

# » Briefing

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## General practice in England: An overview

### Introduction

General practice is for most people the first and most commonly used point of access to the NHS, with nearly 300 million general practice consultations a year (Department of Health 2008b).

General practice has changed considerably over the past decade. Practice size has increased, the workforce has grown and become more diverse, the range of services offered has expanded, and the contracting and financing arrangements for GPs have changed. Current government policy aims to improve access and choice for patients, to enable greater self-management by people with long-term conditions, to expand the role of GPs in areas such as health promotion, to reduce variations in the quality of care provided and to improve quality overall. In the next few years, accreditation will be introduced for GP practices, and new models for commissioning and delivering care will be expanded.

This briefing sets out how general practice is organised, contracted and financed; analyses the impact of recent government policy; and looks at future trends.

### The functions of general practice

General practice forms the cornerstone of primary care in England, yet there is no official definition of its role or the services it offers. The Royal College of General Practitioners (RCGP) adopts a definition of primary care as:

*'... the first level contact with people taking action to improve health in a community. In a system with a gatekeeper, all initial (non-emergency) consultations with doctors, nurses or other health staff.'*

(World Organisation of Family Doctors cited in Royal College of General Practitioners roadmap (2007a))

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The College defines GPs as:

*‘personal doctors, primarily responsible for the provision of comprehensive and continuing generalist care to every individual seeking medical care irrespective of age, sex and state of health.’*

(Royal College of General Practitioners 2007a).

The main roles performed by general practices are listed below.

- **Consultations:** Around 90 per cent of all NHS contacts take place in general practice. The consultation seeks to manage a pre-existing condition or to make an effective diagnosis of a presenting problem and may lead to a combination of advice, a prescription, treatment, or referral to a specialist. The estimated total number of consultations in general practice in England rose from 221.8 million in 1995 to 299.3 million in 2007, an increase on average from 3.9 to 5.4 consultations per person per year (Information Centre 2008e).
- **Prescriptions:** The NHS in England spent £8.2 billion on prescription drugs in primary care in 2006, which represents around a quarter of the total expenditure on primary care. Ninety-eight per cent of these drugs were prescribed by GPs (National Audit Office 2007).
- **Treatments:** GPs provide advice and treatment for minor ailments and some also perform minor surgery such as the freezing and removal of warts and verrucas. Since 2004, practices have also been able to choose to provide more complex and invasive minor surgery such as incisions and excisions and injections of varicose veins (Royal College of General Practitioners 2007b).
- **Referrals:** Patients are usually referred to specialists only after the GP consultation – for this reason GPs have been seen as gatekeepers to other NHS services. Ninety per cent of those who use primary care services will be diagnosed and treated without being referred to secondary care (Department of Health 2008g).
- **Screening and immunisation:** Most general practices run screening programmes (eg, to detect for possible cancers or risk factors related to heart disease and diabetes) and immunisation for both adults and children.
- **Management of long-term conditions:** Most practices now keep registers of people at risk of, or with, heart disease, diabetes, asthma and other long-term chronic illnesses with many developing active disease management programmes.
- **Health promotion:** Most practices provide information and many host meetings and events designed to promote patient health, usually led by nurses or other community health staff. At the GP consultation, health promotion advice is common and is sometimes supplemented with information prescriptions, which might include telephone numbers and website addresses to help patients understand their illness and to enable self-care.

## How general practice is organised

### Practice numbers and size

In England the vast majority of the population are registered with a general practice. Every general practice is responsible for the care of patients who choose to register on its list; the average number of patients on a practice list in England in 2007 was 6,487 (Information Centre 2008c, table no 3). There are currently 8,230 practices in England (The Information Centre 2009). They range in size from single-handed GPs to multi-partner practices

employing several nurses and other clinical staff, with consulting rooms for visiting specialists. The number of single-handed GPs is falling as older GPs retire, down by 28 per cent since 2004 (The Information Centre 2009). While the number of GPs increased between 1997 and 2007 (*see below*), the number of practices decreased over the same period by 9 per cent. This reflects the fact that more GPs now work in larger practices.

### Practice distribution

The distribution of general practices varies markedly in England, ranging from 43 to 88 GPs per 100,000 people (Department of Health 2007). There is a close correlation between areas with the lowest life expectancy and those with the fewest GPs (Department of Health 2007).

### Workforce

There was a total of 30,936 full-time equivalent (FTE) GPs and 75,085 FTE practice staff working in general practice in England in 2007 (The Information Centre 2008c, table 2 and table 4). In the 2000 NHS Plan, the government promised to fund 2,000 more GPs and 450 more GPs in training by 2004. In fact, this target was exceeded, and by December 2004 the number of qualified GPs had increased by 3,330 (Department of Health 2005). Between 1997 and 2007 the total number of GPs in England rose by 19 per cent (The Information Centre 2008c, table 1).

A 2008 report by the NHS Workforce Review Team forecast that demand for primary care services would continue to increase and that more training provision was required to avoid 'a significant medium-term risk of GP shortages' (NHS Workforce Review Team 2008, p 6). The NHS Next Stage Review recommended that at least half of all doctors should train as GPs to meet this increased demand (Department of Health 2008a, p15).

### GPs with a Special Interest

The NHS Plan also promised 1,000 specialist GPs, from among existing practitioners, who would take referrals from fellow GPs for services usually carried out within hospital. These doctors – GPs with a Special Interest (GPwSI) – provide services such as dermatology, care for older people, care for those with epilepsy, and respiratory medicine (Royal College of General Practitioners 2006). The impact of GPwSIs is uncertain. One study suggested that work carried out by GPwSIs in community settings had no impact on waiting times and found that this model was more expensive than hospital-based clinics. This was partly attributed to slower throughput and longer appointments and partly because, on average, GPwSIs are paid more than the staff who might deliver equivalent care in hospitals (National Co-ordinating Centre for Service Delivery and Organisation Research Programme 2006). Some other studies have been more favourable.

### Other practice staff

The number and range of staff in general practice has also increased; the number of practice nurses, for example, rose by 44 per cent between 1997 and 2007 (The Information Centre 2008c, table 4). The proportion of consultations in general practice undertaken by nurses has also continued to rise; from 21 per cent to 34 per cent from 1995 to 2006 (The Information Centre 2008e). This trend in part reflects the fact that nurses have taken on more responsibilities that would have previously been carried out by GPs.

## General practice contracting and finance

Most GPs are independent contractors, not direct employees of the NHS. There are various types of contract, which are described below.

### General Medical Services (GMS)

Before 2004, most GPs in England were employed under a nationally negotiated General Medical Services contract. In broad terms this meant that GPs were contracted as individuals and were paid for each piece of work carried out and on the basis of the number of patients who were registered with them.

From 1 April 2004 a new GMS contract was agreed. The main elements are that:

- it is the practice that is contracted by the primary care trust (PCT), rather than the individual GP
- the contract enables GP practices to provide 'enhanced services':
  - Directed Enhanced Services (DES). Services or activities provided by GP practices that have been negotiated nationally – for example, providing extended opening hours, improving treatment of heart failure. Practices are not contractually obliged to provide these services but most do and payment is at a nationally agreed rate.
  - National Enhanced Services (NES). Services that a PCT, using national specifications, can choose to commission from a practice – for example, minor injury services and enhanced care for the homeless. Again, payment is at nationally agreed rates (NHS Employers 2009).
  - Local Enhanced Services (LES). Locally developed services designed to meet local health needs – for example, enhanced medical care of asylum seekers, and specific services for people with learning disabilities (Royal College of General Practitioners 2007b); these are commissioned by PCTs and fees for these services are locally negotiated.
- The contract provides a 'global sum', which is determined by linking the amount paid to a practice to the needs of its registered patients. The average is £56.20 per patient per annum (British Medical Association 2008). In addition, 90 per cent of practices receive funding from a scheme known as the Minimum Practice Income Guarantee (MPIG). This was introduced to compensate practices that would otherwise have received less income under the new contract than they did under the old one (National Audit Office 2008). The MPIG payment is now being phased out (NHS Employers 2008).
- The contract introduced the Quality and Outcomes Framework (QOF), which is a system of financial incentives that reward practices for providing high-quality care. The scheme is voluntary but nearly all practices take part. Under the QOF practices are awarded 'points' for delivering services that are based on best available evidence of effectiveness in general practice. The more points a practice receive the higher the payment (Department of Health 2008d). There is currently a maximum of 1,000 points available across four domains: clinical (650 points); organisational (167.5 points); patient experience (36 points); and additional services (146.5 points) (Department of Health 2008d; NHS Employers 2009b). Currently QOF payments account for around one-third of average practice earnings (National Audit Office 2008).

- The contract removed the obligation on individual GPs to provide 24-hour cover for their patients, which they could either do themselves or organise others to do on their behalf. Under the new arrangements the contract was with practices not individual GPs and practices were given the option to opt out of out-of-hours care (defined as care between 6.30pm and 8am on weekdays and over weekends and bank holidays). The vast majority of practices chose to opt out.

The new GMS contract remains the bedrock of general practice in the UK with most practices operating under this scheme (62 per cent of practices in 2006) (The Information Centre 2008a).

As an alternative to the national contract, a Personal Medical Services (PMS) contract allows GPs and other NHS staff to contract with their primary care trust.

### Personal Medical Services (PMS)

In 1998, the Department of Health introduced a pilot Personal Medical Services contract, which was adopted as a permanent arrangement in 2004. One of the key aims was to enable individual contracts with practices that are appropriate to the specific needs of local populations and to improve the provision of GP services in under-doctored areas (Department of Health 2003). Key elements of this contract are:

- it enables GPs and others to enter into locally negotiated contracts with, or to be directly employed by, their PCTs, to provide services outside the scope of GMS which meet the needs of the local population.
- the provider need not be a traditional GP partner-led practice. Under PMS, NHS trusts, PCTs, and other health care professionals including nurses and dentists can also be contracted
- it allows PCTs to employ GPs directly on a salaried basis
- rather than a 'global sum', PMS providers are paid a fixed annual rate for the provision of services negotiated with their PCT. This is another way of allowing them to tailor their services to meet local needs.

The differences between PMS and GMS contractual arrangements have decreased since 2004. For example, the arrangements for out-of-hours contracting are the same, and most PMS providers take part in QOF and provide enhanced services. In 2006, 37 per cent of all general practices operated under PMS (The Information Centre 2008a). The number of GPs employed in practices as locums or salaried employees has risen significantly: from 846 in 1997 to 6,022 in 2007 (The Information Centre 2008c, table 1).

GMS and PMS practices provide care for nearly 100 per cent of the population in England. Two other contracts were also introduced in 2004.

**Alternative Provider Medical Services (APMS).** This allows PCTs to commission primary care from commercial or voluntary providers, or from foundation trusts. The opening of the market to alternative providers was, like PMS, intended to plug gaps in provision in under-doctored areas and provide a greater choice of primary care provider to patients (Department of Health 2004a). Research by The King's Fund found that use of alternative provider medical services contracts (APMS) by PCTs was limited and that very few APMS contracts had been awarded to independent providers (Walsh *et al* 2007).

**Primary Care Trust Medical Services (PCTMS).** This contract allows PCTs to provide general practice services themselves. This was envisaged as a way of providing increased capacity in areas where the lists of local GMS and PMS practices are full (Department of Health 2003). Before the introduction of the new GMS contract in 2004 only GPs were able to sign contracts to provide general practice.

The four new contracts outlined above can be entered into by other health care professionals such as pharmacists and nurses, and, as a result, a small number of nurse-led practices have emerged (The Queen's Nursing Institute 2008).

### Did the new contracts provide value for money?

The Department of Health had expected that GP pay would rise by 15 per cent under the 2004 GMS contract (2002 business case to the Treasury cited in National Audit Office 2008) but also that the new contract would lead to gains in productivity. In fact, in the first three years of the contract, average pre-tax pay for GP partners (GMS and PMS) increased by 58 per cent (National Audit Office 2008), and research by the National Primary Care Research and Development Centre found that after the introduction of the contracts GPs were on average reporting a four-hour reduction in their working week (House of Commons Health Committee 2007).

The new out-of-hours arrangements in the GMS contract also incurred costs. Ninety per cent of GP surgeries in England chose to opt out of providing out-of-hours care (National Audit Office 2006); as a result, responsibility for securing out-of-hours care fell to PCTs. Although GPs forfeited on average £6,000 income a year by opting out, it has been estimated that provision of out-of-hours care by PCTs would cost an average of £9,500 per GP. In fact, the average cost to PCTs in the first year of the new contract was £13,000 (National Audit Office 2006). Many PCTs have employed agencies and organisations led by local GPs to do this work – in effect, many have been re-providing out-of-hours care on better terms and conditions.

Partners in a GP practice pay themselves from the profits of the practice and there are no nationally agreed pay scales. In 2006/7, the average income before tax in the UK was £103,530 for GP partners working in GMS practices and £118,499 for GP partners working in PMS practices. The pre-tax incomes of salaried GPs were much lower – £52,551 for GPs working in GMS practices and £55,459 for GPs working in PMS practices (The Information Centre 2009). However, these figures do not represent the average full-time salary of individual salaried GPs as 19 per cent of them work part-time.

Finally, the cost of the QOF scheme proved a great deal higher than had been expected. The Department of Health had estimated that GP practices would achieve an average of 75 per cent of the maximum 'points' available under QOF in its first year (National Audit Office 2008). In fact, in the first year practices achieved 91.3 per cent (rising to 96.8 per cent by 2007/8) (The Information Centre 2008b). In short, GPs delivered more than was expected and the scheme was therefore more expensive to run.

## Future developments

A number of recent policy developments are set to change further the role of general practice. These include changes in way the quality of care is monitored, regulated and published; changes in organisational models and commissioning; and changes to encourage the greater personalisation of care.

### Quality

The Department of Health has acknowledged that the quality of primary care in England is variable, stating in 2008 that 'the current system of NHS primary care does not ensure a consistent level of safety and quality across the country, with poorer areas being overrepresented among the areas with lower and even insufficient levels of quality' (Department of Health 2008g).

From 2011, all GP practices will be required to register with the Care Quality Commission (CQC) (Department of Health 2009c). Alongside this, the Department of Health has funded the Royal College of General Practitioners to develop a voluntary accreditation scheme under which practices are assessed on non-clinical aspects of care (Royal College of General Practitioners 2009).

GPs as individual professionals will also be subject to a revalidation process, which has two elements. First, from autumn of 2009 all doctors will be required by law to hold a licence (subject to renewal every five years) from the General Medical Council (GMC 2009) and there are also proposals for re-certification for doctors on the specialist or general practice registers – this will be carried out by the relevant Royal College or specialist society at least every five years.

### **Choice and information**

In 2009 the NHS Constitution enshrined the right of patients to choose their GP practice and to be accepted by that practice ‘unless there are reasonable grounds to refuse’ (Department of Health 2009d). The NHS Choices website will include information about the performance of GP surgeries, allowing patients to put comments and feedback. The website will also be developed so that patients are able to register electronically with a GP practice (Department of Health 2008e). The Department of Health is also planning to help PCTs develop ‘balanced scorecards’, which would consolidate data available, for example, from QOF and patient surveys and give a practice red, green or amber ratings (Department of Health 2008f).

### **The Quality and Outcomes Framework**

The QOF is changing in three main ways. First, responsibility for developing a menu of indicators has been given to the National Institute for Health and Clinical Excellence, partly in response to concerns that the development of QOF indicators needed to be made more transparent. The final choice of indicators will remain a matter for negotiation between the British Medical Association and NHS Employers (Department of Health 2009b). Second, the distribution of points within the QOF is changing to ensure that it focuses more on measuring outcomes, such as the health of patients, rather than processes, such as the management of the practice. Third, there are proposals for a ‘local’ QOF under which PCTs would be given flexibility to select indicators from a national list that reflect local health improvement priorities (Department of Health 2008c). These proposals have not yet been finalised.

## **Organisational models and commissioning**

### **GP-led health centres**

There are moves to encourage GPs to come together in larger centres. Lord Darzi’s review of health services for London proposed new GP centres called polyclinics, which are to house GP practices alongside other primary, community and outpatient services. They are intended to provide ‘one-stop-shop’ care for people with long-term conditions and to allow services to shift out of hospitals; the first seven polyclinics opened in April 2009 (Healthcare for London 2009).

However, an examination by The King’s Fund of the international experience of polyclinics found that the co-location of professionals does not guarantee integrated care. It also highlighted the importance of ensuring that patient continuity of care is safeguarded within a polyclinic-based system (Imison *et al* 2008). The impact of polyclinics will need to be evaluated.

In the NHS Next Stage Review, the government announced that 152 new GP-led health centres would be built across England. These centres could be used by patients regardless of where they were registered. The government also committed itself to funding more than 100 new GP surgeries in the areas of the country with the fewest GPs; £250 million was allocated to pay for both these initiatives (Department of Health 2008f).

### Practice-based commissioning

Practice-based commissioning (PBC) gives GP practices the opportunity to use funds to 'purchase' or 'redesign' services (including hospital care) for the benefit of their patients (Department of Health 2004b). This is usually undertaken by practices coming together to form local consortiums. PBC is intended to make care 'more responsive to patient needs' and to encourage investment in community-based alternatives to hospital care (Department of Health 2004b).

Progress has been slow since the PBC policy was launched in 2004 (Curry *et al* 2008) but the Department of Health has recently re-emphasised the important strategic role PBC should play in the NHS (Department of Health 2009a). Current guidance suggests that practice-based commissioners may over time evolve into new forms of organisation that both provide and commission care to meet the needs of their patients (Department of Health 2009a). The fact that PCTs have been asked to concentrate on commissioning and to separate the community services they currently provide themselves (Department of Health 2008e) also offers an opportunity for the development of more integrated primary, medical and community care provider organisations (Imison 2009).

### Long-term conditions and personalisation of care

Recent government policy is that patients with long-term conditions should receive personalised care, and this will change the role of general practice in supporting these patients. First, the primary and community care strategy recommended that patients with long-term conditions should have access to a personalised care plan by the end of 2010 (Department of Health 2008f). Second, patients in some areas and with some conditions will also be given access to a nominal personal health budget, managed on their behalf by a third party (potentially their GP) to pay for their care. And third, from autumn 2010 the Department of Health will launch a series of pilots whereby patients will be given direct payments to pay for their care, although this is subject to assent being granted to a Bill currently going through parliament (Department of Health 2008e). The role of general practice in implementing these proposed arrangements remains unclear.

### Conclusion

Recent changes in the contracts and financing of general practice mean that there are now greater incentives for quality. This, combined with increasing regulation, means that the quality of services is likely to come under still greater scrutiny. General practice will no doubt continue to fulfil its traditional function of providing a gatekeeper function to specialist care, but there will be an increase in the range of treatments offered and an expanded role in terms of commissioning local services and supporting those with long-term conditions. These demands are driving the development of new delivery models, which may transform general practice in England towards larger organisational groups and 'federations' of multidisciplinary professionals.

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