systems throughout the UK should be facilitated. This will be the challenge once the present GP Systems of Choice (GPSoC) initiative in England expires. Plurality of clinical software system suppliers, as provided by GPSoC, with choice between systems determined by the business needs of individual practices is important to promote system development and ensure best support of general practice throughout the UK.

IT projects should be based upon requirements defined by clinicians to enhance direct or indirect patient care. They must have realistic timescales, and a managed pace of change. More problems occur where projects have been rushed or badly thought through. Developments in IT systems must be timely. For example, the current position where changes to the Datasets and Business Rules supporting the QOF are not integrated into clinical systems until six to nine months into the year, leads to avoidable retrospective work. This diverts resources from patient care.

Steps need to be taken to ensure that clinicians are both involved in and signed up to IT projects. This will be facilitated by credible clinical engagement at development, procurement, roll-out and monitoring stages at board level or equivalent. Confidentiality continues to be an imperative requirement of healthcare. Concerns about issues of patient consent and confidentiality must be resolved. Capabilities of modern IT systems allow increasing sharing of information, but the disadvantages as well as benefits must be considered for each and every proposal.

IT systems should continue to be developed to support inter-operability (use by different systems) and sharing of appropriate information. Systems which are designed to be the same across whole health communities including different types of healthcare (eg secondary and primary) are likely to have more drawbacks than benefits and should not be introduced.

A national IT strategy is essential to ensure the above benefits and positive developments can be realised. The elements of the English National Programme for IT (NPFIT) that impact on general practice should be reviewed, and those which have been shown to have a positive effect on healthcare should be supported and built on. These include GP2GP (a means of rapid communication of medical records

between doctors), GPsOC (providing practices with a choice of recognised IT systems), Pathlinks (a secure electronic messaging service for test results between hospitals and surgeries), and EPS (the electronic prescription system).

Innovative ideas and a willingness to modernise have already placed general practice at the front of using new technology for patient services. Further developments could include greater use of email or text messaging for prescription requests, touch screen check-in systems at reception, improved communication methods for people with disabilities such as sight impairment. These IT developments should be funded and based on asking patients what they need.

### Recommendations

- Support for data quality and moves to paperless practices need to be fully supported and financial incentives offered to facilitate such development.
- IT projects should have realistic timescales, and a managed pace of change. More problems occur where projects have been rushed or badly thought through.
- Concerns about issues of patient consent and confidentiality must be addressed.
- Innovation in general practice IT needs to be encouraged, rather than top-down solutions being imposed. The core list of IT equipment should be expanded to allow practices to provide improved services for their patients.
- NPFIT: In the National Programme for IT the GP elements in particular need to have a future. GPsOC and other agreements need to be honoured and progressed.

# Conclusion

The last 10 years have brought significant changes to the way primary care is organised, and there will be more to come whichever political party is in power. Added to this are the financial challenges faced by the public sector, which will be a constant factor over the coming years. But GP practices have always offered value for money and striven to improve no matter what the financial environment. Practices have evolved out of all recognition from 20 or even 10 years ago, and given the right support will continue to improve and respond to the needs and wishes of their patients, recognising that the systems and environments that were appropriate even a few years ago have had to adapt and modernise. General practice in the UK really is fit for the future – a future that needs to build on its strengths, and preserve those values that are so highly prized by patients.

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