
2 The evolving role and nature of general practice in England

This chapter examines the inquiry's interpretation of the nature and role of general practice in England and how this has evolved over time. It examines the history of general practice, the core values that underpin it, the scope of the services it provides, and the way that it is funded and organised. It examines how general practice has had to adapt continually to the changing social and political context in which it operates, including the new skills and responsibilities that will be required as GPs and general practice play a central role in the reformed NHS.

The history of general practice

We understand 'general practice' to be at the core of the primary care team that involves GPs, nurses and other practice-based staff. However, while there are many definitions of primary care, there is no clear definition of general practice.

When the NHS was formed in 1948, general practice became responsible for all personal medical care, and became the gateway for individuals to access hospitals, specialist care and sickness benefit. However, even in those early years, the lack of explicit standards for general practice, few incentives for medical professionals to take on the GP role, and a rapidly growing demand for services were recognised as challenges (Collings 1950).

Since that time, the professional status of GPs has increased, with clearer professional standards, formal postgraduate training, and greater financial incentives to work as a GP. General practice has evolved considerably in terms of the scope and nature of the services provided, the workforce, and how it is funded, as described in the box below.

The evolution of general practice: historical timeline

1948 – The NHS is formed

- With the formation of the NHS, GPs took on responsibility for covering the entire population and controlling access to specialist care – a major expansion in their role. Within one month, 90 per cent of the population had registered with a GP.
- GPs chose to remain outside the NHS as independent contractors rather than salaried NHS employees.

1950s – A troubled start

- The Collings report – the first major report on quality in general practice – found poor standards of care, bad working conditions and isolation from other professionals. Many GPs worked under considerable pressure, with limited support.
- Most GPs worked in single-handed practices or with one partner. The NHS Act (1948) had intended that, over time, GPs would be re-housed within health centres, but this proved unaffordable.

1960s – Contractual improvements

- In 1966 a new contract improved pay and conditions for GPs, instituting a maximum list size of 2,000 patients and providing resources for professional education, improvement of premises and hiring of support staff.
- The following years saw improvements in terms of recruitment and facilities and an increasing trend for group practice to become the norm.

1970s – Professionalisation

- The creation of the Royal College of General Practitioners, in 1972, gave GPs an official representative body for the first time.
- After years of concern about the adequacy of GP training, from 1976 three-year postgraduate training programmes became mandatory.
- With the Alma Ata declaration on primary health care in 1978, prevention and health promotion became seen as an increasingly central part of the GP's professional role.

1980s – Increased scrutiny

- The Royal College of General Practitioners (RCGP) Quality Initiative was launched in response to evidence of large variation in clinical practice, and in line with a wider political trend to subject public services to greater scrutiny.
- Early attempts to measure quality in primary care and provide incentives for improvement proved controversial, and generated professional resistance.

1990s – Evolving roles, new contracts

- The trends towards increased scrutiny and evidence-based medicine were consolidated in the 1990 GP contract, which launched an era of greater external management for general practice and introduced elements of performance-related pay.
- GP fundholding allowed GPs to take on responsibilities for commissioning services on their patients' behalf, creating an incentive for GPs to become more involved with the wider health system.

2000s – Quality, commissioning, competition and choice

- The 2004 GP contract represented a new relationship between GPs and the NHS, putting an increased emphasis on performance-related pay, as measured by the QOF.
- The Darzi review (Department of Health 2008c) encouraged the use of quality indicators at all levels in the health system, including general practice.
- Stronger regulatory and governance mechanisms were introduced for primary care, with annual appraisals for GPs from 2002 onwards; a requirement to register with the Care Quality Commission by 2011; and moves towards a mandatory revalidation process.
- GPs' involvement in commissioning continued through practice-based commissioning, introduced in 2006, and GP commissioning, introduced in pilot form in 2010.

- In 2007, the RCGP published the first national training curriculum for general practice. Successful completion of the assessment for membership of the RCGP (MRCGP) has since been compulsory for doctors undertaking the specialty training in general practice.
- Competition in primary care was encouraged through enabling patient choice of general practice, scrapping practice boundaries, and introducing independent-sector competition through ‘any willing provider’ contracts.
- The shape of primary care provision also underwent significant change, with expanded roles for nurses and other practice staff, increased use of information technology, and the growth of a range of alternative access points.

A commitment to generalism

Despite all the changes that have taken place within the system, general practice retains a core commitment to generalism that is manifest in two key concepts: patient centredness and holism. We now go on to explore these.

Patient centredness means that the individual patient’s priorities must be identified and respected in order to reach an appropriate clinical decision – a process facilitated through the development of good doctor–patient relationships over time (Howie *et al* 2004). It also means organising services for patients based on their needs, not on provider convenience. The document *Good Medical Practice* identifies the following as key to a partnership between the patient and doctor:

- be polite, considerate and honest
- treat patients with dignity
- treat each patient as an individual
- respect patients’ privacy and right to confidentiality
- support patients in caring for themselves to improve and maintain their health
- encourage patients who have knowledge about their condition to use this when they are making decisions about their care (General Medical Council 2006).

A related concept is family centredness – the need to explore the illness and needs of a patient so that the care that is provided is culturally responsive, flexible and relevant to each individual in the context of their family. Advocates of family practice suggest a model in which the generalist plays a key role in helping to support families to function effectively. This is regarded as particularly important in the care of children, adolescents and pregnant women and at end of life – and yet seems to be lacking, according to research commissioned by the inquiry (Addicott 2010; Smith *et al* 2010).

The second core value of general practice is that of holism. Holism represents a method of care where the decisions made on the diagnosis and management of a patient should reflect the entirety of a person’s needs – it is also termed ‘the biopsychosocial approach’. It is more than providing a service that addresses multiple health issues.

General practice lies at the heart of care delivery in the English NHS. Yet it has not always been confident about its own future and the role of generalists in an ever-increasing specialised medical system, to the extent that at one point the profession even asked: ‘Do we have a future, or are we an unwanted anachronism?’ (Royal College of General Practitioners 2004).

The scope of general practice

GPs will be familiar with the description of the skills and competencies they need in *Being a General Practitioner* (Royal College of General Practitioners 2007a). *Good Medical Practice* (General Medical Council 2006) also provides more general guidance for all doctors about what is expected of them. Despite these descriptions of what a general practitioner is expected to do, the scope of the services provided in general practice is less clear cut.

For most people, general practice is the first and most commonly used point of access to health care in England (*see* the box opposite). Since 2004, patients have been registered with a practice, rather than with an individual. So, the patient of today increasingly has a relationship with a general practice team rather than with 'their own' GP. First contact with a care professional may be provided in a range of ways, including (Jones *et al* 2010):

- GP consultations
- nurse practitioner triage
- practice nurse and health visitor consultations
- telephone consultations with the 'duty' doctor
- deputising services that provide out-of-hours care.

The consultation with a GP remains at the core of general practice. The purpose of the consultation may be to manage a pre-existing condition or to make an effective diagnosis of a presenting problem. The consultation may involve the practitioner giving advice and information, prescribing medication, treating the patient, or referring them to a specialist or another service. Over the years, practice activities have expanded, and today services include:

- screening and immunisation
- health promotion
- active disease management programmes
- responsibility for a number of services previously provided in hospital and community settings.

General practice provision

General practice is heterogeneous, ranging from 'traditional', single-handed practitioners to large, multi-partner practices employing a variety of clinical staff. However, as the box opposite shows, there is a distinct trend to larger practices, while the pattern of availability of general practice continues to reflect the inverse care law – that is, the availability of medical care tends to vary inversely with the need of the population served (Tudor-Hart 1971). For example, the number of GPs in areas with the greatest health needs has increased in recent years, but GP levels – weighted for age and need – are still lower in deprived areas (National Audit Office 2010). Policy-makers have looked to develop new models of care that enable more accessible integrated services – particularly in areas where single-handed GPs struggle to provide the full range of services now expected to be delivered in the community (Imison *et al* 2008).

Many general practices have established specialist clinics within their own practices run by GPs with a special clinical interest (for example, in dermatology) (Salisbury *et al* 2005), while others have worked with hospital specialists to establish innovative services in the community. The services provided in general practice settings have grown considerably over the years, branching out into providing a range of new care options for patients, such as public health advice, well-being services, minor surgery, specialist clinics and so on.

General practice: key facts and figures

- In 2009, there were 32,111 full-time equivalent (FTE) GPs and 72,153 FTE practice staff working in general practice in England across 8,228 practices (not including GP registrars or GP retainers).
- In 2008 there were 300 million general practice consultations, 62 per cent of which were undertaken by GPs.
- GPs made 9.3 million referrals to secondary care, suggesting that around one in 20 GP consultations results in a referral to secondary care. That means 19 out of 20 GP consultations, plus consultations with other general practice staff, were resolved within general practice by health professionals with generalist skills.
- There is a varied distribution of GPs across England, ranging by primary care trust (PCT) from less than 50 to more than 80 per 100,000 population.
- Overall, the number of single-handed GP practitioners is falling: down 35 per cent from 1,949 in 2004 to 1,266 in 2009.
- The number of FTE GPs increased by 21 per cent in the 10 years to 2009, and the number of practices decreased over the same period by 9 per cent.
- The number of FTE practice nurses increased by 37 per cent between 1999 and 2006, peaking at 14,616, but between 2006 and 2009 dropped 7 per cent to 13,582.
- The proportion of female GPs rose from 30.6 per cent to 43.7 per cent of the whole GP workforce between 1999 and 2009 (not including GP registrars or GP retainers).
- Between 1995 and 2008 the proportion of general practice consultations undertaken by nurses increased from 21 per cent to 35 per cent.
- The number of salaried GPs employed in practices has risen significantly: from 786 in 1999 to 7,310 in 2009.
- In 2009, 55.3 per cent of GP practices held General Medical Services (GMS) contracts (covering 4,554 practices), equating to 50.2 per cent of the total GP contract count (not including GP registrars or GP retainers).
- 41.3 per cent of practices in 2009 held purely Personal Medical Services (PMS) contracts – equating to 45.1 per cent of the total GP contract count (not including GP registrars or GP retainers).
- Between 2002/3 and 2006/7, expenditure on GP services grew from £4.9 billion (7.5 per cent of total NHS expenditure) to £7.9 billion (7.9 per cent).

Sources: Boyle *et al* (2010); Foot *et al* (2010); Hippisley-Cox and Vinogradova (2009); National Audit Office (2008); Information Centre (2008, 2010).

Polyclinics, where general practices co-locate alongside specialists and a range of other services, have been held up as one such model. There is also an increasing number of GP federations, whereby a number of practices join together but maintain practices in separate locations. The RCGP has developed a toolkit to support the development of these new organisations (Imison *et al* 2010). In localities such as NHS Redbridge, the concept has been further advanced as a polysystem, designed to have a polyclinic at the heart of a network of health care professionals such as GPs, pharmacists, opticians and community services.

Workforce

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 needed to avoid ‘a significant medium-term risk of GP shortages’ (NHS Workforce Review Team 2008). The same report identified a bulge in the number of overseas-qualified GPs aged between 55 and 65, who are expected to retire over the next five-to-ten years. This ‘bulge’ represents 16 per cent of GPs. In addition, it found that ‘the practice nurse population is ageing and capacity of the system to fast track newly qualified nurses into primary care is only growing slowly’ (NHS Workforce Review Team 2008). The NHS Next Stage Review recommended that at least half of all doctors should train as GPs to meet the increased demand (Department of Health 2008a).

The working patterns of GPs themselves have also evolved. Partnership opportunities are increasingly scarce, and around one-third of care is now delivered by sessional GPs (locums, salaried and retainer GPs). The number of salaried GPs employed in practices has risen significantly: from 786 in 1999 to 7,310 in 2009 (Information Centre 2010). Meanwhile, the influx of women into the GP workforce has brought increasing requirements for flexible working and part-time working (Royal College of General Practitioners 2007b). It is forecast that by 2013 women will form a majority of practising GPs (Royal College of Physicians 2010a).

The wider practice team

Practice teams are becoming larger, with care being provided and managed by an increasingly multi-professional team that may include GPs, nurses, physician’s assistants, health care assistants, practice managers and receptionists. This broader skill-mix has enabled GPs to relinquish many routine and non-clinical tasks. Nurses have already assumed a range of responsibilities that would previously have been undertaken by GPs. The number of FTE practice nurses increased by 37 per cent between 1999 and 2006, peaking at 14,616, although it then fell back 7 per cent between 2006 and 2009 to 13,582 (Information Centre 2010). Between 1995 and 2008 the proportion of general practice consultations undertaken by nurses increased from 21 per cent to 35 per cent (Hippisley-Cox and Vinogradova 2009).

Physician’s assistants are a more recent addition to the general practice team. They work under the direct supervision of a doctor, and are trained to perform a number of clinical roles in the diagnosis and management of patients. Health care assistants are able to carry out routine procedures and care management tasks, thereby freeing up the skilled health professionals for more complex activities.

This sharing of the workload does not, as yet, seem to have reduced the demand for GP appointments, as the GP consultation rate rose slightly from 3.0 to 3.4 per patient year between 1995 and 2008 (Hippisley-Cox and Vinogradova 2009). However, if general practice is to meet the workforce and quality challenges of the future, GPs will need increasingly to focus their time on ‘intuitive’ medicine and complicated cases while nurses take over more of the rules-based care – especially in the realm of managing patients with long-term conditions. The trend of shifting routine and organisational tasks to non-clinical staff will similarly be a necessary part of meeting the efficiency agenda.

Contracts

Before 2004, most GPs in England were employed under a nationally negotiated General Medical Services (GMS) contract, through which GPs were contracted as individuals and received payment for each piece of work according to their number of registered

patients. In April 2004, a new GMS contract was introduced that was held by the practice rather than the GP. The contract provides a 'global sum' based on a needs-adjusted capitation. The average payment is £63.21 per patient per annum (Department of Health 2010b). Additional funding is available for the provision of 'enhanced services' – for example, extended opening hours, minor injuries services and other services designed in negotiation with the PCT.

The 2004 contract also introduced the QOF, to reward practices for providing high-quality care. QOF payments accounted for around one-third of average practice earnings in 2004/5 (National Audit Office 2008). Although the scheme is voluntary, 99.8 per cent of practices in the United Kingdom participate (Lester and Majeed 2008). QOF payments account for around 15 per cent of expenditure by PCTs on GP services in England (National Audit Office 2008). At its launch, the Department of Health estimated that in the first year of the QOF, GP practices would achieve an average of 75 per cent of the maximum points available (National Audit Office 2008). In fact, practices achieved 91.3 per cent, rising to 96.8 per cent by 2007/8 (Gregory 2009).

The other main contract is the Personal Medical Services (PMS) contract, which since 1998 has allowed GPs and other NHS staff to enter into locally negotiated contracts with PCTs. These contracts enable providers to develop services outside the scope of GMS to meet the specific needs of the local population. The provider need not be a traditional GP partner-led practice: NHS trusts, PCTs and other health care professionals, including nurses and dentists, can also be contracted. PMS providers are paid a fixed annual rate to provide services negotiated with their PCT.

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.

Another contract – the Alternative Provider Medical Services (APMS) contract – enables PCTs to commission primary care from commercial or voluntary providers, or from foundation trusts. The opening of the market to alternative providers was intended to plug gaps in provision in under-doctored areas and to provide a greater choice of primary care provider to patients (Department of Health 2004).

The number of private organisations set to deliver general practice care under APMS ranges from multinational corporations, such as United Healthcare, to companies run by groups of GPs, such as ChilversMcCrae Healthcare and IntraHealth. Other NHS primary care services that are provided by private companies include walk-in centres, mobile screening units, occupational therapy and health visitors. However, use of APMS remains limited, and very few APMS contracts have been awarded to providers that are not already part of the NHS (Ellins *et al* 2009).

The changing social context

The changes that are taking place within general practice run alongside, and are linked with, changes within society as a whole. These include:

- demographic pressures
- funding pressures
- patient expectations and expertise
- new technology.

Each of these is described below.

Demographic pressures

Of the many external factors that impact on general practice, the ageing population will potentially have the greatest impact. We are living longer, and by 2033 it is projected there will be 3.2 million people aged 85 and older, compared with around 600,000 in 1983 (Royal College of Physicians 2010). People aged 65 or over consult their GPs on average more than twice as frequently as people aged 15–44 (Stationery Office 1995, cited in Royal College of Physicians 2010).

Part of the extra years of life is likely to be spent with long-term chronic illnesses that are not curable, but need active management. This task is complex, as few patients have single conditions and, when above the age of 65, 65 per cent of the population have two or more long-term conditions – many have five or six (Haslam 2005).

A 2010 report by the Royal College of Physicians concluded that the biggest single change facing doctors was in making the shift from treating episodic periods of illness to one dominated by working in partnership with the growing numbers of patients living with long-term conditions, to help them maintain stability in their lifestyles (Royal College of Physicians 2010). Providing general practice services to an ageing population with multiple chronic conditions will require different ways of working, including a key role in supporting self-management.

Funding pressures

In the current climate of economic austerity and public spending cuts, high-quality care must also be cost-effective. General practice accounts for 90 per cent of patient consultations and just below 8 per cent of the total NHS budget. Funding for GP services has risen in recent years in line with a strategy to increase the investment in general practice. Prescribing accounts for a significant proportion of general practice expenditure. Around a quarter of the total expenditure on primary care relates to prescription drugs, and 98 per cent of these drugs are prescribed by GPs (National Audit Office 2007).

Compared to other parts of the health care system, GP services are estimated to be less costly. GP care for a whole year costs less than a single day's hospital admission. GP consultations cost less than outpatient consultations, accident and emergency and ambulance calls. A face-to-face consultation with a GP costs the NHS about the same as a telephone consultation with a nurse through NHS Direct (Royal College of General Practitioners 2008b).

However, media reports about high GP partner earnings, and variable quality, can give the impression of poor value for money (Royal College of General Practitioners 2007b). A review by The King's Fund found that no conclusions could be drawn about productivity changes in general practice over the past decade because of a lack of routine and consistent data on which to calculate unit costs (Wanless *et al* 2007).

Patient expectations and expertise

In recent years, patients have become more demanding in what they expect from general practice. According to the RCGP (Royal College of General Practitioners 2007b), patients want:

- greater responsiveness from GP practices
- better co-ordination, extra services and greater emphasis on health promotion
- the GP practice to be the basic unit of care
- to protect the special relationship that exists between a patient and a GP who knows them.

Increasingly patients are acting as informed consumers by taking on more responsibility for managing their own health and health care and developing a degree of expertise about their own health and condition. According to the RCGP, 'A doctor's opinion is no longer regarded as sacrosanct and a new dialogue is developing between healthcare consumers and providers' (Royal College of General Practitioners 2007b). For some professionals it can be challenging – but professional attitudes are changing, and resistance is much weaker than it was in the past. We are moving rapidly towards a partnership model of decision-making, where both the professional and the patient bring something to the encounter (Dixon 2008).

New technology

Patients with mobile phone and internet-driven lifestyles now expect the same benefits of information technology in their interactions with general practice. Such technology provides greater convenience through the introduction of 24-hour online systems that enable patients to book and cancel appointments, order repeat prescriptions and view their records. Within the practice, touch-in arrival screens help avoid long queues. Ease of access has improved through telephone consultations and the exchange of routine information by email between the patient and practice. The proportion of GP consultations by telephone in England had risen to 12 per cent by 2008/9 (Hippisley-Cox and Vinogradova 2009), although evidence is sparse on whether patients are happy with this trend (Boyle *et al* 2010).

Technology also offers new platforms for monitoring symptoms, and to support and motivate health-behaviour change. For example, telehealth allows patients to record vital signs such as blood pressure at home and phone the results to their doctor (Field and Grigsby 2002). Telephone support can be used to encourage people with long-term conditions to change their lifestyles and stay well (NHS Birmingham East and North 2009). Such developments support self-management, help reduce the amount of general practice time taken up by routine checks, and benefit patients who find it difficult to travel to the surgery.

In most other industries, productivity has been driven by embracing new technology and harnessing the resources of the consumer. In this respect, general practice lags behind other service industries and has not yet exploited the enormous potential that technology offers for the patient to be a co-producer not only of health but also health care.

In general, information technologies are seen as 'overlays', or add-ons, to current structures. It is rare for the NHS to rethink how available information technologies can help fundamentally to alter the way of working and to contribute to service redesign (Dixon 2008). There has also been a problem with slow uptake and adoption of technologies in the NHS due in part (Liddell *et al* 2008) to:

- lack of resources
- lack of resources leadership
- a tendency to focus on cost rather than value
- the need to make services changes
- the complexity of the procurement process.

General practice needs to embrace such technological advances while recognising that their adoption may require changes to clinical practice and a proportion of patients may resist their use, or need help to master them.

The policy context

In the White Paper *Equity and Excellence*, the coalition government has set out its proposals for further reform of the NHS (Department of Health 2010a). The intention to increase patient choice and competition is likely to result in a greater diversity of primary care providers. The White Paper also puts a strong emphasis on involving patients in decisions about their treatment and care – under the slogan ‘no decision about me without me’. This will require GPs to engage patients more actively in decision-making about their treatment and care.

The proposal to devolve commissioning to GP-led consortia gives GPs the lead role in the design and delivery of services on a scale not seen before. The implementation of GP-led commissioning will require rapid transformation in the skills and working practices of GPs. Much greater and more informed use of information, data and indicators will be imperative if general practice is to meet the challenges integral to its new role.

The White Paper also proposes that local authorities will have responsibility for the integration of health and social care and for public health in future. This will require general practice to engage with people and institutions beyond the walls of their practices.

A major challenge will be how GPs, and other professionals working alongside them, can balance their dual roles as providers and commissioners. Part of the logic of the coalition’s reforms is to align provider and commissioner so that the system can be imbued with clinical leadership and commissioning decisions can lead more directly to changes in physician behaviour. However, in so doing, general practice will have to demonstrate that there are no conflicts of interest in their activities both as providers and commissioners.

To avoid some of the conflicts inherent in this relationship, the new NHS Commissioning Board is intended to be responsible for commissioning GP services and holding GP contracts. However, it has also been proposed that all GP commissioning consortia will have an ‘explicit duty’ to support the board in continuously improving the quality of primary care services (Department of Health 2010d). The board will be able to delegate responsibility so that consortia ‘will play a systematic role in helping to monitor, benchmark and improve the quality of GP services, including through clinical governance and clinical audit’.

While the board will retain the formal role of ensuring a practice meets its contractual duties, it ‘will be able to delegate some responsibilities for managing the GP Performers List to GP consortia, where it makes sense to do so’ (Department of Health 2010d, para 4.82). This means that consortia will have a dual responsibility of commissioning services on behalf of practices, and supporting them to improve their performance as providers.

This new contractual relationship between GP commissioner and general practice should be used to support peer review – and should encourage commissioning consortia to adopt broad approaches to quality improvement, rather than simply monitoring minimum standards. However, as the consortia will not have the formal authority that comes with being the contract holder, if they are to have a meaningful enforcement role with the poorest-performing practices then they will need clearly defined powers.

In the reformed system, general practices will be held to account for quality, both as providers and in their role as members of GP consortia responsible for commissioning services. This means that the process of judging the quality of general practice will shift from a focus on the clinical activities delivered within the surgery to the broader questions of:

- whether the health status of the local community is improving

- whether patients' expectations are met
- whether they have secured value for money for the taxpayer.

Under the public health reforms, GP consortia will be encouraged 'to maximise their impact on improving population health and reducing health inequalities', and there will be increased incentives for GP practices to improve the health of their patients (Department of Health 2010a).

Conclusions

The role of general practice has changed significantly since the NHS was founded. General practice is no longer responsible for round-the-clock care, and many doctors are employed in larger practices and work alongside a growing number of nurses and other clinicians. General practice must now adapt to the changing context in which it finds itself with the demands of an ageing population, a tighter funding environment, and patients who are more informed and are accustomed to using technology in their everyday lives.

Policy changes mean that general practice will have to take responsibility as a commissioner of care, as well as a provider of care. This means that if the quality of care is to be sustained and improved in the future, there is a great need for practices to demonstrate the quality of care they provide – either by themselves or in partnership with others.

Delivering high-quality care in this environment will require general practice to change. We will explore what these changes mean for the future of general practice in Chapter 6. In the chapter that now follows, we go on to look at how quality of care in general practice is measured in England.

Key points

- The range of activities provided in general practice has increased. General practice plays an increasingly important role in co-ordinating care provided in other settings.
- There is a trend towards larger practices and federated models of working. Between 2004 and 2009, the number of single-handed GP practitioners fell from 1,949 to 1,266.
- The availability of GPs is still not equitably distributed, ranging from fewer than 50 to more than 80 per 100,000 population.
- Nurses play a greater role in general practice than in the past.
- There are projected shortages in the general practice workforce due to an ageing workforce and changing working patterns.
- Contractual arrangements in general practice are now more diverse. The number of salaried GPs employed in practices has risen significantly – from 786 in 1999 to 7,310 in 2009.
- The ageing population and the increasing number of people living with co-morbidities require general practice to work in partnership with patients and to support self-management in order to improve the quality of care.
- Patients today expect a more responsive service than they did in the past. Patients want to play a much more active role in making decisions about their care.

- Technology is available that could transform the way patients interact with general practice. However, general practice has been slow to adopt it.
- GPs will have a key role to play in the reformed NHS as commissioners as well as providers of care. They will need new skills and will need to make greater use of information, engage with local authorities and other public services, be more open and transparent and be more widely accountable.
- General practice will become increasingly involved in, and responsible for, the health of local populations. This includes those who are most in need of care but currently do not receive it.