November 2014

General practice in England

An introduction to general practice for finance managers

Medicine for Managers

shaping healthcare finance …

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Foreword

This guide to general practice is the third briefing in the HFMA's Medicine for Managers series. Earlier briefings covered paediatrics and mental health.

We have chosen to focus on general practice because it is used by almost everyone, it significantly affects other NHS expenditure and it faces challenges at present.

The aim of this briefing, as with the others, is to enhance the knowledge of finance staff and help them to engage confidently with their clinical colleagues in order to improve quality and efficiency in their own organisation and the wider NHS.

The HFMA is grateful to the following contributors to this briefing:

- David Chandler, head of finance, Sunderland CCG
- Dr Henry Choi, GP, Washington locality GP lead and clinical effectiveness lead, Sunderland CCG
- Dr Jackie Gillespie, Coalfield locality GP lead and prescribing lead, Sunderland CCG
- Dr Michael Gregory, GP within West Timperley Medical Practice and clinical director (strategy and policy), Trafford CCG
- Ian Howard, assistant head of finance, NHS England Wessex Area Team
- Rachel Pickering, Clover Group service manager, Sheffield Health and Social Care NHS Foundation Trust

We are also grateful to the HFMA Financial Management and Research Committee. The lead author was independent consultant Steven Bliss under the direction of HFMA head of policy and research Emma Knowles.

1 Temple Way, Bristol BS2 0BU
T 0117 929 4789
E info@hfma.org.uk
www.hfma.org.uk

The objectives are to develop an awareness of:

- The background, role and structure of the service
- The staff delivering the care
- The main conditions or diseases they treat
- The financial facts and figures
- Current service issues
- Future challenges and potential changes to services.

The HFMA, along with others, has been a keen advocate of increasing the financial management knowledge of those who deliver and manage healthcare. But while clinicians' understanding of financial management has improved, the HFMA is keen to ensure that its members' understanding of clinical practice keeps pace.

NHS accountants, whether they work mainly with commissioners or providers, have a key role in contributing to the delivery of high-quality, value-for-money services. They can only do this properly if they understand the services they support and the other services that affect their organisations.

Finance staff can gain significant benefits from developing greater clinical awareness. This understanding – or 'knowing the business' – goes beyond a familiarity with the specific language used and includes an understanding of the key features of the day-to-day provision of services, the key challenges and inter-relationships with other services, and the likely impact of future clinical practice and innovations.

We hope you find the guide useful and would welcome your feedback and any suggestions you may have for future briefings.

Andy Hardy, HFMA president

Introduction to general practice

What is general practice?

General medical practice is the largest element of primary care, which also includes dentists, opticians and pharmacists. All of these are independent contractors, not employed directly by the NHS. This briefing only covers general practice in the English NHS. Below are some of the main differences in the rest of the UK.

Scotland

Scotland had eight GPs per 10,000 population in 2011 compared with just under seven in England[1]. Average practice list size varies widely[2]: 5,000 or more in the major conurbations compared with 2,000 to 3,000 in the Highlands and Islands. GPs come under local health boards.

Wales

Wales has about the same number of GPs per head of population as England[1]. GPs come under local health boards, which also directly manage hospitals.

Northern Ireland

There are about six GPs per 10,000 population[1]. Northern Ireland's arrangements are closer than England to the federated model of services discussed on page 18 of this briefing[3].

General practitioners (GPs) see patients who are ill, or believe themselves to be ill and cover mental as well as physical health. They see patients with any presenting condition for urgent or non-urgent care. The aim is for the GP to know the patient and to provide holistic care over the patient's life. This requires special personal skills.

As the Royal College of GPs puts it 'Each consultation is unique … For example, a consultation with a young and inexperienced mother worried about the planned immunisation of her first baby will require the expression and emphasis of different competencies than a consultation with the same woman to discuss with her the implications of her recent diagnosis of breast cancer.'[4]

The English system of general practice has existed with only gradual change for so long that we tend to take it for granted. But it is not the only way to organise these services, as will be seen later; other advanced economies do it differently.

Almost everyone in England is registered with a GP practice. On average each of us has some sort of consultation with their GP practice (not always with the GPs themselves) five or six times a year. GPs and practice nurses see more than 800,000 people a day[5]. But the demands that different people make on general practice, and the way that general practice meets those demands, vary widely.

Why focus on general practice?

There are four main reasons for looking in some depth at general practice:

- We tend to take it for granted and often do not understand how it is organised or what it costs.
- What GPs do, or sometimes don't do, has a significant effect on how the rest of the NHS operates, and GP services have a high political profile.
- General practice is under some pressure at present, including restricted funding levels, growing demands and some difficult workforce issues.
- Many professional and other bodies are reflecting on how general practice should change, although there is not yet an agreed strategy.

1 www.nuffieldtrust.org.uk/data-and-charts/gp-numbers-relative-uk-populations

2 ISD Scotland national statistics release

3 Reported in *GPonline*, November 2013

4 Royal College of General Practitioners (2010 revised 2013), *The core curriculum statement: being a general practitioner*

5 NHS Commissioning Board (now NHS England: 2012), *Securing excellence in commissioning primary care*

There is surprisingly little hard information on what sorts of cases GPs typically see. Such information is not routinely collected

What sorts of cases are dealt with in general practice?

The absence of hard information

A wide variety of patients (typically 30 or more) can be seen by a GP on any day. To give only a small number of examples:

- Elderly patients with several long-term conditions, incurable but needing continuing care
- Symptoms that might be potential new cases of cancer
- Newly pregnant women
- Patients recently discharged from hospital, needing the GP to take over their continuing care
- Patients with long-lasting depression
- Patients requested to attend by the GPs themselves – for instance, to review medicine or give flu jabs.

All of this makes a GP's work interesting and demanding. But there is surprisingly little hard information on what sorts of cases GPs typically see. Such information is not routinely collected. There is no equivalent of the detailed coding and healthcare resource group (HRG) system used for acute care.

What we do know nationally

The last information collected on the total number of consultations in general practice was over five years ago in 2008. At that time there were an estimated 300 million consultations a year, and if the growth experienced since 1995 has continued that would be about 340 million now[6]. The rising number of consultations is caused partly by the ageing population, as there is evidence that elderly people see their GP more often.

One of the major costs that GPs incur, and which their clinical commissioning group (CCG) pays for, is the cost of prescribing. The average English citizen had 18 items prescribed each year at an average cost of £9 per item in 2011/12[7]. Total prescribing expenditure can be analysed down to practice level, in detail by type of drug and hence by type of condition being treated. An analysis of cost is used in programme budgeting (the analysis of actual NHS expenditure by type of illness). The 2012/13 programme budgeting data[8] shows that the three largest categories of prescribing expenditure for most PCTs were, in order of size:

(i) Endocrine, nutritional and metabolic problems
(ii) Problems of circulation
(iii) Problems of the respiratory system.

Below are further facts about general practice, as quoted by the British Medical Association[9]:

- The average time a GP spent with a patient for each consultation was 12 minutes in 2009.
- Each GP practice takes between 30 and 50 calls from patients each day.
- Of every 20 consultations, 19 are dealt with in primary care alone – they do not require a referral on to secondary care.
- Almost 87% of patients rate their experience of GP services as good or very good (although, as discussed later, they are less satisfied with the time it takes to get an appointment or with out-of-hours services).

The financial picture

Planned expenditure in 2013/14

The *Health and Social Care Act 2012* made NHS England accountable for primary care including general practice from April 2013. Previously primary care trusts (PCTs) held the budgets. For the financial year 2014/15, NHS England's total funding is £98.4bn, by far the greatest share of the total NHS funding. This will be spent as follows (all figures are from NHS England's business plan[10], relate to financial year 2014/15 and are planned not actual expenditure):

- £65.9bn goes directly to CCGs to pay for most elements of healthcare, including the cost of GP prescribing.
- £13.5bn is spent on specialised services.
- £12.3bn is spent on primary care such as GP and ophthalmic services.

6 NHS England (2013), *Improving general practice – a call to action*, Evidence pack

7 www.nuffieldtrust.org.uk/data-and-charts/cost-prescription-items-uk

8 www.england.nhs.uk/resources/resources-for-ccgs/prog-budgeting/

9 BMA General Practitioners Committee (2013), *Developing general practice today*

10 NHS England (2014), *Putting patients first: the NHS England business plan for 2014/15-2016/17*

- The rest is spent mainly on central programmes, social care, running costs and some technical items.

How expenditure has changed
Like the NHS generally, GP services saw material increases in the early years of the 21st century but very little increase in recent years. Spending on GP services was just over £5bn in 2003/04, then increased significantly in 2004/05 (linked to the changes in the GP contract). It continued to increase more slowly after that and has flattened off from 2010/11.

The total spending on GP services has been static in money terms in recent years, so that its share of overall NHS spending (which has at least had an inflationary increase) has declined slightly. GP services, excluding the cost of prescribing, represented 8% of total NHS spending in 2008/09 and fell to 7.5% in 2012/13[9]. As the workload placed on GP services appears to have increased, there is a pressure that forms one of the chief current service and financial issues.

Expenditure per head of population
Across the whole of England, total spending on GP services stayed flat at about £143 per head of population in the years 2010/11 to 2012/13[6]. That excludes, for example, prescribing costs and diagnostic tests, which were accounted for separately. The cost of a year's GP services per head of population is less than the cost of a single day in hospital[6].

Hence there is an argument, explored in the final section of this briefing, that additional investment in GP services could be cost-effective if it leads to a reduction in hospital admissions.

How equitably is the money spent?
It is possible to get a good sense of how expenditure varies across England by looking at numbers of GPs[6]. In 2009 there were significant variations across the then PCTs in the numbers of GPs per head of population, from less than five to more than eight per 10,000 population, and this is unlikely to have changed. What is more, the numbers of GPs do not show any clear correlation with the health needs of the population (as measured by weighted capitation, which is their fair share of overall NHS funding) or the quality of GP care provided (as measured by scores under the Quality and Outcomes Framework).

Compared with weighted capitation need, the south of England (excluding London) has more GPs per head and the north fewer[11].

How general practice services are provided

This section covers five topics:

- A brief history of how GP services have evolved since the NHS was first created
- How services are currently organised
- Comparisons with other countries
- Details of how GP contracts work
- The problem of 'list inflation'.

A brief history[12]
Before the NHS was set up in 1948, family doctors were mostly paid in cash by those who could afford it. Although local arrangements supported doctors working together, there was no over-arching system in place.

With the formation of the NHS, these doctors took on two key responsibilities on behalf of the NHS: to provide primary medical care and to control access to specialist care. These are still their two main roles. Within a month of the NHS being created, 90% of the population had registered with a local GP. But the doctors did not want to be NHS employees; they preferred to remain as independent contractors running their own small businesses.

It became clear in the 1950s that there was scope for improvement in general practice. Most GPs worked in single-handed practices or with only one partner and had little contact with other professionals. The premises they worked from had few facilities. Unsurprisingly the quality of care, to the extent that it could be measured at all, was inconsistent and sometimes poor.

Total spending on GP services has been static in money terms in recent years, so that its share of overall NHS spending has declined slightly

11 Centre for Workforce Intelligence (2011), *Medical specialty workforce fact sheet, general practice*

12 This brief history is based on a summary in The King's Fund (2011) *Improving the quality of care in general practice*

Early attempts to measure quality of care more rigorously proved controversial. The 1990 GP contract introduced greater external scrutiny with an element of performance-related pay

Steps were taken to improve GP services in the 1960s. In particular a new GP contract was introduced with better pay and conditions and restricting list sizes to 2,000 patients. More GPs were recruited and group practices became more normal. A key step was the creation of the Royal College of General Practitioners (RCGP) in 1972. From 1976, three-year postgraduate training programmes for GPs became mandatory. GPs also took on (and still have) a wider role for health promotion.

In the 1980s continuing evidence of large variation in clinical practice led to the RCGP Quality Initiative. However, early attempts to measure the quality of care more rigorously proved controversial. The 1990 GP contract introduced greater external scrutiny with an element of performance-related pay. GP fundholding (introduced by the Conservative government and later abandoned under Labour) allowed some GP practices to hold a budget and purchase some secondary care services – the first of many attempts to give GPs direct responsibility for commissioning healthcare.

The 2000s saw growing investment in the NHS – and expectations of it. The most significant change was the GP contract in 2004. This substantially increased earnings and allowed GPs to opt out of out-of-hours care. In return, there was a drive for higher standards, with a greater element of performance-related pay under the Quality and Outcomes Framework (QOF).

The 2008 Darzi review urged the use of quality indicators across the whole healthcare system, including primary care. Governance was tightened, with annual appraisals for GPs and a requirement to register with the Care Quality Commission. Prior to this, the RCGP produced the first national training curriculum in 2007. GP involvement in commissioning increased in various organisational forms.

In addition, the way GPs provided services changed, with broader roles for practice nurses and other staff, supported by the wider use of IT. All these changes, often driven via negotiation of the GP contract, produced the system of providing GP services in existence today.

How services are currently organised

The NHS reorganisation in 2012 made groups of GPs, called clinical commissioning groups (CCGs), responsible for commissioning most healthcare services. The budget for primary care and the legal responsibility for administering it passed to NHS England and its area teams. This responsibility had previously been with the now abolished PCTs.

As a result, NHS England inherited whatever existed locally in the PCTs – varying types of practice, types of contract and earnings for the GPs, and known variations in provision (at least in numbers of GPs) across the country. NHS England took early action to standardise its procedures and approach, creating a suite of policies in the summer of 2013. Those policies include an assurance framework for primary medical services. NHS England has also begun to consult on the longer term future for general practice, in *Improving general practice – a call to action* (2013).

Ultimately, NHS England holds the purse strings and responsibility. It can close GP practices, suspend GPs or use any of the other powers in the various forms of GP contract. But it is the CCGs that have the closest day to day contact with GPs and work with them to improve services.

To make this work is complicated. Research by the King's Fund and Nuffield Trust[13] highlights some of the issues. CCGs were clear that, like the PCTs before them, they needed to influence GP behaviour in prescribing and referrals to hospital, as CCGs meet these costs. GPs also saw this as a legitimate role for CCGs. There was less clarity or agreement on other aspects of general practice (for

13 Naylor et al, *Clinical commissioning groups: Supporting improvement in general practice*, The King's Fund and Nuffield Trust (2013)

example, infrastructure, workforce and quality), with only 55% of GPs seeing this as a legitimate role for CCGs. Most respondents, however, agreed that CCGs should aim to improve general practice by encouraging training and education, providing comparative data and offering financial incentives. Most respondents did not think NHS England's area teams would have the capacity or local relationships to monitor GP contracts closely – in practice CCGs must be involved.

There is, unavoidably after the 2012 Act, dual management of general practice. The CCGs have the 'softer side' of managing general practice ('carrots') and NHS England has the harder sanctions ('sticks') if needed. However, CCGs do have some sanctions and could ultimately expel a practice from the CCG. CCGs and NHS England's area teams have to work closely together on general practice. It is too soon to assess how well it works.

The contracts NHS England holds are with each GP practice. In 2012[14] there were 8,088 practices in England. Practice sizes vary widely. The average practice consists of four GPs, two practice nurses and nine other staff (all figures are whole-time equivalents based on the September 2012 census[15]). In 2009, there were still 1,266 single-handed GPs (down from 1,949 in 2004). About 75% of GPs are independent contractors, so they do not have a normal contract of employment but are partners in their business and take a share of the profits. The other 25% are salaried GPs.

The two case studies (right and overleaf) cover the experiences of finance staff in a CCG and in NHS England who work with GP practices. The independent status of GPs is

14 NHS England, *Evidence to the review body on doctors' and dentists' remuneration for 2014*

15 Health and Social Care information Centre (2013), *NHS Workforce: Summary of staff in the NHS: Results from September 2012*

Case study 1: Experience of a finance manager within a CCG

David Chandler, head of finance at Sunderland CCG, describes how he works with GPs

Sunderland has six GPs on its governing body and a high degree of clinical engagement from other local GPs. Finance managers in the CCG work closely with all of them. Almost every day I will have some form of face to face contact with a GP – that is how closely we work together. I've been very impressed how passionate, engaged and dedicated they are to take the opportunity the CCG presents to get better health for Sunderland residents. My work with GPs covers the following main areas:

- We work closely to focus time and resources on agreed clinical priorities. The CCG has about 30 workstreams, each with a GP leader. The GP workload varies from one session a month to one a week, and the CCG funds this, usually paying the practice to cover the GP time. The total cost is about £120,000 a year. The CCG decides the priorities for these workstreams and the CCG medical director (a GP) has a lead role in selecting GPs to take on the work. A good example of how workstreams operate is a recent tender for urgent care centres, where a GP has led the process supported by finance and other officers from the CCG.

"Thirty practices have already signed up to a federation model that could operate to provide more care outside normal hours"

- We work together to develop enhanced services, which include absorbing some work from secondary care. I also help to manage these payments with contracting staff.

- Like other CCGs, and PCTs before them, the CCG has incentive schemes for engagement, demand and capacity planning and referral management, paying practices against agreed criteria. The soft evidence is that these schemes operate better than in the previous PCT, with more clinical leadership in setting them up and more credibility among GPs. There are strict financial criteria, to ensure value for money, and part of my job is to ensure that payments under the scheme are valid.

- The CCG runs well-attended time-out sessions with its GPs – currently 10 a year – that are very well attended (about 150 GPs each time) to discuss training and other issues. The CCG pays for this out of its running costs budget, which I help to manage.

- The recent national fund to improve GP access has aroused a lot of interest among GPs. Finance managers, including me, were involved in putting together a bid against this fund. Thirty practices have already signed up to a federation model that could operate to provide more care outside normal hours, and more practices may join. This initiative may encourage wider working as a federation.

Case study 2: The role of a senior finance manager in NHS England

Ian Howard, assistant director of finance in an NHS England area team, describes his work with primary care

I am relatively new to primary care, taking on the strategic financial oversight for an area team. As such, I rarely talk to GPs on the ground to understand their perspective on the reforms. I do, however, have a good perspective of life facing primary care within the area team.

The first priority of our team was the integration arrangements in our first year as NHS England. This was a time of upheaval in terms of staffing structures, commissioning arrangements and processes. Part of this involved gaining a detailed understanding of the contracts and baselines we had inherited from six PCTs, collecting the information we needed and standardising processes.

One of the main challenges we faced was managing our reputation as a new area team to general practice. As a result of the new arrangements, GPs had significant changes to payment processes and remittances, which in many cases meant them receiving payments from multiple new NHS organisations. This caused much confusion and vexation with the new system. In the first few months our team were very much "hands to the pump" in dealing with numerous queries, while designing and implementing standardised processes and creating remittances that would enable GPs to understand what their payments related to.

"One of the main challenges we faced was managing our reputation as a new area team to general practice"

From April 2014, GPs have seen further changes in funding streams with the reduction of QOF points and phasing in of price per patient to offset this reduction. This has had big impact on personal medical services (PMS) practices, which receive more funding than the national average price per patient. We are also looking at phasing out the minimum practice income guarantee (MPIG) for general medical services (GMS) practices, with these savings being reinvested in frontline primary care. The finance team, working closely with commissioning colleagues, is involved in supporting and understanding what changes to the national GP contract mean to each practice. With more than 300 GP practices more than 100 of which are PMS – this is no small feat. It is essential we communicate these messages clearly, and support GP practices to understand the changes to their contracts.

Nationally, there is a call to action to improve access to primary care. Part of this work includes inviting CCGs to co-commission aspects of primary care. This is still at an early stage, but the message is that primary care is a key part of any health system, and needs to be integrated with the work of CCGs in order to drive forward the changes needed in the NHS. My overall synopsis of my year in primary care finance is that it is constantly evolving, with a new challenge around the corner. The key is to embrace this changing landscape, and support our stakeholders to understand and embrace it with us.

something of an anomaly. It is unusual for independent businesses to earn almost all their income from a single customer – in this case NHS England. Also "uniquely among self-employed people" GPs "have access to a defined benefit pension scheme, effectively guaranteed by the Exchequer"[14]. Independent status looks attractive but the number of salaried GPs is rising.

Originally patients registered with a GP, but now they register with the practice. Most patients would probably regard a single named GP as 'their' GP, but they can see any of the practice GPs available and they may benefit from seeing a GP with a special interest in their type of illness. From April 2014, all patients aged 75 and over, and those with complex health needs, will have a named GP. GPs will be responsible for co-ordinating care and developing and regularly reviewing personalised care plans for these patients. All patients are to have a named GP from 2015/16.

Under the 2014/15 GP contracts patients will not need to register with a practice where they live; some may prefer to register with a practice near their workplace. However, given that GPs are meant to have a key role in commissioning healthcare for their local community, the system still requires the vast majority of patients to register with local practices and at present they do.

One final point to note relates to out-of-hours services. Traditionally GPs were responsible for providing 24/7 primary care to their patients. If a patient was ill at night or a weekend, the GP would be called out (in practice GPs usually collaborated on cross-cover or employed locums). The 2004 GP contract allowed GPs to opt out of providing out-of-hours services, forfeiting some income.

About 90% of practices have now opted out, and the local CCG commissions out of hours services. NHS England remains responsible via its practices where the practice still provides out of hours care. The most recent GP patient survey[16] reported that 77% of patients were satisfied with the hours that their

local practice was open and 66% felt that the overall experience of their out of hours service was good (compared to 86% with a good overall experience of their GP surgery).

Comparisons with other countries

The model of general practice in England has evolved slowly. But other countries do it rather differently[17], as the following examples show.

Medium sized practices of four to six GPs are common in the UK; less so elsewhere. In the Netherlands, Germany and France most GPs are single-handed, although often within health centres and other shared facilities.

In the UK, general practice and primary medical care mean the same thing. A key role of the GP is to control access to secondary care. It is not so everywhere. In eastern Europe, France and to some extent the US, patients can go direct to specialists.

Our small business model of general practice is almost unique to the UK. In many countries, GPs are simply employed by the local health authority or the state. In others, such as France, they operate much as they did in England before the NHS, paid directly by the patient (who is then fully or partly refunded by the state). It is also quite unusual for GPs to be paid, as in England, mainly on a capitation basis (a fixed sum per patient irrespective of how little or often they see the patient).

GPs in England are rarely organisationally linked to secondary care, but there are some examples of foundation trusts running some primary care services under a joint venture with GPs. One example is set out in case study 3 (right). As is well known, Kaiser Permanente in the US provides both

16 NHS England (2014) GP patient survey 2013-14

17 This section is based mainly on a discussion on the website of Support 4 Doctors, a Royal Medical Benevolent Fund project

Case study 3: General practice within a foundation trust

Rachel Pickering, a service manager within Sheffield Health and Social Care NHS Foundation Trust's Clover Group Practice, describes the history of the arrangement and some of the issues she faces in her work

Sheffield Health and Social Care NHS Foundation Trust is a large trust supplying mental health and other related services to the population of Sheffield. It also, unusually, runs some GP services, one of only a few in the country at present. The GP practices managed by the trust are within the Clover Group and based in four locations across Sheffield.

Clover Group practices have unusually high ethnic populations (over 50% Bangladeshi and Asian, asylum seekers and a growing number of Slovakian Roma). Some argue whether the GP funding formula adequately covers the needs of such populations. But it is clear from experience that some sources of GP income are hard to earn from such populations – women can be reluctant to have cervical screening or cancer screening can be misunderstood.

In the 1990s, before it became part of the Clover Group, one of the practices got into severe financial difficulties. This is why alternative contracts such as APMS (alternative provider medical services – previously primary care trust medical services) were set up, finding a new organisation to run essential services in an innovative way, so services continued. The practice moved into an NHS organisation (Community Health Sheffield, which became Sheffield Health and Social Care NHS FT). Other practices joined later due to a variety of similar difficulties and they merged to form the Clover Group Practice. There are undoubted benefits from the arrangement but also issues to manage.

The GPs want to manage their finances well, but they are used to doing it in different ways. They have their own independent finance support from people used to dealing with primary care GP budgets, not the foundation trust regime. The sort of financial reporting and monitoring that works well for normal foundation trust activities does not always fit well with primary care. So a lot of time is needed to build good working relationships and an understanding about the regimes. The financial procedures of the foundation trust – for example, controlling recruitment – apply to primary care too, but they fit less smoothly. GPs running their own practices would be less bound by the rules and could fix staff problems more quickly.

Any successful foundation trust needs a good grip of both its income and its expenditure. Primary care usually has a good grip on its expenditure (mainly staff and overhead costs), but its income is much more volatile than the sort of block contracts still in place for much of mental health. About 40% of the practice income depends on earnings under QOF and other performance and enhanced services. Not only does actual performance against the standards fluctuate, but the standards themselves change and new standards are sometimes misunderstood at practice level. Hence a great deal of work is needed to keep a good track on expected income.

There are advantages for having general practice as a small part of a larger organisation. Any short-term financial problems can be managed. But general practice is not let off the hook. It has to recover its shortfalls eventually and contribute to cost improvement programmes like any other service. We have a good model for running primary care, but it took a financial crisis to make it happen and time to work together. The financial problems facing primary care in the coming years may force more practices into this way of working.

The Quality and Outcomes Framework is a crucial part of the 2004 GP contract, designed to achieve higher and more consistent quality of primary care

primary and secondary care and appears to do it well. However, what works in parts of the US for people wealthy enough to afford health cover might not work for everyone in England.

Details of how GP contracts work

There are currently three types of GP contract, which are covered in more detail[18] below:

- General medical services (GMS) contracts, which came into effect in 2004 and are negotiated nationally. About 53% of practices are covered by GMS contracts.
- Personal medical services (PMS) contracts, introduced in 1998 and agreed locally. About 44% of practices are covered by PMS contracts, although this is likely to reduce.
- Alternative provider medical services (APMS) contracts, that can include the private or voluntary sector and cover about 3% of practices.

GMS contracts

In simple terms – though the detail is far from simple – the GMS contract has three main income streams: a payment under capitation (so much a year per patient) called the 'global sum'; additional payments for achieving quality measures (the QOF); and additional payments for enhanced services. There are also four further funding streams applicable in certain circumstances.

The global sum is designed to cover all the normal costs of providing essential services for the registered patients. Essential services cover care during illness (where it can be managed within primary care), the general management of chronic disease and care for the terminally ill. As with the financial allocations to CCGs, there is a detailed resource allocation formula to ensure fairness. This formula takes account of the number of patients, their age and sex, list turnover, numbers of patients in nursing homes and rurality.

As well as the essential services, there are certain voluntary services (not to be confused with the enhanced services described later), which practices can opt in or out of, such as contraceptive services, child health and out-of-hours services. The global sum is reduced where practices opt out.

Payments for quality are paid under the Quality and Outcomes Framework (QOF). This is a crucial part of the 2004 GP contract, designed to achieve higher and more consistent quality of primary care. The QOF is voluntary but most practices take part. It sets out a range of quality standards that can be measured, in four domains:

- Clinical
- Public health
- Quality/productivity
- Patient experience.

Points are awarded for each standard achieved and each QOF point generates an extra payment to the practice of about £130[19]. The details of the QOF are revised with each new contract negotiation, usually annually.

Enhanced services are extra more specialised services or services delivered to a higher standard. There are (or were) two sorts:

- Directed enhanced services (DES) must be commissioned – for instance, childhood immunisation. After 2012 NHS England took over commissioning DES, although it may devolve the management to CCGs.
- Local enhanced services (LES) are optional and were previously negotiated locally. Effectively they have now ceased, although CCGs can still use their own funds to invest in local community-based services.

As well as the three main funding streams in the GMS contract, there are four more funding streams:

- For GP premises – a means of ensuring that GPs provide services in suitable premises
- For IT services necessary to support the NHS workload – but not for the business element of the practice.

18 Based on the HFMA *Introductory Guide to NHS Finance*

19 NHS England (2014), *Review of PMS contracts* (a slide pack)

NHS England has delegated its management to CCGs
- For seniority – based on the number of years a GP has worked in the NHS
- For locum cover – for example, to cover maternity, paternity or sickness.

Arguably these special payments sit rather oddly with the idea of independent self-employed contractors, but they arose to meet a need and have been part of the GP contract for many years.

PMS contracts
Personal medical services contracts are negotiated locally. They allow each practice to negotiate a local agreement with their commissioner. A PMS contract defines a required level of service based on local needs.

Practices are still eligible for quality payments, and also for enhanced service payments if these are not already in the local contract. They are also eligible for the additional payments for premises, IT and seniority in the GMS contract. A GP practice that enters into a PMS contract retains the right to opt back in to a GMS contract.

When NHS England took over commissioning GP services, its area teams raised concerns about the value for money of some of the PMS contracts inherited from the former PCTs. PMS contracts tended to cost more per head of population and there was a concern that some of the extra funding was, in effect, paying for core services in GMS.

NHS England decided to conduct a national review of PMS contracts, which reported in February 2014[19]. It found that across England, PMS contracts cost £325m more than the GMS equivalent (equal to £13.52 per weighted patient). A total of £67m was linked to defined enhanced services, but it was not clear what, if any, benefit the NHS was getting for the remaining investment.

APMS contracts
Alternative provider medical services contracts (APMS) can be let to private sector, voluntary and not-for-profit providers of general medical services, as well as to traditional GP practices, NHS trusts and foundation trusts. Typical uses of APMS are to provide new services in an area that has insufficient GPs and/or has difficulty recruiting or it could be to replace a GP practice that has closed. Currently only about 3% of GP services are provided under APMS.

The problem of list inflation

GP income, under any form of contract, depends heavily on the number of patients registered with the practice – the list size. List sizes may be overstated, for several reasons:

- Patients move and register with a new practice without being removed from the former practice
- Students might be on two GP lists
- Patients leave the country or die and are not removed.

Nationally, it is estimated that this discrepancy adds about 2.8 million people[20]. At practice level, the overstatement is 5% on average but it can be up to 30%. Many GP practices are significantly overpaid (by about £100 or more per duplicated patient). While there is little evidence of deliberate fraud, there is no incentive for GPs themselves to trim their lists. The NHS England commissioning team has created its own framework to tackle list inflation.

It is worth mentioning that list inflation also affects the populations covered by CCGs, as they are based on the lists of the practices in the CCG. However, to offset this, the overall CCG population is scaled down to match Office of National Statistics figures when target funding for CCGs is calculated.

Many GP practices are significantly overpaid. While there is little evidence of deliberate fraud, there is no incentive for GPs to trim their lists

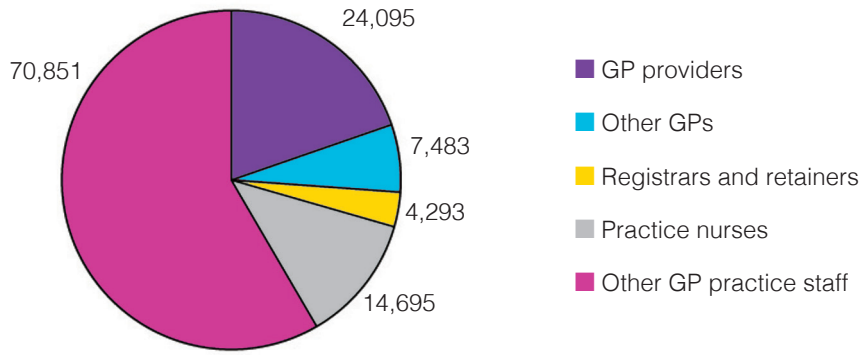
20 NHS England (2013), *Tackling list inflation for primary medical services*

Who is involved in providing general practice services?

This section of the briefing covers:

- Overall staffing in general practice
- How GPs are trained
- A typical week for a GP
- The GP as independent contractor
- Salaried GPs
- GPs with special interests
- The GP role within the CCG
- Dispensing GPs
- The widening role of the practice nurse
- Other staff in general practice.

Chart 1: Whole-time equivalents by type of staff



Case study 4: A typical working week for a GP

Dr Michael Gregory, a GP within the West Timperley Medical Practice, is also clinical director (strategy and policy) at Trafford CCG

My typical working week begins on Sunday evening, reviewing the weekend's clinical correspondence on a secure IT link for about an hour. Most weekdays begin at 7.30am or 8.30am, seeing booked patients every 10 minutes until about 12 noon. My practice also offers telephone triage, where patients can speak to a GP on the phone without an appointment, so sometimes I do that instead of seeing booked patients. Typically the GP doing triage will handle about 40 calls a day from patients.

Between 12 and 1pm we have a practice meeting once a week, with a chance for informal discussions on other days; otherwise the time is spent on visits, phone calls and urgent correspondence. There is then normally a second full session of seeing booked patients from 3pm to 6pm. Any 'spare' time between 1pm and 3pm is spent catching up on correspondence, mainly on clinical matters, but also keeping the business side of the practice going.

Some days depart from this pattern. I spend most of one day a week reviewing and authorising prescriptions, in addition to seeing patients, and I also have commissioning duties for the CCG.

Overall staffing in general practice
In 2012[15] 177,555 staff (headcount) equal to 121,417 whole-time equivalents (WTE) were recorded as working in general practice. The chart below analyses WTE by type of staff. Staff numbers rose significantly in the 10 years after 2002, GPs by 22% (almost 2% a year) and other staff by 28% (nearly 3% a year).

How GPs are trained
To begin with, all GPs will have gone through a five-year undergraduate medical programme and then a two-year foundation level programme. GPs then take a three-year postgraduate course, 18 months of which is spent in hospitals seeing a wide range of acute conditions at first hand, and 18 months in one or two general practices.

A typical working week for a GP
Case study 4 shows a typical working week for a GP.

The GP as independent contractor
Originally all GPs were independent contractors and most still are – 26,886 headcount and 24,095 WTE at September 2012[15], about 75% of the total number of GPs. They operate under contracts previously described. The most recent figures for earnings[14] cover 2011/12, when average gross earnings per independent contractor were £178,000 and average net income before tax £106,000. About 3,700 GPs (almost one in seven) earned over £150,000 net income. Typically about 95% of GP earnings come from the NHS and 5% from private income.

Over the period 2002/03 to 2011/12, the pay of GP contractors rose, on a cash basis, by 41%, compared with increases over the same period of 25% for consultants and 18% for nurses. GPs saw a rapid rise in their earnings with the introduction of the 2004 GP contract. Income growth flattened off after that and there has been no material growth in recent years.

A series of focus groups run by the BMA[21] explored GPs' views on the future of general practice. The

GPs identified five main reasons for choosing their career:

- Variety in the patients they see
- Being able to develop long-term patient relationships
- Flexibility to work in multiple roles
- Good work-life balance, regular hours
- Autonomy and being your own boss.

While salaried GPs have some of these advantages, only the independent contractor has all of them.

Salaried GPs

The number of salaried GPs has increased significantly, from about 1,000 in 2002 to 8,898 now[15] (headcount – WTE figure is 7,483). Being a salaried GP offers the chance to agree working hours to suit one's lifestyle and avoid the commitments of running one's own business. Salaried GPs are not generally as well paid as independent contractors, even for full-time work, rarely earning more than £80,000 a year[22]. They may also have less varied work and potentially less job satisfaction. One GP in the BMA focus group[21] said: 'I know a salaried GP who sits down at their desk at eight in the morning and gets up from their desk at six in the evening … All they have done is see patients'. This may be untypical: the fact that the numbers of salaried GPs has steadily increased suggests that most of them negotiate acceptable working arrangements.

GPs with special interests

A GP with special interests (GPwSI, often pronounced 'gypsy') is a generalist with an interest in a particular field of medicine or practice. There are typically three sorts of role for a GPwSI[23]:

- The lead role for certain sorts of illness within a fairly large multi-partner GP practice
- Work within a local commissioning group – for example, to develop local clinical guidelines
- A more formal role, appointed by the CCG (now) to cover a large local area or county, the aim usually being to avoid unnecessary specialist care in hospitals.

Sometimes the GPwSI will specialise in an indirectly clinical area, such as commissioning or education. Common areas of clinical work for a GPwSI are diabetes, dermatology, COPD, cardiology, women's health, musculoskeletal or reproductive health. A GPwSI would expect to be paid enough to arrange backfill for the hours of normal GP work they give up, ideally with payment for training and study leave. All this is negotiated locally.

The GP role within the CCG

All GPs are required to belong to a CCG. They are not all required to play an active role within the CCG, but the CCG will not function without a number of GPs who work hard to run it and a majority of other GPs who are content to work within the CCG's policies and priorities. All the constituent GP practices must be represented on the CCG's 'council of members', but the executive roles are mainly performed by the chair, the 'accountable officer' (who may be a GP but does not have to be) and the chief finance officer.

CCGs do not commission general practice. Where the CCG is commissioning any work from a GP practice – for example, for a GPwSI to take over work from secondary care – it is crucial that GPs from the practice involved take no part in the decision. CCGs pay for GP prescribing and referrals to secondary care, so they have to work closely with the GP practices. CCGs have a running cost allowance, which may be used to support the costs of GP time spent on CCG work.

Dispensing GPs

In rural areas, with no nearby retail pharmacist, it is common for GPs to provide the drugs themselves rather than give a prescription for them. Such GPs are called dispensing GPs. The BMA estimates that there are more than 1,300 practices in England (almost one in six) that provide dispensing services, to about 4 million patients[24].

In more rural and remote practices, up to half the practice income could come from dispensing. Dispensing doctors

GPs are not all required to play an active role within the CCG, but the CCG will not function without a number of GPs who work hard to run it

21 British Medical Association (2013), *BMA GPs' views on the future of general practice – focus group findings*

22 Quoted in www.prospects.ac.uk/general_practice_doctor_salary.htm

23 Quoted in www.medicalcareers.nhs.uk/specialty_pages/general_practice/gpwsi_article.aspx

24 Quoted in www.nhshistory.net/gppay.pdf

Some practice nurses take the lead role in managing patients with certain chronic conditions. The bigger the GP practice, the more scope there is for nurses to specialise

typically earn more than non-dispensing doctors as they are running two connected services.

GP registrars
There are now nearly 4,500 GP registrars, compared with about 2,000 in 2002[15]. They perform a range of duties to support the GPs.

The widening role of the practice nurse
Roughly a third of patient visits to GP practices are to see a practice nurse not a GP. In September 2012[15] there were 23,458 practice nurses (headcount – WTE figure is 14,695).

Nurses perform a variety of roles which at one time the GP would have done – taking blood samples, syringing ears, treating small injuries, health screening, family planning, vaccination and work on smoking cessation. Some practice nurses take the lead role in managing patients with certain chronic conditions, such as asthma. The bigger the GP practice, the more scope there is for nurses to specialise in various ways.

Practice nurses must be qualified as registered nurses. Those with suitable experience can apply for more senior jobs as nurse practitioners. Nurse practitioners take on extended roles such as seeing patients with minor illnesses and chronic disease management. Nurse practitioners can organise investigations and prescribe within agreed formularies. The GP practice is responsible for their education and training.

Other staff in general practice
The other staff employed in general practice total 113,832 headcount or 70,851 WTE[15]. They fall into two groups, clinical and administrative. Clinical staff can include healthcare assistants, dieticians and pharmacists. Administrative roles always include reception and switchboard. There is also often a practice manager role, looking after practice-wide administration and finances.

Current service and financial issues

This section explores four linked areas:

- The way that pressure on NHS finances is affecting general practice
- GP involvement with system-wide savings plans (QIPP)
- Workforce issues
- Quality of service.

Pressure on NHS finances
The overall position is well known and is summarised in NHS England's *A call to action*[25] (2013) and HFMA's *NHS financial temperature check*[26]. The demand for NHS services is continuing to increase because of an ageing population, more patients suffering long-term conditions and increasing expectations. The supply of NHS services is under pressure because of increasing costs, limited scope for productivity gains and constrained public resources. There is little prospect of much real growth in NHS funding in the next few years, but the pressures continue to mount.

QIPP programmes
A specific issue is GP involvement with local Quality, Innovation, Productivity and Prevention (QIPP) programmes. Commissioners generally plan to avoid hospital admissions where possible. This makes sense on quality and financial grounds. But it does require GPs to provide more and different care for these patients than if they were admitted to hospital. Mechanisms exist to invest more in general practice, to be funded by savings in hospital care, but this requires confidence that the savings can be made.

Meanwhile some GPs may feel they have to handle (with no extra funding or staff) the natural pressures of general practice and a further pressure of absorbing work from secondary care. When QIPP programmes do not succeed as planned, unnecessary expenditure continues to be incurred and service improvements are delayed.

Workforce issues
The GP workforce is changing. First, more GPs are now salaried (and

25 NHS England (2013) *The NHS belongs to the people: a call to action*

26 HFMA (2014) NHS financial temperature check

not always full-time) rather than independent contractors. Second, and related to this, more of the workforce are women[6]. In 2012 57% of the GP workforce was male and 43% female. Between 2002 and 2012 the number of women GPs rose by nearly 5% a year and the number of men reduced slightly. If, as seems likely, some of these women work part-time because of childcare commitments, the available workforce is smaller than it seems.

Finally, more of the workforce is likely to leave in the next few years because of the age profile of current GPs. Nearly 9% of GPs under 50 and 54% of GPs over 50 expect to quit direct patient care in the next five years[14] (both figures are significantly higher than when last surveyed in 2010). There are clearly concerns with a workforce where fewer people want the responsibilities of running the business, more want to work part-time and a growing proportion of the experienced staff want to retire shortly.

Softer evidence also reveals concerns. The most recent *GP Worklife survey*[27] reports that the level of job satisfaction recorded by GPs is the lowest since 2001. Stress levels in all areas of the job increased between 2010 and 2012.

The 2012 NHS reorganisation is one factor – nearly 45% of GPs sampled thought the introduction of CCGs had increased their workload a lot. According to the BMA, NHS England appears unable to provide as much support as PCTs[28] – 'Area teams have far fewer staff and resources than their predecessor PCTs … The support practices may need to help with development is often absent'.

GPs are not the only people in the NHS (or elsewhere) who feel under pressure, especially since 2012. And it is not a new phenomenon. A study by the Royal College of GPs[29] in 2002 included GP quotes such as these:

'I never thought the workload, vast amounts of paperwork and constant changing would become so stressful.'

'Patients will continue to suffer due to the NHS reforms.'

'I am at times very demoralised about how both the government and the public see/treat GPs and doctors in general.'

Some GPs are saying much the same now[22]. The dissatisfaction many GPs felt in 2002 was alleviated by the 2004 GP contract, which invested in quality, paid GPs more and allowed them to opt out of providing out-of-hours care.

But that was an expensive solution today's NHS cannot afford again. Something else has to be done to improve the recruitment and retention of GPs. As part of this, Health Education England[30] plans to increase the number of GPs in training, but the impact of that on actual services will be slow.

In October 2014 the health secretary announced a GP workforce review to establish how many GPs should be trained to cope with future pressure. The results will be published by Health Education England in 2015.

Quality of service

If GPs are under greater pressure, with worsening morale, what is that doing to quality? A detailed study commissioned by the King's Fund[31] looked at precisely that issue in 2011. Its main findings are summarised below.

First, the study found that quality in general practice was an underdeveloped area of study and one 'not much given to self-reflection and self-challenge'. That said, standards of clinical care were generally high but not consistently high. There were inexplicable differences in prescribing and referral rates between practices.

Care of long-term conditions had improved, especially for those with diabetes, but there were unnecessary hospital admissions. GPs were more likely to mis-diagnose acute rather than non-acute illness. Treatment of obesity was inconsistent, with some GPs seeing it as more of a lifestyle issue.

Fewer people want the responsibilities of running the business, more want to work part-time and a growing proportion of the experienced staff want to retire

27 Hann et al (Manchester University on behalf of the Department of Health, 2013) *Seventh national GP worklife survey*

28 BMA (2013) *Developing general practice today*

29 Evans et al (RCGP 2002) *GP recruitment and retention: a qualitative analysis*

30 Health Education England (2013) *Workforce plan for England*

31 Goodwin et al (The King's Fund, 2011), *Improving the quality of care in general practice*

Case study 5: Improving cancer services

Dr Henry Choi, cancer lead for the CCG in Sunderland, describes his work to improve cancer services

We know that Sunderland has too many premature deaths from cancer and cardio-vascular diseases. For more than two years I have been leading a project for the CCG on improving cancer services, concentrating on three of the worst killers: lung cancer, colorectal cancer and pancreatic cancer. All of these have poor survival rates if not detected early. It soon became clear that the priority was to improve services at the front end. If we don't detect cancer until a patient arrives at A&E, it can be too late to prevent death. Delays at the front end arise for at least three reasons:

- Patients are often slow to recognise the symptoms
- There can be delays in getting the patient from the GP into secondary care
- There are then avoidable delays in secondary care, especially diagnostics.

I led the project that completely redesigned the pathway for lung cancers to remove the second and third types of delays.

"It used to take at least 15 days to get X-rays reported and then back to GPs. Now it is done within three working days"

It used to take at least 15 days to get X-rays reported and then back to GPs. Now it is done within three working days, with GPs having access to the hospital's information system to check results quickly. Once we had the test results, it used to take two weeks before the patient was seen in hospital. Now, if the tests are at all abnormal, the hospital radiology department will arrange for an urgent CT scan, book a two-week wait cancer appointment with a consultant, and inform the GP about the appointments at the same time. In the past, it might have taken two months for a patient with suspected lung cancer to see the specialist with a CT scan done; now it takes two weeks.

I led this project, with support from the hospital consultants, radiology department, Durham University, Cancer Research UK and four other local GPs. The project went live at the beginning of April. The really satisfying thing was being able to persuade all the clinicians to change the way they have always worked. It is a good example of how GPs in CCGs can improve services – supported of course by finance and other managers. Apart from some coordination, there are no extra costs: the same tests and consultations are done as before, but much more quickly. When it is fully evaluated, this can be rolled out as best practice to other areas.

On the other cancers, I have persuaded colleagues to accept the Hamilton risk score for colorectal cancer, which has a lower threshold for picking up cancer than NICE guidance. I've also led on developing a pathway for patients with suspected pancreatic cancer, which is hard to identify in its early stages. Now any patients referred to the suspected pancreatic cancer pathway will get rapid access to a CT scan covering the chest, abdomen and pelvis before seeing the consultant at their two-week wait cancer appointment clinic.

Access to GPs also varies. The latest GP patient survey[16] found that 27% of patients did not find it easy to contact their GP surgery by phone, but the great majority of patients were satisfied with the care they received when they saw a practice GP. On out-of-hours care, only 60% of patients felt they had to wait for about the right time to receive care and only 79% had full confidence in the out-of-hours clinician.

The most overall significant finding, however, was that on most measures patient experience of GP services had deteriorated slightly since it was last measured in 2013 – a sign that the service is under some pressure.

Case study 5, on cancer services, provides an excellent example of what GPs with lead roles can do to improve services.

Inconsistencies in quality of care across practices and CCGs are hardly surprising. A system of independent contractors has its strengths but it is not ideally suited to deliver uniform quality. And the number of GPs per head of population is known to vary[6], with some deprived areas poorly served.

On the whole the GP service seems to be holding up, although with some worsening patient experience recently. However it has not managed to prevent growing admissions to hospital[6] and it is not necessarily right for the future.

Future challenges are addressed in the final section of this briefing.

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Future challenges

The preceding section makes it clear that general practice is already under strain. Limited NHS finances do not make it possible simply to invest more in the current model of general practice without changing anything else. There is also a consensus that it is possible and desirable to move more care out of hospital, which again means general practice has to expand and/or change. This section looks at current thinking on how that could be done.

The creation of NHS England, with its role as commissioner of all general practice in England, gives an ideal opportunity to rethink how general practice may be best provided in future.

NHS England has already begun its thinking on this, in *Improving general practice: a call to action* (2013). This set of slides, supported by a detailed evidence pack, sets out 'the case for changes to the way general practice services are commissioned and provided'. Its main purpose is 'to stimulate debate in local communities…as to how best to develop general practice services'. Hence it is not yet a set of answers or detailed strategies.

Meanwhile, many organisations have set out their own thinking on the future of GP services as follows:

- British Medical Association (2013), *Developing general practice today* (supported by a document summarising GPs' views from focus groups)
- The King's Fund (2011), *Improving the quality of care in general practice*
- The King's Fund and Nuffield Trust (2013), *Securing the future of general practice*
- NHS Alliance (2013), *Breaking boundaries: manifesto for primary care*
- Royal College of General Practitioners (2013), *2022 GP: a vision for general practice in the future NHS*
- The King's Fund (Addicott & Ham, 2014), *Commissioning and funding general practice: making the case for family care networks*. This paper develops further ideas for GP federations and capitation-based contracts with providers
- The Nuffield Trust (2014), *Is general practice in crisis?*

The King's Fund and Nuffield Trust are neutral observers, while the other organisations might tend to favour changes that enhance the role of GPs and increase their numbers. The summary below covers areas in which there is some degree of consensus.

Out-of-hours services

NHS England has already made its views clear. A December 2013 board paper (*NHS services, seven days a week*) envisages the creation of 'a fully integrated service delivering high-quality treatment and care seven days a week'. Part of this is to be done by requiring all acute hospitals to meet minimum clinical standards on all seven days over the next three years.

But that is only the first stage. NHS England has also begun work to develop 'a complementary set of standards for primary care'. Also services in primary and community health services and social care at weekends and evenings must be improved and the barriers between organisations removed. NHS England will commission pilots in 2014/15 to set up improved access to general practice for at least half a million people. It will then evaluate the pilots and support a more integrated approach to urgent care in 2015/16.

The HFMA supported NHS England in costing the impact of seven-day services in acute hospitals[33]. All eight hospitals the HFMA worked with felt that to be truly efficient, seven-day working had to apply to primary as well as secondary care.

The other organisations listed above might not agree with the detail of NHS England's plans here, but they generally agree something must be done. The BMA accepts the need to improve urgent and out-of-hours services, which it thinks can best be done mainly by commissioning integrated models of care, telephone

NHS England envisages the creation of 'a fully integrated service delivering high-quality treatment and care seven days a week'

33 HFMA (2013) *Costing seven day services*

Appendix A: Abbreviations used

APMS	Alternative provider medical services
BMA	British Medical Association
CCG	Clinical Commissioning Group
COPD	Chronic obstructive pulmonary disease
GMS	General Medical Services
GP	General practitioner
GPwSI	GP with special interests
HRG	Healthcare resource group
ONS	Office for National Statistics
PCT	Primary care trust
PMS	Personal medical services
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners

triage by clinicians, setting minimum ratios of clinical staff to population for out-of-hours services, and getting GPs more closely involved in monitoring their quality. It also suggests practices should collaborate to provide extended hours services at different times across a community.

The NHS Alliance argues that we need to 'develop 24/7 primary care with all of us able to access the care we need at the time we need it' and 'rethink the separation of the care provided in hours by practice and that provided out of hours'. It does not advocate a return to making GPs responsible for 24-hour care, only greater alignment.

The BMA similarly does not envisage GPs themselves providing more out-of-hours care but does expect services to be reshaped to improve the oversight and management of patients between the practice team and others.

So, to summarise, most of the organisations agree there is a problem and something must be done, but it isn't yet clear what should be done or how it can be afforded.

Collaboration between GP practices, and other models of organising practices

The pressures on general practice at present mean small practices have little time to think about managing the future, as they are struggling to manage the present. Changes to organisational models might release time and improve efficiency and quality. The most detailed work on this has been done by the King's Fund and Nuffield Trust in *Securing the future of general practice* (2013)[34]. They looked at 12 models of primary care which already exist in England or elsewhere and decided that four of them showed greatest promise for the English NHS:

- Networks or federations, where practices come together to share responsibility in certain areas – say for the care of long-term conditions, out-of-hours services, training and development or back office support
- Super-partnerships through formal mergers of existing partnerships, offering some economies of scale and wider career opportunities for GPs
- Regional/national multi-practice organisations, where a single partnership or GP-led company has practices over a wide geographical area with centralised management and back office
- Community health organisations with an extended range of health and social care services, usually serving disadvantaged communities with strong community involvement.

The other studies cited above support some of this. The BMA argues that patient access and the quality of care could be improved if GPs work in larger practices or in federations and meet in larger groups for peer-group learning to improve consistency. Such larger groups might also make better use of GP premises.

The NHS Alliance is clear that 'general practices will need to work together', with significant advantages from working at scale.

One of the options it puts forward is the concept of a 'primary care home', where GPs and other primary care providers come together in an integrated organisation. The RCGP is equally clear that 'the general practice teams of the future will be working with groups of other practices and providers – as federated or networked organisations.'

Key advantages of federation from the GP perspective are that it is voluntary, flexible to suit local circumstances and achievable now if the will is there[35]. One disadvantage from the national perspective is that it might move too slowly and inconsistently to make any early impact. Another is that, of itself, it does not break down barriers between general practice and secondary care.

34 The King's Fund and Nuffield Trust (2013), *Securing the future of general practice*

35 Family Doctor Association (2013), *The basics of federation: factsheet no. 1*

The changing role of the GP

The brief history given earlier shows that the role of the GP has expanded gradually over the life of the NHS. It is now likely to expand again, rather more rapidly, in the following ways:

- More integrated care, closer to home, delivered by a team built around the GP practice. The key aim would be for GPs to manage more proactively the growing numbers of patients with multiple and complex long-term conditions and avoid hospital admissions where possible
- More collaborative working between secondary and primary care, with more diagnostics and specialist care delivered in community settings
- Better emergency access to GPs, and simple care plans for vulnerable patients to avoid hospital admission
- Changing roles for GPs in a practice, with more specialisation (partly through the GPwSI). A key question for general practice is: how generalist does it now need to be? This also has implications for GP training, with both the BMA and RCGP arguing the case for a longer training period in general practice
- More efficient use of time through wider use of IT. GPs often do part of their work with patients over the phone now, but there seems to be less use of IT, which could help with the care of those patients with long-term conditions requiring monitoring
- More shared decision-making with patients, with patients more involved in managing their own care
- GPs widening their role to be not merely the gatekeeper to secondary care but the navigator through the whole healthcare system on the patient's behalf.

The above summary is not exhaustive but covers the key issues raised by the various bodies.

There seems to be a broad consensus that the GP workforce will have to change the way it works and, probably, expand in numbers. There is currently no workforce plan to achieve this, and there couldn't be as according to Health Education England (HEE)[29] there is 'a lack of consensus as to the future scale and shape of the GP and wider primary care workforce'.

The HEE is mandated to ensure that in future 50% of medical students become GPs, but it does not know whether that will provide enough GPs or whether it needs to change the way they are trained. It says: 'We must quickly move to a position where the training we are commissioning is validated by reference to a transparent perspective of future need.'

We do not yet know what NHS England will decide on the future of general practice and how much it will emerge locally. It is encouraging that there is a large degree of consensus on both the problems facing general practice and the likely solutions.

But that is a long way from having a developed and affordable strategy. And then any strategy would have to be implemented mainly via independent contractors and with little extra money available for incentives (although there is scope to release some funds from the reviews of list sizes and PMS).

The best and cheapest way to deliver high-quality care might be with more GPs and fewer hospitals, but how, and how quickly, can we get there? ■

Appendix B: Further information

The following sources (among many quoted in the footnotes to this report) give useful information:

British Medical Association
www.bma.org.uk
Particularly useful for its views on the future and on GPs' views of both present and future

Health and Social Care Information Centre
www.ic.nhs.uk
Publishes the NHS workforce census

HFMA
www.hfma.org.uk
Numerous publications, particularly the *Introductory guide – NHS finance*

King's Fund
www.kingsfund.org.uk
Well known for many publications on healthcare including those used in this report

NHS England
www.england.nhs.uk
As the commissioner of GP services NHS England publishes much of the most recent definitive information on general practice

Nuffield Trust
www.nuffieldtrust.org.uk
Like the King's Fund, with which it sometimes works, the Nuffield Trust is a respected commentator on many healthcare issues

Royal College of GPs
www.rcgp.org.uk
Numerous publications, especially on the training and professional values of GPs

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For more than 60 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has a particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

Our vision & mission

The vision that inspires us is a world where we see:

Better quality healthcare through effective use of resources

In order to help deliver our vision, we are committed to our mission of:

- Representing and supporting healthcare finance professionals
- Influencing healthcare policy
- Promoting best practice, education and CPD

HFMA
1 Temple Way
Bristol BS2 0BU

T 0117 929 4789
F 0117 929 4844
E info@hfma.org.uk

www.hfma.org.uk