

Fit for the future – The evolution of general practice

Executive Summary

March 2010



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This document has been developed by the UK General Practitioners Committee (GPC) of the BMA. It sets out some of the ways general practice is moving forward and evolving, and puts forward a range of ideas and concerns about the future.

General practice is recognised throughout the world as one of the most cost-effective, high quality means to deliver care. This system provides value for money and a good deal for patients, and studies have shown the importance of primary care in producing better outcomes for patients at lower costs. Key features of general practices are:

- personal service and continuity of care
- holistic approach to patient care by highly-trained clinical generalists
- provision of a broad range of comprehensive services
- coordination of care – especially for those with a chronic or long-term condition.

The range of services GPs provide has increased dramatically, especially in terms of diagnostic and monitoring services, minor surgery, and a growing range of health promotion activities. GPs use their local knowledge to get involved in commissioning to ensure their patients get the best and most appropriate care, forming close links with secondary care and providing a focus for guidance and support for patients in the wider NHS and social care. The wider primary care practice team is playing an increasingly important role, with the GP as the hub of it, in managing increasingly complex patient and public requirements.

The Quality and Outcomes Framework (QOF) has been a huge benefit of the new GP contract. Practices have performed outstandingly against QOF targets. The QOF has led to improvements in public health and this has been recognised internationally. Generally, the role of general practice in promoting public health is under-valued. While governments rightly wish to improve patient experience, maximise care and offer better value for money, most professions would be extremely happy that 84 per cent of their clients were satisfied with the access to care offered. This figure comes from a national patient survey, while we believe more local surveys would allow practices to be more responsive to patients' wishes. It is important to recognise that different practice models can achieve high quality care – small as well as large. PCOs need to engage constructively with practices to work in partnership with patients and local communities. Patient choice could be improved by giving them the chance to register with more than one practice, should this not prove too complex. GPs are open to change and innovation as long as they are evidence based and properly thought through.

Commercialisation is already a part of the NHS in England. We do not share the Government's view that introducing competition always forces up standards and quality and there is little evidence to support this. The independent contractor status of GPs in their traditional practices continues to show value for money and is rated highly by patients. The new GP-led health centres are not proving as attractive to patients as the Government had predicted – making them even worse value for money. No doubt the NHS can become more efficient – but the introduction of a market, in some areas solely to maximise profits for commercial bodies, is not the only way to achieve this. Once existing structures are dismantled it is sometimes difficult to rebuild them. Further commercialisation should be limited to prevent long-term damage and prevent the loss of the staff goodwill on which the NHS has always relied. Competition can also lead to fragmentation, and confusion for patients about different services. There is a danger of losing that personalised, continuing and holistic care offered by GPs directly providing the service themselves.

GPs are on the front line of patient care – they know what their patients need and they know what services are available locally. They help patients exercise choice. Practice Based Commissioning (PBC) in England can bring efficiencies and free up resources for other service innovations like moving a service closer to home. This must not however be at the expense of destabilising essential local hospital services. Effective commissioning requires good management support at PCT level and good quality information. Any service reconfiguration required must take place in an environment of cooperation, be evidence led and with outcome assessment mechanisms, and must enhance the standard of care. Budgets for commissioning should be entirely separate from GP contract funding. Linking pay or profits to commissioning budget would create perverse incentives. This also applies to some referral management schemes where they are designed purely to maintain or reduce referral rates.

Since responsibility for out of hours (OOH) provision passed from GPs to PCOs in 2004, there has been a marked variation in the quality and funding for these services. Services are most likely to be effective where local GPs are involved in their commissioning. However, the removal of direct obligation to provide 24-hour cover has transformed the lives of many GPs and helped to save general practice from the workforce shortages that affected it before 2004. Many GPs remain very much involved in providing OOH services, but they should not return to being the 'providers of last resort'. Funding for OOH must match the clinical needs of the local population.

A new centrally negotiated UK GP contract was agreed in 2003. The GPC believes it is essential to maintain a national contract and that it should be formally negotiated between the GPC/BMA and UK Government, that it should provide fair funding and financial stability for practices, and new funding for additional work. Rapid attrition of the principles of the new contract since its introduction has damaged GP morale and induced suspicion. The difficulty of negotiating for different types of contract such as PMS and APMS has not helped. While it is true that GP income went up initially as a result of the new contract, for the past few years it has reduced. Average expenses rose by 1.3 per cent resulting in a fall of 3.1 per cent in average net income – a reduction of over 7 per cent as measured by RPI inflation. Because of the innate variations in practice funding, a fairer mechanism to apply funds needs to be developed. Decisions on annual increases in contractual funding should be determined by the Doctors and Dentists Review Body. While GP practices have traditionally been independent small businesses, different business models are now emerging including practice federations, grouping practices to work together. At the same time there are increasing numbers of salaried and sessional GPs, partly as a result of huge workforce changes. To allow all GPs a choice of career, practices should consider offering partnerships to salaried GPs working with them.

The QOF as mentioned above is unique, and has been recognised internationally. There is increasing evidence that the QOF is starting to reduce the incidence of chronic disease, and improve morbidity and mortality rates. It also provides the basis for excellent data collection. For GPs to continue to have confidence in the QOF, it must remain clinical evidence based especially now that the National Institute for Health and Clinical Excellence is overseeing the review process. QOF must continue to be UK wide and the GPC does not support 'local QOFs'. QOF was designed to recognise process as well as outcome, as practices cannot afford to gamble on increased expenditure in the hope of hitting an end of year target. Some of the funding going in to QOF could be invested instead in basic practice income to ensure equity and appropriate funding for the number of patients in an individual practice.

Other healthcare professionals make a huge contribution to general practice and this has increased since the new GP contract. Generally the primary care workforce is changing – more women GPs and more GPs who do not wish to work full time. There are fewer partnerships available. As a result of these factors the number of salaried and sessional GPs has increased dramatically. Partnership does seem to remain the preferred career option for the majority so general practice needs to ensure it can

offer this. Better management of the GP workforce at national level, perhaps through an equivalent of the old Medical Practices Committee, could also help, as might incentives to encourage practices to offer partnerships. Funding should be reintroduced for the GP retainer scheme and the flexible careers scheme. It is vital that young GPs should not become disenfranchised because of excessive exams, cuts in their pay, and a lack of attractive career options. The GPC supports the extension of GP training if properly funded and structured, and with clarity over terms and conditions for trainees.

The increasing range and level of services provided means that practice premises are often too small and not fit for purpose. Lack of funding, as well as practical constraints on space, are key issues. GPs recognise the importance of attractive functional premises and want to invest, though long-term investment can feel risky in an environment where GPs do not know what funding will be available to their practice year on year. PCO managers as well as GPs need to develop more expertise in premises development.

General practice has the highest level of computer use and literacy in the NHS. This is vital for modern healthcare – information technology (IT) can help patients with new ways to make appointments, ordering and processing prescriptions, contacting and consulting with clinicians. There will need to be continual improvement in data quality in general practice and progression towards a paperless practice, all of which will require continued focus on confidentiality and safeguarding privacy. IT projects should be based on clinician requirements and should directly or indirectly enhance patient care. Problems occur where projects are rushed or not thought through. A national IT strategy is essential to ensure the benefits and positive developments can be realised.

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.

Suggested improvements/ recommendations

QUALITY

- 1 There should be a requirement to consider, through appropriate piloting prior to introduction, how changes would help improve public health and address health inequalities.
- 2 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.
- 3 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.
- 4 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.
- 5 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

- 6 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.
- 7 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.
- 8 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.
- 9 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.
- 10 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.
- 11 Contract holders should have day-to-day involvement in the running of any practice.

COMMISSIONING

- 12 Management resources should be made available to all GPs involved in commissioning, in addition to the resources available for PBC in England.
- 13 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.
- 14 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.

- 15 Referral management schemes must be handled carefully to ensure that they do not provide similar perverse incentives.
- 16 There should be excellent collaboration between primary and secondary care both in commissioning care and in any proposed reconfiguration of services.

OUT OF HOURS

- 17 Practices and PBC groups should be involved in the commissioning of OOH services but GPs should not be the providers of last resort
- 18 PCOs should make available adequate funding to provide a safe, high quality OOH service.
- 19 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

- 20 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.
- 21 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.
- 22 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.
- 23 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.
- 24 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.
- 25 All salaried doctors, working in GMS, PMS or APMS should be offered terms and conditions equivalent to the BMA model salaried GP contract.
- 26 Practices should consider offering salaried GPs the option of becoming a partner in the practice.

THE QUALITY AND OUTCOMES FRAMEWORK

- 27 The QOF must continue to be evidence based.
- 28 Neither PROMS nor the 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.
- 29 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.
- 30 All new QOF indicators must be fully evaluated in a pilot process before adoption.
- 31 QOF should only be reviewed every two years unless there is a significant change to clinical evidence.
- 32 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

- 33 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.
- 34 Practices should be encouraged to include in salaried GP contracts incremental payments to reflect skills and experience.
- 35 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.
- 36 A career development fund should be established to support additional postgraduate training after 10 years of practice.
- 37 Ring-fenced funding for the GP Retainer and Flexible Careers schemes should be re-established as evidence suggests without this, these will not happen.
- 38 GP trainees should have a single contract throughout their training, held by a single body depending on the outcome of piloting.
- 39 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.
- 40 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.
- 41 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

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

INFORMATION TECHNOLOGY

- 46 Support for data quality and moves to paperless practices need to be fully supported and financial incentives offered to facilitate such development.
- 47 IT projects should have realistic timescales, and a managed pace of change. More problems occur where projects have been rushed or badly thought through.
- 48 Concerns about issues of patient consent and confidentiality must be addressed.
- 49 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.
- 50 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.

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