What struck us from reading the research we commissioned was the wide range of demands that are now placed on general practice, and the growing complexity of the care needed to address these demands. In future, general practice will be further required to extend the scope and range of services provided in the community or at home, and it will have to meet the needs of an ageing population where co-morbidity is the norm. The coalition government’s proposals in *Equity and Excellence* (Department of Health 2010a) will have profound implications for general practice involving:

- new relationships with patients, including as co-producers of their own care
- new responsibilities for the GP team, including wider provision of services
- new types of relationships with other practices, through provider and commissioning consortia
- new stakeholder partnerships – particularly with other local services and local authorities
- new accountabilities, with greater responsibility for meeting population-based needs.

The dual role of the general practice as both commissioner and provider of care will also bring new challenges. In future, GPs will have to take responsibility for both the costs and outcomes of care.

In this final section we reflect on the shift that is needed to make general practice fit for the 21st century.

**How does general practice need to change?**

**From solo practitioner to multi-professional team**

Almost all general practices now work as health care teams, but the skill-mix needs to continue to evolve. As well as doctors, practice nurses, practice managers and other administration staff, other health professionals will need to be increasingly based within the general practice and/or the practice network to which it is affiliated. This might include hospital specialists doing outreach, health visitors, physiotherapists, speech therapists and counsellors. The exact configuration of the practice workforce will be affected by the interfaces with the wider primary care team, including district nurses, school health teams, and other community health professionals.

As more care is transferred from hospital to community, the volume of demand on general practice will increase. To accommodate these changes, a shift in roles and responsibilities between the different members of the general practice team is needed. GPs should focus more on patients with complex problems, and work closely with their practice team where the roles of practice nurses, health care assistants and other team members will be enhanced. With the creation of a ‘team without walls’ patients should be better able to access the skills and expertise that they need. GPs should therefore work in partnership with their practice team and other professions to ensure patients receive...
a co-ordinated, seamless package of care. Such changes will have particular implications for the education of GPs and other practice-based staff, suggesting a need to develop a common curriculum in certain aspects of their training.

Valuing generalism while embracing specialist knowledge

The diversity and range of services that general practice is currently, and increasingly, expected to deliver makes it unrealistic for any individual practitioner to be able to meet all those demands. Thanks to technology, patients who previously had to be seen or treated in a hospital setting can now be treated and seen in a community or home setting. The growing complexity of general practice caseloads has precipitated the trend towards differentiation and specialisation.

GPs and general practice have been incentivised over the years to offer more specialist care within practices, and this has blurred the boundary between generalists and specialists. Among GPs, there is an ongoing philosophical debate about whether they should remain pure generalists (in other words, specialists in generalism), or whether it is appropriate for them to develop specialist expertise.

The NHS Plan (Department of Health 2000) committed to providing 1,000 GPs with a special interest (GPwSI) from among existing practitioners. These GPwSIs take referrals from fellow GPs for services that previously were usually carried out within hospital – particularly in areas such as dermatology, care for older people, epilepsy and respiratory medicine (Gregory 2009). There are moves for GPwSIs to perform some therapeutic procedures and minor surgery in primary care settings. When a practice is unable to offer these extended services, it will be able to refer a patient to another local unit or provider (Royal College of General Practitioners 2007b).

The evidence on the impact of GPwSIs is mixed. One study suggested that they had no impact on waiting times, and that costs were higher – 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 2006). However, other studies have formed a more positive view.

Rather than a strategy based around the development of GPwSIs, there is evidence to support multi-professional teams as a better means of delivering care to patients most effectively. In order to care for the range of patients now seen in general practice, GPs must have the ability to consult specialists in order to provide advice and expertise to enable a diagnosis to be made and appropriate treatment offered.

General practice will need to work with specialists in a variety of different ways. These may include commissioning sessional services from them, working in an integrated team, or differentiating activities across a pathway of care. General practice needs to include specialist support during the consultation process, during care planning, and in ongoing care, to support patients to manage their own illness. The consultant contract and the organisational incentives faced by trusts (including foundation trusts) must allow consultants to work flexibly and to collaborate with general practice to improve integration and reduce duplication and waste.

Developing shared care

The research we commissioned was consistent in showing a need for general practice to work more closely with hospital and community services in order to co-ordinate care – particularly for those with long-term conditions. Even in areas such as diagnosis of acute illness and subsequent referral, good communication with specialists and clarity
of roles are needed. For those with complex needs, including more serious mental health problems, general practice needs to see itself as the hub of a wider system of care, and must take responsibility for co-ordinating and signposting to services beyond health care – in particular, for social care, housing and benefits.

Although there are many standards and guidelines, these are not always explicit about the role of GPs and the contribution they can make to high-quality care in this area. However, we believe that there is often a role for general practice in models of shared care in which the responsibilities of different care givers are clearly defined, along with that of the patient and carer.

It is essential that general practices ensure good communication, undertake appropriate triage and referral, identify medical and social risk factors, and take appropriate action for ongoing medical management, even where they are not the lead professional. If there is no recognition of such roles and their limits, it is not possible to ensure that general practice staff have the capability and training to fulfil these roles. NICE standards must be clear about the role of different professionals (including GPs) in care pathways. Even where the main elements of care are to be delivered by other staff, there may be important roles and responsibilities – for example, to ensure communication, co-ordination and competence.

This means that achieving higher-quality care requires general practices to develop multi-specialty local clinical partnerships and a shared care model of working – as described in a recent Nuffield Trust/NHS Alliance report (Smith et al 2009). The opportunity presented by transforming community services to develop closer integration between general practice and community services has been limited by the transfer of many PCT provider arms to acute trusts.

As the evidence we presented on managing long-term conditions suggests, there is a need for closer integration between primary and community care teams (see pp 61–74). There is a risk, therefore, that these developments might undermine the potential for improvements in key areas of care. So, we recommend that a closer working relationship is forged between general practice and community services that meet the goals and aspirations of both parties while seeking to improve care to patients. Indeed, it is incumbent on general practice to establish such relationships with many other providers including consultant medical staff, community mental health teams, and midwives.

Various models have been suggested for this integration of general practice with other primary, community and outpatient services. For example, clinical networks, polyclinics and GP-led health centres have been put forward as a way of developing one-stop-shop care for people with multiple service needs (Gregory 2009).

Similarly, integrated care organisations (ICOs), in which professionals from primary, secondary and social care work together in teams that straddle traditional organisational boundaries, have also been piloted with the aim of better managing patients across the interfaces of care and developing packages of care that meet complex needs (Lewis et al 2010). In future, these ICOs may take on some shared risk for managing health care budgets with commissioners, thus enabling ‘make or buy’ decisions to be made and creating strong ties between partners in terms of meeting both the quality of care and cost-effectiveness goals.

**From gatekeeper to navigator**

The ICO model is a relevant one, since the evidence presented to the inquiry strongly suggests that higher-quality care in general practice will only arise when GPs and their teams begin to look beyond the care that takes place within surgery walls.
General practice has a vital role to play in co-ordinating the care of people with more complex needs. As GP commissioning develops, general practice will increasingly need to take more responsibility for the quality of the pathway that patients take, and for the care they receive from a variety of agencies. This may involve new roles for non-clinical staff – for example, to ensure that patients are signposted and referred to other relevant available services in order to meet their wider social needs as well as their health needs. This will require closer working with a wide range of external partners, including social and education services, the voluntary and private sector.

This is a new agenda for general practice, building on existing ways of working with a registered list of patients to act as their advocate and navigator across the system. Developing a care co-ordination capability is particularly important for people living with chronic long-term conditions or disabilities, and for those who are at the end of their lives. GPs ‘must be engaged fully in deploying their key skills of interpreting complex choices for patients’ (Royal College of Physicians 2010).

The co-ordinating role of primary health care teams, in close collaboration with other services, will play an important role in minimising any disruption to care when crossing between primary, secondary and social care, and in avoiding expensive duplication of investigations (Royal College of General Practitioners 2007b). Members of the general practice team need to facilitate timely access to the appropriate care and advice at all times, and practices will need to put in place active triage of patients to make sure appropriate use is made of available staff and services.

A new deal with patients

In taking on the care co-ordination function, there is also a need for a new dialogue between general practice and patients, to ensure that those patients who want to can become more active participants in decisions about the care and services they receive. Patients need to be able to take greater control (and with it, responsibility) over decisions about their care and for their health. This means clinicians actively supporting shared decision-making, self-care and self-management where patients so desire.

Armed with information about their health and care through access to their personal health records, patients can begin to take greater responsibility for their health and can start to shape the services they need. Shared decision-making requires clinicians to be more open about the risks, benefits and uncertainties associated with the available options. Practices need to make greater use of patient decision support in order to ensure that their patients understand the options and trade-offs they face, and to elicit patients’ preferences more systematically.

General practice also needs to develop a renewed dialogue with patients in order to empower patients to become fully engaged in managing their own care. Providing information to patients can effectively help patients to manage their own care or prevent deterioration in illness, but general practice needs to become more proactive in providing or signposting patients to receive support in caring for themselves – for example, through remote monitoring of their condition or joining an education or peer support group. Structured support for carers is also important in this regard, and general practices should be tasked with ensuring that carers are also offered access to education and support.

From treating illness to promoting health

General practice is regarded as uniquely well placed not just to provide medical care, but also to promote the health and well-being of the practice population (Boyce et al
2010b), and to address health inequalities (Hutt and Gilmour 2010). However, there has been little success in drawing GPs ‘beyond the surgery door’, and GPs still concentrate on what are essentially clinical activities (Gillam et al 2001; Gillam 1992). Generally, GPs focus their prevention-related actions on patients at high risk rather than taking a whole-population approach or maximising opportunities for health promotion advice to all patients who might benefit.

There is support within the profession for general practice to play a stronger role in health promotion, as argued by the Royal College of General Practitioners (2007b):

*Practices are at the heart of their communities and could play a key role, with appropriate development and support, in tackling many aspects of the public health agenda … Methods should be found to deliver the public health agenda within new models of care.*

The ageing population and rising prevalence of obesity and other risk factors makes a focus on prevention an imperative for general practice. In future, this is likely to mean working more closely with local authorities.

The development of health and wellbeing boards provides an opportunity for general practices and GP commissioning consortia to engage more proactively with local authorities in addressing inequalities and the wider determinants of ill health. This will require practices to consider the needs of the population beyond those on their registered lists.

A significant amount of work is also required for data and information flows to be realigned, so that GP consortia and local authorities can effectively share data. While GP commissioning consortia will have a statutory duty of partnership with health and wellbeing boards, the legislation contained within the 2011 Health Bill to promote joint working more formally is weak. The evidence from our inquiry suggests that there is a great need for general practice to play a proactive public health role, but there is a significant risk that it may not do so.

**Individual and population health**

General practice is uniquely placed to take responsibility for population health and for addressing inequalities in the quality of care provided to a population, through its registered list and community-based focus. High-quality care is not only about meeting the needs of the individuals who present themselves – it is also about reaching out to meet the needs of people who need care but may not seek it actively from general practice. As GP-led commissioning consortia take on their new responsibilities, they will have to contribute to the health of the population they serve, working closely with local authorities.

The performance of general practices, as providers and commissioners of care, should not only be assessed in terms of whether individuals can access high-quality services. It also needs to be judged on the extent to which it meets the health needs of the wider population, including people experiencing homelessness, veterans, refugees and asylum seekers, people with mental health problems, and those with drug and alcohol problems, who may not actively seek care from general practice.

Practices will also need sufficient incentives to actively seek to register vulnerable and itinerant people, and to provide primary medical services. This may involve commissioning services from general practice – something that in future will be the prerogative of the NHS Commissioning Board. It is also expected that consortia will be responsible for commissioning services for patients who are not registered with a practice.
The government (and, depending on their powers, the commissioning board or local authorities) will need to ensure that the responsibility for commissioning high-quality care for these groups does not fall between consortia.

The role of general practice in GP commissioning, as outlined in the coalition’s plans, rightly emphasises the importance of working in partnership to deal with the wider issues of public health and health inequalities. As such, it might enable the more population-focused approach that the inquiry’s work suggests is necessary to improve quality.

Yet the size and structure of GP consortia will not be determined nationally. It is likely that at least some of the consortia will not be co-terminous with local authorities, limiting the potential for joint working – particularly between health and social services for children and older people and those with mental health problems, learning disabilities or dual diagnosis. It is likely for some groups this will involve commissioning jointly with other bodies, such as local authorities. More thought needs to be given to how consortia will collaborate to commission services that cannot be effectively commissioned by individual consortia. Allowing this to happen organically may not be sufficient.

**From cottage industry to post-industrial care**

The required modernisation agenda for general practice has been described in the United States as ‘the transformation from cottage industry to postindustrial care’. This is because it combines three key elements – standardising care, measuring performance, and transparent reporting – and eliminates ‘unwarranted clinical variation, waste, and defects’ (Swensen et al 2010).

Under this prescription, the ‘good doctor’ of today ‘must have a solid fund of knowledge and sound decision-making skills but also must be emotionally intelligent, a team player, able to obtain information from colleagues and technological sources, embrace quality improvement as well as public reporting, and reliably deliver evidence-based care, using scientifically informed guidelines in a personal, compassionate, patient-centered manner’ (Swensen et al 2010).

In England also, doctors are talking in terms of primary care starting ‘to look more “industrial” both in scale and remit’ (Royal College of Physicians 2010).

Although there is growing interest in establishing federations and larger practice organisations, the dominant model remains one of small, independently contracted businesses. While there has been significant capital investment in new GP-led health centres, there are still parts of the country where general practice is operating out of premises that are not fit for purpose. At its heart, general practice in much of England remains a cottage industry, and we believe that this must change radically.

There needs to be much greater collaboration between practices in order to support the delivery of high-quality care. This is not about sweeping away small practices, but it does recognise the benefits that come from being part of larger organisations or networks. The advent of GP-led commissioning will make this a necessity.

We believe there is an urgent need to accelerate the work to establish federations and bring isolated practices into more formal accountability structures, as part of larger provider organisations. Such federations provide the building block for the development of a diverse primary health care team derived from a variety of organisations and providers. Nevertheless, there are aspects of small practices that patients value, and this factor needs to be balanced against the need for the support and challenge of peers and other organisational aspects that are better delivered for larger numbers of patients. So, while isolated practices are likely to find it difficult to deliver high-quality care, we believe...
it is possible to balance the benefits of small practices with the benefits of being part of a larger organisation.

We also recognise that it is harder for practices to deliver high-quality care from sub-standard premises. There has been considerable investment in polyclinics and GP-led health centres in recent years. However, we do not believe that further investment should be made in facilities in primary care until it is clear that existing premises and community-owned infrastructure are being fully utilised. The focus must not simply be on creating bigger and better facilities, although if these facilitate multi-professional working, and enable patients to access a range of services under one roof, these can contribute to higher-quality care (Imison et al 2008).

The future model of general practice

General practice has come a long way in the past 62 years since the establishment of the NHS. We believe that if it is to rise to the challenges of the 21st century, and deliver the highest levels of quality that patients and the public expect, it must continue to evolve.

We believe that the change agenda outlined above means that general practice will be able to deliver high-quality, cost-effective care only by operating on a more industrial scale that makes full use of data and information to drive continuous quality improvements. To achieve this, the future model for general practice must address the fact that many general practices continue to be isolated in the system – both in terms of their relationships with other practices and, more fundamentally, with the care and services that other health and social care organisations currently provide.

To achieve such a future, an underpinning characteristic must be for general practices to work in larger groupings of providers, through polyclinics, federations of practices and/or provider networks. There has already been considerable movement and thinking in this direction. For example, the shift of care from hospital to community-based services requires the creation of a network of new facilities and organisational arrangements to support it.

Much of the drive behind these changes has come from general practice itself. The RCGP has championed the need for federated models of working, and even established a toolkit to encourage general practices to adopt the model (Imison et al 2010; Royal College of General Practitioners 2008). This toolkit sets out a vision in which general practices and primary care teams work together to share responsibility for developing high-quality services for their local communities, enabling them to offer more and better care than is possible in smaller independent units.

By acting collectively, and sharing data on comparative performance, general practices are more motivated to drive each other to improve performance. We strongly support the need for general practice to evolve in this way, and to establish better-networked and grouped practices. This is a priority for the way general practice needs to evolve.

We also feel that there is considerable scope for general practice to begin to consider how to work with other care providers to build up new associations and models of working – especially for patients such as those with long-term conditions, whose care requires a complex mix of support from a range of agencies. These new approaches might give rise to multi-specialty partnerships that incorporate a range of outpatient consultants, community nurses and other professionals (Smith et al 2009).

Another alternative would be to create integrated care organisations in which the activities of general practice are more formally integrated with those provided in the
hospital sector – an approach currently being piloted and/or developed in several locations across England with some success (Lewis et al 2010; Ham 2009).

It is unlikely that there will be one single, correct model into which all general practices will evolve. This is appropriate, given the need for practices to reflect and respond to the specific health needs of the local communities they serve. It is also clear that general practice, and the registered list system, provide the essential building blocks on which such a future should be based.

However, the road towards more integrated primary care will take time and careful steering. Stronger incentives are needed to support general practice to work in collaboration with other providers – not only to improve health, but to rise to the challenge of providing better value and more efficiency in the current context of growing demand in a period of financial austerity. GP commissioning presents general practice with an unprecedented opportunity to meet these challenges and to drive innovation.

Conclusions

The future of general practice is likely to herald the emergence of a radically different way of working. The skill-mix in general practice will become more complex, and practices will work across the federations of practices in which they operate and the GP commissioning consortia of which they are members. These changes will not only see a growing role for nurse practitioners; they will also facilitate a much wider range of professionals working alongside GPs. The basic unit of activity will no longer be a face-to-face consultation with a doctor but the provision of a co-ordinated and multi-disciplinary service that proactively supports patients in managing their own health. Within this vision, the core values of generalism, and the provision of patient and family-centred care, remain as important as ever.

Finally, general practice will need to build much stronger alliances and relationships with individuals and organisations – not only within the NHS but beyond. As commissioners of care with responsibilities for populations, general practice will need to work closely with local authorities, the voluntary sector and the private sector. These are not easy transitions to make, and those leading practice organisations and consortia in the future will have to set out this vision clearly and lead change from the front.

Key points

- Generalism lies at the heart of the future of the NHS, and the system needs to value this. Instead of general practitioners developing more specialist knowledge, general practice needs to make available specialist support during the consultation process, during care planning, and in ongoing care to support patients to manage their own illness.

- General practice needs to see itself at the hub of a wider system of care, and must take responsibility for co-ordination and signposting to services beyond health care – in particular, social care, housing and benefits.

- General practice needs to move from being the gatekeeper for specialist care to being the navigator that helps steer patients to the most appropriate care and support.

- Delivering high-quality care requires effective teamworking within general practice. The skill-mix in general practice will need to evolve, to include a wider range of professionals working within and alongside it. The GP should no longer be expected to operate as the sole reactive care giver, but should be empowered to take on a more expert advisory role, working closely with other professionals.
Delivering high-quality care also requires new models of shared care to be developed with other care providers, including those working in the community, in hospitals, and in care and well-being services. Multi-specialty local clinical partnerships need to develop that integrate services across boundaries. Such models of care will need to articulate the roles and responsibilities of general practice clearly to ensure that care for patients is well co-ordinated.

As referrers – and, in future, as commissioners of care – general practice will have a responsibility to ensure that the services to which they refer patients provide high-quality care (as well as care that gives value for money).

These new responsibilities will require general practice to work with their partners within GP commissioning consortia, local authorities and wider public services to improve the health of the population and to reduce health inequalities. General practice needs to be far more proactive in preventing ill health and taking a population-based approach to care.

In the transition of commissioning from PCTs to GP consortia, the Department of Health and the NHS Information Centre must ensure that information flows, and indicators derived from them, are appropriately and speedily realigned to consortia boundaries.

General practice needs to strike a new deal with patients, in which patients are active participants in decisions about their care and the services they receive. This is important since effective engagement with patients is intrinsic to quality improvement.

Overall, general practice needs to deliver ‘post-industrial’ care in which measuring performance, improving care standards, and transparent reporting are key features of the way care is provided. To achieve this, general practice will need to operate at a scale commensurate with the demands placed upon it.

There is an urgent need to accelerate the work to establish federations, and to bring isolated practices more formally into larger provider organisations or networks. The advent of GP commissioning will make this a necessity.
General practice has played a vital role at the heart of the health care system in England, and with the introduction of GP commissioning this role is set to become even more critical. Indeed, the current NHS reform agenda has far-reaching consequences for general practice. While we believe that GP commissioning has the potential to provide a new platform through which improvements in the quality of care in general practice can be driven, there are a number of tensions to the current reform agenda that will impact on whether this will be the case.

- New integrated models of care are needed for patients with complex and long-term care needs. These can be best delivered when generalists and specialists work closely together. The focus on patient choice of, and competition between, general practices may act as a stimulating environment for quality improvement. However, unless a system of incentives is created where competition can act as a spur for improvement and integration, the ability of general practice to forge new partnerships with other care providers may be undermined.

- The creation of health and wellbeing boards provides a revitalised opportunity for the NHS and local authorities to work in partnership to promote health and address ill health and inequality. However, current legislation is weak, and there is a significant risk that the opportunity for effective joint working to address health inequalities and local public health needs will be lost.

- GP commissioning could provide a new platform through which improvements in the quality of care in general practice can be driven. However, there is a danger that consortia may not actively involve other professionals thus limiting the potential benefits of a multi-professional approach to quality improvement.

- Peer review of performance needs to be accompanied by the ability to challenge practices when quality of care falls below an acceptable standard. There is a risk that the membership arrangements and governance of GP commissioning consortia will allow practices to protect their members’ interests, rather than seeking to challenge and improve quality. The accreditation process must be strong enough to ensure that robust governance systems are in place to promote internal performance management.

- Measures to assess performance, both nationally and locally, need to be aligned so that they promote integrated care between practices, and between practices and other providers. For example, there is a case to be made for GP commissioning consortia and local authorities to share responsibilities for public health outcome indicators.

- General practice and GP consortia must have the requisite information to support their responsibilities as both commissioners and providers. Since many GP consortia will not have coterminous boundaries with local authorities it will limit the routine production of meaningful statistics on populations and make it difficult for them to engage in joint strategic needs assessments.
The current preoccupation with outcome measures as the only relevant criteria on which to judge quality may result in some important aspects of quality being overlooked. Examples include continuity of care, care co-ordination and patient engagement.

The inquiry

This inquiry has set out to:

- describe what constitutes high-quality care in general practice
- assess the current state of quality of care
- make recommendations about how quality could be improved and what changes might be needed to the way general practice is organised.

We have demonstrated how general practice has evolved over time in response to the changing social and political context in which it operates. The inquiry reports at a time of significant reform to the NHS which will require general practice to play a central role in its future, but also to develop new skills and take on new responsibilities. Therefore, in our analysis of quality of care in general practice, we have sought to set our findings and recommendations in this wider context and consider the future relationship of general practice with the wider health system.

Measuring quality

We were clear from the outset that we were interested in quality in its broadest sense – not just as narrowly defined by professionals. We firmly believe that the perspective of patients needs to be strengthened. GPs need to do more to put patients at the heart of what they do: they need to involve, listen and respond to them. So, a new deal with patients is required. However, it is also clear to us that patients’ views and their choices are not sufficient to drive quality and drive out poor performance. Peer scrutiny and challenge are also vital.

We are also clear that the reason for measuring quality, first and foremost, must be to drive quality improvement among those closest to patients. So, our focus has been on the value of measurement for the purposes of improvement, and not for the specific purpose of external judgement, scrutiny and performance management. QOF has helped deliver improvement but has been narrowly focused on secondary prevention and the recording of clinical activities. There needs to be stronger focus on quality across all aspects of general practice.

The inquiry identified a wide array of initiatives to measure quality that could be used for the purposes of quality improvement, but concluded that these were poorly co-ordinated, overlapped in some areas, and left other areas (that were important to high-quality care) unmeasured. Available measures undervalue some of the harder-to-measure aspects of care. Many of the current approaches to measurement have been criticised for reducing general practice to a series of boxes to be ticked. Evidence was presented to suggest that aspects of the quality of care are often not as good as they should be because the focus is diverted to those aspects of care which are measured and rewarded.

We believe that if general practice is to focus on improving quality, it must be able to demonstrate it is doing things differently and better. It is no longer acceptable for professionals simply to claim there is no way of assessing what they do and that they should be trusted with the task. Greater transparency is a necessary prerequisite to a culture of improvement and to maintain public trust.
Balancing trust with control

Perhaps the greatest challenge then is for policy-makers and those working in and with general practice to find the equilibrium between trust and control (O’Neill 2003). Trust-based systems also need to be accountable. Measuring and reporting on performance and improvements in care is therefore a professional responsibility. In recent years there has been a tendency in the NHS to give greater emphasis to external control and performance management. We believe that this may erode an important part of the very professionalism that enables quality improvement initiatives to flourish. The values and professional ethos within general practice is strong. These need to be harnessed in order to address the quality challenges that we have identified, but must be accompanied by a new deal with patients to ensure their trust in general practice is deserved. General practice must listen to and involve patients actively to nurture trust and deliver quality from the patients’ perspective.

We therefore believe that quality improvement needs to balance and combine external scrutiny and regulation with locally driven, peer-led and user-centred approaches. The key to achieving this balance is transparency. Reporting on quality – to patients, between peers, to other care partners, and to commissioners and regulators – helps to create a ‘virtuous circle’ of quality improvement.

Developing sophisticated indicators of quality

General practice is often seen to be as much art as science, but we are strongly of the view that this should not be an excuse for not measuring those aspects of care valued by patients such as continuity of care and the quality of the therapeutic relationship.

We set out to try to identify some new measures suggested by our research teams, and investigated the potential for developing these into indicators of quality. This was a difficult task, and one we were unable to complete. However, we have suggested some ways that practices could begin to audit their own practice in these areas, and made recommendations about how the work we have begun could be used as the basis for future development of quality indicators in general practice. While some of these are harder to define we think that many of these aspects of care can be captured by measuring how patients experience care.

Analysing variations

General practice needs to be challenged to ensure that it delivers its core functions to the highest standards, in the most efficient way. The data we examined was by no means comprehensive, but it became clear that there were gaps in the quality of care and wide variations in the quality of care received by patients. We concluded that more sophisticated analyses are needed in order to explore whether observed variations in the organisation and delivery of care between GP practices can be justified on clinical grounds.

However, we did find evidence for significant variation in the provision of care to patients where clinical best-practice guidance would recommend a specific course of action – for example, in prescribing low-cost statins and in providing patients with all the recommended care in the management of their long-term conditions.

The evidence presented to the inquiry also suggested that more could be done to improve quality through the use of practice audits (for example, in assessing and improving the quality of diagnosis or examining the clinical necessity of referrals) and in responding to
patient experiences and preferences (for example, in terms of access to care, continuity of care and patient engagement).

The evidence also supported the need for general practice to engage more directly with other care providers in order to improve quality. Better standards of care would be gained from a focus on developing forms of integrated, co-ordinated and shared care between general practices and other care providers. This was particularly true for people who present in general practice with complex symptoms, and for co-ordinating care for people with long-term chronic and mental illness. Joint working would also help to prevent emergency admissions for conditions that could be managed in primary and community care settings.

In areas of care where there are specialists who take a lead role (for example, in maternity care) the role and responsibilities of general practice and GPs need to be clearly defined, so that aspects of care do not fall through the gaps. Excellent communication and shared objectives are key to achieving this. In other areas of care, such as end-of-life care, where patients require services from a range of care providers, general practice has an increasingly important role to enable patients to navigate the system, in order to ensure that their care is co-ordinated along the clinical pathway and between organisations.

Celebrating good practice and addressing failure

It has become clear through the course of the inquiry that quality improvement needs to be supported by an organisational context in which data and IT facilitate an understanding of how well a practice and individuals working within it are doing relative to their peers. It is important that good practice is shared and celebrated, while poor performance is identified and support given to improve. Where standards continually fail to be met, appropriate sanctions must be applied.

Greater transparency and peer challenge will be vital to ensure that those practitioners who consistently fail to deliver acceptable standards of care are dealt with swiftly but fairly. Finally, general practice needs to operate within a system of incentives and regulation that supports quality improvement, and where competition can act as a spur for improvement rather than as a barrier to innovation.

Despite some major changes in the scope of services provided in general practice, the size of practices, the profile of the workforce, and the contracts under which general practice operates, general practice is largely made up of small, independently contracted businesses. This model of practice needs to change. The modern GP should be working as part of a multi-disciplinary practice, in larger federations of practices, and engaging more effectively with other public services to co-ordinate care.

General practice needs to embrace technology in a way that allows it to match the experience of patients when they consume other services. Practices will also be taking on new responsibilities as commissioners of care under the coalition government’s health reforms. This means that GPs will need to see beyond the patient in front of them and reach out to the whole of their local population, including those who are vulnerable and unregistered. These responsibilities, and the requirements of implementing GP commissioning, must go hand in hand with a renewed emphasis on improving the quality of care in general practice.

This is a challenging agenda, and will need action on many levels in order to ensure that general practice in England maintains its international reputation for excellence and enjoys its position at the heart of the NHS in future. We hope this report inspires you to take action to ensure that general practice succeeds in its quest for quality.
Key points

- General practice has evolved significantly from its origins. Many practices have been at the vanguard of innovation and quality improvement. However, if general practice is to meet its new responsibilities and maintain its international reputation for excellence, it needs to adapt significantly.

- The transition will not be easy. Those leading practice organisations and GP consortia have the opportunity to build on the strong values and professional ethos to be found in general practice.

- General practice will need to have a relentless focus on improving quality of care to patients, supported by the proactive use of data and information to do so.

- Quality improvement needs to balance and combine external scrutiny and regulation with locally driven, peer-led and user-centred approaches. The key to achieving this balance is transparency. Reporting on quality – to patients, between peers, to other care partners, and to commissioners and regulators – can help create a ‘virtuous circle’ of quality improvement.

- GP commissioning could provide a new platform through which improvements in the quality of care in general practice can be driven.


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