A Focus On

General practice in England

audit commission
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General practice is well used and it is one of the most popular public services. Almost all the population is registered with a general practitioner (GP) and it represents eight out of ten patient contacts with the NHS. Most public surveys show satisfaction levels at around 80 per cent. General practice is also at the forefront of the Government’s plan for modernising the NHS and more is now being expected of GPs and practice nurses in their day-to-day work. General practice has undergone considerable change in the last ten years and has adapted well. But there are some structural barriers, and some pockets of poor practice, that may prevent all patients getting the service they deserve.

This report reviews evidence on general practice in England, highlighting current strengths and weaknesses. It uses published evidence and also makes use of data sources that may not be widely known, such as a database of all practices in England, surveys carried out of patients at more than 400 practices and nursing membership information. The Audit Commission did not itself collect data for this study, but did hold some focus groups of GPs to better understand the reported problems of low morale in the profession and the reality of working lives in general practice. This report does not cover Wales, as some data sources were for England only and, while many issues are common to both countries, there are some distinct concerns for Wales.

This report aims to provide a baseline of evidence at a time of great change, with a new contract for GPs under negotiation, national standards for clinical care and greater powers given to primary care trusts (PCTs) to shape general practice. At such a time of change, it is important that the strengths of general practice are retained, while allowing for improvements.

This report will be followed by a more detailed review next year, which will help PCTs to shape general practice. It may include areas such as information systems, premises, team working and practice management. The Audit Commission will also be publishing later this year reports on general dental services and PCTs, as part of a programme of work on primary care.

This report has six chapters. Chapter 1 provides a summary of the whole report, extracting key evidence from each chapter. Chapter 2 explains briefly how general practice fits in the context of the NHS and how it has developed in the last 50 years. This chapter also summarises recent policy developments and how they may affect the services that patients get.
Chapter 3 considers published evidence on patients’ views of general practice and highlights concerns about waiting times to see a GP or nurse and initiatives to address this. This chapter reviews evidence of variations in the quality of care and explores some of the reasons for this.

Chapter 4 reviews evidence on the changing nature of workload in general practice and examines some of the factors in detail, such as changes in clinical complexity. This chapter makes use of material from GP focus groups convened by the Audit Commission. It also considers published evidence on workload and the impact on general practice of new providers of care, like NHS Direct.

Chapter 5 considers the evidence on resources in general practice. It looks at the way that general practice is funded and how this is changing. It then considers inequalities in how resources have been distributed in the past and the impact that has had on the spread of doctors and nurses across the country. This chapter looks in some detail at workforce patterns, considering those entering and leaving general practice, and issues around recruiting and retaining doctors and nurses. The most detailed evidence concerns GPs, which forms the bulk of this chapter, but the team has also pieced together available data on practice nurses. This chapter also considers the role of the community pharmacist, practice manager and other staff in the practice, as well as the fundamental resources of practice premises and information systems.

Chapter 6 considers what can be done to improve general practice, given its strong foundations. It highlights some of the actions that can be taken at a national and local level and shows how some practices have transformed themselves to deliver better services for patients.

The Audit Commission thanks those who provided expert advice for this review of general practice (APPENDIX 1). However, the views expressed in this report are those of the Commission alone.
1. This report presents an overview of the state of general practice in England in 2002. This is a time of great change, with a proposed new contract for general practitioners (GPs) and greater powers for local primary care trusts (PCTs) to shape general practice against the NHS Plan and other national standards. This review examines existing evidence to establish the ‘baseline position’ of general practice before major changes are introduced. What does general practice look like at the beginning of the 21st century? An analysis of existing evidence should help to identify the key strengths of general practice, which must be retained, the drivers for change and the barriers to achieving it.

2. General practice is an important service, accounting for eight out of ten patient contacts with the NHS, but only one-fifth of NHS spending (£8.3 billion). Most people see the GP as the first port of call when they are feeling unwell and 99 per cent of the population are registered with a GP, usually close to where they live. General practice is highly rated by the public and evidence shows some overall improvement in quality. Evidence from patient surveys within practices shows that patients are happier with the clinical care they receive than with features of the practice’s organisation, where there is scope for improvement.

3. General practice has changed beyond recognition in the last 50 years. Then, general practice was described as a ‘cottage industry’ of one or two doctors (and no practice nurses) mainly operating from their homes. The modern practice is now likely to house a team of diverse professionals in large premises, offering a range of services from diabetes clinics to minor surgery. Many patients now have a choice about who they see – for instance, a woman GP or a specialist nurse who has experience in managing people with diabetes. The proposed new GP contract offers opportunities for some services, that in the past would have been provided by every practice, to be delivered by other means. The NHS Plan promises faster access to services and a range of providers. It is important that some of the traditional strengths of general practice, such as continuity of care, are not lost.

4. GPs and practice nurses feel under pressure, although evidence over the last ten years shows a smaller number of patients per doctor, longer consultation times (on average 9.36 minutes), fewer out-of-hours demands and only slightly increased weekly hours of patient contact. But these national averages do not reflect changes in the complexity of workload, with more care being delivered outside hospital, new clinical standards, complex drug regimens, greater expectations,
wider social needs and liaison with a host of outside bodies. More is expected of general practice staff, and new organisations, such as NHS Direct and Walk-in Centres, have not eased this demand to date. While more work has shifted out of hospital, there has not been a corresponding shift in the balance of resources. Growth in spending on general practice (not including drugs) has risen by 20 per cent in real terms over the last ten years, compared with over 60 per cent on hospitals over the same period. At a local level, funding crises in hospitals have often overshadowed the needs of primary care. Subsuming primary care within the unified budget held by the PCT may not help this.

5. The NHS Plan sets out the vision of a patient-centred service, with patients discussing with their GP options for further care, including the time and place of hospital treatment. These choices are best made at the practice, but this places even more pressure on the GP consultation, which is already stretched, with new requirements to review patients and record information in line with national standards. More time is needed to do this well, as well as proper investment in management, training and information systems. It is important that current targets to reduce patient waits do not result in less time for patients with the doctor or nurse.

6. Resources for general practice are not spread equally across the country because in the past they followed investment decisions by GPs. Historic patterns of funding and staff have resulted in inequities across the country. The highest resourced areas have twice as much funding per head – for example, £63 in Oxfordshire compared with £33 in Gateshead – and more than double the number of GPs as the lowest resourced areas. Areas with fewer GPs are not compensated by having more practice nurses, and these ‘under-doctored’ places tend to be in deprived areas with greater health needs. In these under-resourced areas, patients had to wait longer for an appointment – one in five people in inner London have to wait three or more days to see a GP, compared with one in eight overall.

7. Deprived areas have greater difficulty in finding and keeping staff – for example, in one inner city area in February 2002 one in five GP posts was vacant. These areas also tend to have worse premises. Across the country, 9 per cent of practices do not meet very basic standards, such as washbasins in treatment rooms, and eight out of ten do not have the space to meet all current requirements. Changes to the system of funding and investment in premises should reduce these inequalities, but these need to be monitored carefully to ensure real improvement in the most deprived areas.
8. Although data are scarce, existing evidence shows considerable variation in the quality of services for patients. For instance, one study showed that only one-half of patients with diabetes had received appropriate eye checks. Another indicated that one-third of practices recorded less than half of the information needed to manage people with asthma. And some areas are spending six times as much as others on drugs that are known to be less effective. The proposed new GP contract should provide incentives for quality improvements in general practice, although it is important that the ‘high trust’ ethos still allows for adequate monitoring to ensure that progress is being made.

9. There is evidence of low morale among staff in general practice and some problems in recruitment and retention with one-third of GPs and practice nurses approaching retirement age. Although more doctors are being trained, at present the number of new GPs joining the workforce is only marginally higher than the number leaving. More staff have been promised by the Government but it will be difficult to meet these targets given current rates of growth.

10. The medical workforce in general practice is changing – one in three GPs is a woman and more GPs now work part-time, combining time in general practice with families or diversifying into teaching, research and special clinical interests. Two-thirds of medical students wanting to go into general practice are women. The traditional model of a GP ‘principal’, staying in one practice full-time for their working life, is looking increasingly outdated. These changes are positive, providing new opportunities for doctors and patients. But in the short term, it may make it difficult to deliver all that is needed from general practice. The proposed new contract should enable some of these changes to be managed more easily, but more should be done to make best use of the pool of ‘non-principals’ to meet current demands.

11. Not enough has been done to date to promote and develop nurses in primary care. Current skill-mix in general practice (only one nurse for every 2.3 GPs) is very different from that in hospitals (four nurses to every hospital doctor or 12 nurses to every consultant). Put another way, whereas one in three doctors is a GP, only one in twenty nurses work in general practice. This reflects historic assumptions in which most clinical care was provided by the GP, with the optional support of practice nurses. If staffing in general practice was being planned from scratch today, it might look rather different. The vast majority (85 per cent) of practice nurses work part-time and more could be done to encourage increased hours among existing
staff, given the competing demands placed by NHS Direct and others for experienced community nurses. Overall, a national strategy is needed to promote nursing careers in general practice and to develop skilled nurse practitioners (at present, a very small number), who could take on more responsibilities.

12. Better use could be made of pharmacists as a primary care resource, to advise on ways to improve prescribing practice, to help to manage the drugs budget and to provide advice and information for patients. Spending on drugs is greater than on all general medical services and has grown by 60 per cent (unadjusted for inflation) in the last six years, putting pressure on other parts of the budget. But at a local level, there is two-fold variation in spending on drugs, most of which cannot be explained by differences in health needs, suggesting better management can make a difference. Pharmacists can provide advice to practices and give information and advice to patients. One study showed that community pharmacists can substitute effectively for GPs in treating patients with some minor ailments. But there is currently a shortage of trained pharmacists, with a vacancy rate around 10 per cent (more than three times higher than for GPs).

13. Much of general practice has been unmanaged in the past, resulting in a wide diversity of practice. PCTs now have greater powers to shape general practice, although our review confirms that there is no single blueprint for what works best. But there is now greater emphasis on national standards and greater clinical accountability. The task of the PCT is to ensure that these standards are met, while enabling diversity to meet local needs. The adaptability of general practice has been one of its greatest strengths – the NHS Plan promises more and better primary care, but this can only happen if general practice adapts fast enough to the latest challenges.

14. If practices are to meet the demands of the 21st century, they need to make best use of all members of the team, including nurses, community pharmacists, receptionists and practice managers. Those practices which have reviewed the way they work have managed to reduce waiting times by 50 per cent in a matter of months, with patients offered the third available GP appointment in 1.7 days on average compared with 3.7 days previously. More effective organisation of the practice will also allow more time to be spent with those patients with greatest needs; evidence shows that longer consultation times are associated with better outcomes for patients.
There has never been a more exciting time for general practice. The proposed new GP contract offers greater flexibility in how care is provided and more resources have been promised to strengthen primary care. But the Government may be expecting too much, too soon from general practice, given limited staff capacity and a history of patchy investment. And the differentiation of particular functions of general practice that underpins new contract proposals may make the pattern of services more complicated, and potentially more fragmented, for patients. Practices need excellent information and management in order to achieve the Government's vision of a patient-led service. The next phase of the Audit Commission's review of general practice will provide further analysis to help PCTs to shape general practice. The aim is to build on the best in general practice and to sustain improvements in patient care.
2 Introduction

Changing context

16. General practice represents eight out of ten patient contacts with the National Health Service (NHS) and enjoys higher satisfaction ratings than any other public service in England and Wales. General practice has extended its reach in recent years and has improved quality standards, while adapting dynamically to many fundamental changes. The diversity of general practice, in effect working as autonomous units with few central controls, has often been a strength. But there are real problems that need to be addressed, including an uneven spread of services, varying quality standards, a shortfall of staff in many areas, which may get worse, and inefficiencies in the organisation of some practices.

17. The Audit Commission reviewed general practice in 1992 in its study of Family Health Services Authorities (FHSAs). That study concluded that ‘the structures for providing support and investment for general practices and for holding them to account [were] weak’ (Ref.1). By contrast, in 2002 primary care trusts (PCTs) are the principal budgetholders for all local NHS services and have much greater power to influence and shape general practice (BOX A).

BOX A Primary care trusts now have real levers to improve general practice, which were not available ten years ago. These include:

- An explicit remit to ‘manage, develop and integrate all primary care services’.
- Clear national standards, including NHS Plan targets which must be secured through general practice or other means.
- A unified budget (increasing to 75 per cent of all NHS spend) which allows PCTs to allocate resources between hospitals, community settings and general practices.
- Unified budgets are calculated taking into account the amount of non-discretionary General Medical Services (GMS), allowing areas with under-resourced general practice more funds.
- The ability to develop local contracts with practices to deliver services for a pre-determined budget through Personal Medical Services (PMS) pilots and GMS Local Development Schemes.
- Stronger regulatory powers, including a responsibility to maintain lists of GPs, including those working on a temporary basis as locums and to declare practice vacancies, following the abolition of the Medical Practice Committee, and powers to suspend and remove GPs from practice.

Source: Audit Commission
18. A new contract is being negotiated with GPs, which will set in place future working conditions for general practice staff. If agreed, the contract will further strengthen the powers of PCTs to plan, commission and monitor general practice. Now is a good time to take stock of general practice and see how well equipped it is to meet the challenges of the next ten years.

What is general practice?

‘Providing whole person care… one of the attractions of general practice after hospital is seeing the whole person.’

Source: GP focus group convened for the Audit Commission, 2002

19. This report looks at general practice, as one part of the increasingly complex and important world of primary care. There are distinctive features of general practice that make it worth examining at this point, although it cannot be wholly separated from the wider context of primary care, which has been defined as ‘first contact, continuous, comprehensive and co-ordinated care provided to populations’ (Ref. 2).

20. General practice is an interesting example of public/private partnership. GPs are, for the most part, independent contractors. The National Health Service Act in 1946 was the product of a fierce battle between Government and the profession, which opposed the notion of a whole-time salaried service (Ref. 3). The resulting legislation ensured that the relationship between GPs and the state would be largely contractual and not one of direct employment. The contract for general medical services has, to date, left individual practitioners with a great deal of freedom about where and how they organise their work and what care they deliver. This autonomy has been greatly valued by GPs (Ref. 4). General practice has been relatively ‘unplanned’; until recent legislation most investment in setting up practices rested with GPs and not with local primary care organisations. This has resulted in inequitable distribution of practices, with desirable areas attracting more GPs. It has also enabled innovation, with practices responding to the needs of the practice populations in ways that a centrally directed service may have found difficult to achieve. Indeed, the history of general practice has been characterised by freedom from regulation.

‘I value autonomy in decision-making about patient care.’

‘I think one of the things that I value about being a GP at the moment is the independence compared to having been in hospital posts.

Source: GP focus group convened for the Audit Commission, 2002
21. Premises have also largely remained outside public ownership, with 63 per cent now owned by GPs and a growing proportion owned and financed by the private sector (Ref. 5). Overall, only about 16 per cent of primary care premises are owned by the NHS and earlier visions of state-owned health centres failed to materialise. But unlike the other three primary care contractor professions – dentists, opticians, and community pharmacists – most of general practice income comes from the NHS. The service remains largely free to the patient at the point of delivery, except for prescription charges (although four-fifths of items and half of prescriptions are exempt from charges) (Ref. 6). In short, general practice is characterised by a unique private/public partnership.

22. Nearly all people (99 per cent) are registered with a GP (Ref. 7), who provides ‘cradle to grave’ care. By contrast, only about one-half of the population at any one time is registered for treatment with an NHS dentist. The benefits of a list system include the fact that a medical record is lodged with the practice, enabling continuity of care and population-based health monitoring, including screening.

‘[The best things about general practice are...] continuity, the experience of seeing people over time, seeing people we know.’
Source: GP focus groups convened for the Audit Commission, 2002

23. There are four features of the care given by GPs: prevention, investigation, diagnosis and treatment. The skill of the GP is in making risk assessments based on the whole history of the patient. Many patients will present with vague and undifferentiated symptoms. After seeing a GP, some patients will be referred to other healthcare professionals for more specific diagnosis and treatment; the GP will usually then take on responsibility for ongoing management.

I The Dawson Report (1920) envisaged ‘state-owned’ primary health centres, staffed by a multidisciplinary team of health workers.
‘I think in very small ways, general practice is still, and always has been, innovative and creative and problem-solving.’

‘I think general practice is the business of responsibility, of living with uncertainty.’

‘We’re not snapshot photo people – we see the whole film. So what we see is the progress and the development [of the patient’s illness], but the specialist doesn’t. The specialist sees a snapshot so they have a lot of detail. But that can be sometimes just as meaningless.’

Source: GP focus group convened for the Audit Commission, 2002

24. To many people, primary care is synonymous with general practice – the local surgery, where they can see a GP or practice nurse for all problems which are not medical emergencies. In fact, general practice is part of a complex web of primary care services, with different professionals working together for different groups of patients (EXHIBIT 1). There is a range of services within primary care – some of them new – to provide a first point of contact to patients with undifferentiated health problems. These include community pharmacies, NHS Direct, Walk-in Centres, minor injuries units and A&E. In addition, there are a number of services and professionals who support people with particular needs in their own homes and to which the GP will refer many of his or her patients. These include specialist nurses (for example diabetes or respiratory disease specialist nurses), community mental health teams, district nurses, health visitors, school nurses and podiatrists.

25. Many aspects of the British model of general practice are the envy of other countries (Ref. 8). The list system ensures almost universal coverage of basic health services whereas, for instance, the uninsured 17 per cent of the US population has no regular access to primary care. The British system has been praised on grounds of equity – enabling a population-wide coverage of basic health services – but also cost-effectiveness. General medical services spending (without drugs) accounts for about £3.4 billion, or less than one-tenth of all spending in the NHS. Although total spending is relatively small, GPs act as gatekeepers to more specialised services (EXHIBIT 2, overleaf) and this may contribute to the comparatively low rate of expenditure in the UK at 6.7 per cent of GDP, about one-half the proportion of the US and considerably less than the European average of 8.7 per cent (Ref. 9). The development of group practice health maintenance organisations in the US indicates that the role of primary care gatekeeping is recognised in containing healthcare costs.
EXHIBIT 1  General practice as part of wider primary care

The general practice team is one part of a complex web of primary care services.

Source: Audit Commission
General practice is an important part of the complex healthcare system and acts as a gatekeeper to other specialised services.

Source: Audit Commission
26. The average general practice today is quite different from 50 years ago, when over three-quarters were staffed by one or two GPs, many working out of their home. Particularly striking is the recent increase in very large practices; in 2001 one-third of GPs worked in partnerships of six or more compared with one in five in 1988. This has been accompanied by a growth in purpose-built premises and a dramatic expansion in the employment of practice nurses in the last 20 years, as well as other practice staff (EXHIBIT 3, overleaf).

How has general practice developed?

27. The history of general practice can be characterised by continuity, with a few significant milestones (BOXES B and C, overleaf).

Recent policy changes

28. In the last five years, general practice has seen significant changes. PCTs now have powers to influence general practice and allocate resources. General practice, as with other parts of the health service, is now tasked with delivering national standards for clinical care and designing services around the needs of patients. General practice is seen as key in delivering the ambitious vision of the NHS Plan (Ref. 10).
EXHIBIT 3 Changing profile of general practice

There has been an expansion of practice nurses and other practice staff in the last ten years and a recent increase in larger practices.

### Box B: Key milestones in general practice

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<td>1911</td>
<td>National Insurance Act establishes the principle of a family doctor and a registered population (although restricted to workers earning more than £2 a week).</td>
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<td>1948</td>
<td>National Health Service created with free access to care from a family doctor, regardless of ability to pay. Key features have remained virtually intact – service free to the patient at the point of delivery; the GP list; the partnership as the main unit of organisation; independent contractor status; GP as gatekeeper to other specialised services.</td>
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<td>1952</td>
<td>Establishment of the Royal College of General Practitioners.</td>
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<td>1960+</td>
<td>Widening gap between hospital and general practice, with lifetime earnings of consultants estimated as 45 per cent higher than GPs in early 1960s; low morale and status of general practice – Standing Medical Advisory Committee of 1966 labelled it a ‘cottage industry’ – leads to threat of mass resignation of GPs.</td>
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<td>1966</td>
<td>Family Doctor Charter heralds new contract, which enhances GP pay and status and allows for the development of the practice. Changes include the reimbursement of 70 per cent of expenses of practice staff (including nurses) and opportunities for GPs to invest in premises, leading to a huge expansion of purpose-built premises – only 28 health centres were built between 1948 and 1967, but 700 new surgery premises were built in the following decade (Ref. 11).</td>
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<td>1979</td>
<td>Introduction of first phase of mandatory vocational training for general practice (previously GPs had trained in hospitals) and continued growth of academic departments of general practice.</td>
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<td>1990</td>
<td>NHS and Community Care Act introduced option for GPs to manage their prescribing budgets and the budget for some hospital services (GP fundholders). The first wave started in 1991 and by 1997 almost half of all GPs were fundholders, controlling about 15 per cent of all NHS spending. The impact of this scheme varied (Ref. 13); a recent review showed some effect in containing prescribing costs and increasing levels of services, but with high overall transaction costs (Ref. 14). However, it showed potential for GPs to drive changes locally.</td>
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System of GP remuneration. Contract was initially unpopular with the profession, but did result in increased pay, improved patient care and some reduction of inequalities (Ref. 12).
BOX B CONT  Key milestones in general practice

1990  Family Health Services Authorities (FHSAs) established as strategic bodies with responsibility for planning in primary care for the first time, introducing medical audit and indicative prescribing budgets. However, Audit Commission review suggested that ‘the structures for providing support and investment for general practices and for holding them to account [were] weak’ (Ref. 1).

1990s  Changes to GP out-of-hours arrangements, notably the development of GP co-operatives leading to more efficient organisation of on-call duties for GPs.

1997  First PMS pilots introduced. GPs could choose to opt out of GMS contracts and agree a budget to address particular local needs. By April 2002, about one-fifth of GPs were in this scheme1. Although not as innovative as some hoped, early evaluation shows some progress in use of staff, particularly in nurse-run pilots, recruiting staff to deprived areas and reducing inequalities (Ref. 15).

1998  First wave of PCGs established as subcommittees of health authorities, replacing fundholding and advising on commissioning of secondary care. They enabled collaboration between practices and stronger clinical networks. These were transitional organisations before primary care trusts were set up, but were important in their own right in ‘changing the organisational and cultural climate of primary care’ (Ref. 16).

1999+  National Service Frameworks setting standards for care in mental health, coronary heart disease, cancer and others. Concept of clinical governance, with duty of quality, introduced in all NHS organisations.

2000  First primary care trusts (PCTs) established with unified budgets across hospital, community and general practice services. More levers to influence general practice, including powers to develop local contracts through PMS schemes.

2000  NHS Plan describes the objective of a patient-centred service, with the general practice in a key role working with informed patients, targets for improved access to primary care and investment in staff and premises (see below).

2001  Participation in clinical governance and annual appraisal a requirement for all doctors. Five-yearly revalidation for all medical practitioners to follow.

2002  New GMS contract under negotiation for all GPs.

Source: Audit Commission

1 See www.doh.gov.uk/pricare/pca.htm
A framework for the new GP contract is now out for consultation. The proposals come from longstanding discussions with the profession, recognising some of the weaknesses and inflexibilities of the 1990 contract. The proposals build on the positive features of the voluntary scheme for practices, which could opt to be a PMS pilot. This scheme has proved popular, with about one-fifth of GPs joining this scheme by April 2002, enabling practices to change the way they work and providing more resources for disadvantaged populations. Some of these features are evident in the proposals for the new GP contract. Key changes proposed as part of the new contract include (Ref. 18):

- See www.doh.gov.uk/pricare/pca.htm

**BOX C** NHS Plan – key points relating to general practice

Overall, the vision is of a patient-centred service, where the patient and their GP together discuss treatment options, if necessary selecting the specialist and the time and place of treatment, as part of the consultation.

Another general move is for a further shift of secondary care services to primary care settings, particularly easier access to diagnostics, with an extension of specialist roles for GPs and nurses.

Other specific targets are:

- Patients to see a GP within 48 hours and a primary healthcare professional within 24 hours by 2004;
- Five hundred one-stop health centres by 2004 (one or two for every PCT);
- Three thousand surgeries upgraded by 2004 (about one-third of all practices);
- All GP practices to be connected to the NHSnet by 2002 and electronic patient records to be available by 2004 in 50 per cent of PCTs;
- Two thousand more GPs;
- Twenty thousand more nurses (for all sectors);
- NHS LIFT, a new private-public partnership, to develop premises;
- Annual appraisals for GPs from 2002;
- Up to 1,000 GPs with special interests taking referrals from other GPs; and
- Other relevant additions, for example, 1,000 primary care mental health workers and 500 community mental health staff.

Source: Ref. 17
• The patient list will belong to practices, rather than to individual GPs, allowing for more flexibility in the use of staff.

• Funds will be distributed by a global allocation to practices, rather than by retrospective reimbursements, allowing proper budgeting and less paper work.

• A distinction between ‘essential’ and ‘additional’ services at a practice level, as well as a wider range of optional enhanced services. All practices are expected to provide essential services.¹ Most practices are also expected to provide additional services, such as management of patients with chronic diseases, immunisation and ante-natal care.

• The PCT will be responsible for commissioning the complete range of primary care services for its population, so that where a practice opts to provide only essential services for the patients on its list, the patients will have access to additional services from another provider.

• Removal of responsibility for out-of-hours services from each GP – this responsibility will lie with the PCT, which can commission services from other providers, not just practices.

• A substantial proportion (30-50 per cent) of practice income will be related to agreed quality standards.

30. If implemented, the new contract will result in further movement from the traditional model of general practice. And there are tensions between some of the features of the ‘old’ and the ‘new’ (EXHIBIT 4). For instance, under the new contract, a PCT might contract with a group of community nurses to provide routine care for people with diabetes. This might result in better care, or more cost-effective care, but it is also more complicated for the patient and may lead to fragmentation of care or having to travel further. It also might not be clear who the patient should go to when feeling unwell.

¹ Defined as ‘the management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, and the general management of patients who are terminally ill’ (Ref. 18). This is the first time that the core business of general practice has been defined officially in this way.
EXHIBIT 4 Tensions in general practice

General practice is now being pulled in different directions, and there are tensions between traditional models and modern expectations.

Source: Audit Commission
31. Other questions relate to the possibility that changes in the new contract may result in ‘two-tierism’. While some larger practices offering a range of services (including national enhanced services, like endoscopy or advanced minor surgery) may attract more patients and expand, others offering only essential services may result in a poorer service overall, with deskilled and demotivated staff. This may threaten the existence of smaller practices and the expectation that people will have access to reasonably local family doctor services. There are also difficult trade-offs between the range of staff and ease of access. Larger practices, with multidisciplinary teams, may be able to offer longer opening hours and a range of staff with different skills, but travel time for some patients may be longer. Can the PCT ensure that patients have a real choice about the kind of general practices they want?

32. The terms of the new contract have not yet been agreed. But the direction of travel looks very promising in terms of the potential to achieve nationally defined standards of service and a more equitable distribution of resources and secure more manageable workloads within practices. Changes in funding should also redress some of the historic inequities and enable PCTs to plan all primary care services in their areas. There is also greater emphasis on quality and outcomes, although the pledge for a ‘high-trust, low-bureaucracy’ system of assessment raises some questions. And there are still a number of unresolved tensions in terms of what is expected of general practice and what it can deliver. Some of these tensions are explored in more detail in the following chapters.
33. This study examines existing evidence to establish the ‘baseline position’ of general practice, before major changes are introduced. It aims to identify the main strengths and weaknesses, and the challenges facing general practice in England in 2002. It does not cover Wales. This is partly because some of the data sources relate only to England, but also the particular features of general practice in Wales would give this analysis a different emphasis.

34. PCTs now have greater powers to allocate resources to general practice and to monitor their performance against national standards. To do this they need better information at a practice and PCT level. The Audit Commission will be working with PCTs in the next year to develop effective tools for shaping general practice to improve patient care.

35. This study considers existing evidence on general practice in England, covering:
- quality and service provision;
- pressures, demands and workload; and
- resources and supply (including workforce issues).
Summary

36. Patients are, on the whole, happy with general practice. Satisfaction levels are about 80 per cent, higher than for almost any other public service, perhaps reflecting frequent contact. New data show that patients are more satisfied with the clinical care they receive than with aspects of the practice organisation. The greatest source of dissatisfaction is time waiting for an appointment. This is particularly true for younger people (who do not wait longer) and for Londoners and people from minority ethnic communities (who do in fact wait longer than average).

37. The Primary Care Collaborative, a national initiative to support improvements in general practice shows what can be achieved through better team working and process redesign, with participating practices reducing the average wait to see a GP from 3.7 to 1.7 days.

38. Evidence on the quality of care in general practice is limited, but suggests considerable variation in the range and quality of services available to patients. For instance, one study showed that a third of practices recorded less than half the information needed to manage patients with asthma. It also appears that variation in the level of services is not matched to needs, and it is not clear that the variation in quality is related to the amount of resource available. However, there have been marked improvements, particularly in preventative measures and narrowing of inequality gaps. Studies of the type of practice – for example, size, training status, location – and whether that affects quality conclude that different practice types perform well on different measures – there is no simple blueprint for good practice.

Patient satisfaction

39. General practice is one of the most popular public services. While satisfaction surveys are not always reliable as a measure of quality, they are useful in providing some measure of the patient’s experience. A MORI poll in 2000 showed that 62 per cent of respondents rated general practice as the most important public service and general practitioners continue to command high levels of public confidence, comparing well with other health sectors (EXHIBIT 5). This poll showed that satisfaction was higher among those using the services – the frequency of contact with general practice services might be one contributing factor to its popularity.
40. The largest national survey about general practice was carried out in 1998. While there was no single question on overall satisfaction with general practice, 90 per cent of respondents felt that their GP had taken appropriate action and 99 per cent felt that the practice nurse had done so (Ref. 7). Satisfaction was similar for all social classes, although younger people were slightly less satisfied (although still high overall). Other general surveys reinforce the evidence of high levels of satisfaction; in fact the 2000 British Social Attitude Survey showed that satisfaction levels had remained relatively stable throughout the 1990s, with about three-quarters of respondents reporting that they were quite or very satisfied with their local GP (Ref. 19).

EXHIBIT 5 Satisfaction with GP services

General practice satisfaction rates are higher than those for other healthcare services.

Source: MORI poll commissioned for Audit Commission, 2000
41. New data are also available for more than 47,000 patients using general practice services. The data are derived from surveys of 407 practices and 1,535 GPs across the UK, published for the first time here, using the tool called the ‘Improving Practice Questionnaire’ (IPQ). A weighting scale was used to score patient ratings in percentage terms. Overall, patients rated the clinical aspects of care more highly than organisational features. For instance, 78 per cent of the scores showed an ‘excellent’ rating for communication with the doctor or nurse during the consultation but this fell to 57 per cent for appointment arrangements and 37 per cent for time waiting in the surgery. This tool presents an opportunity for practices to identify areas for improvement and measure changes over time. But overall it indicates that more work is needed to help practices review their organisation to meet patient expectations. The framework for the new GP contract proposes that patient satisfaction is one dimension of quality that practices will be expected to measure and act on.

Access to general practice

42. While levels of satisfaction are high overall, difficulty in getting an appointment is the biggest cause of dissatisfaction. Waiting times accounted for 55 per cent of the dissatisfaction in the 2000 MORI poll. Similarly, the 2000 British Social Attitude Survey showed that 51 per cent of respondents reported that the GP appointment system was in need of improvement (Ref. 19).

43. The National Patient Survey showed that one in eight (13 per cent) of respondents had to wait three or more days to see a GP and one-fifth (19 per cent) thought that they should have been seen sooner (EXHIBIT 6). This dissatisfaction was more marked for younger people, with 23 per cent of under 35s thinking they should have been seen sooner compared with 11 per cent of over 65s. People living in London (31 per cent) and those from minority ethnic groups (34 per cent) were similarly dissatisfied. However, survey results showed that younger people were not waiting longer to be seen, suggesting that the difference was in expectations, but people from minority ethnic communities and Londoners were waiting longer (for example, 21 per cent of those living in inner London wait three or more days to be seen, compared with 13 per cent overall).

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1 The survey was administered by Client-Focused Evaluations Programme based in Devon, Exeter. Permission to use these data was given by Dr Michael Greco, University of Exeter.
EXHIBIT 6  Satisfaction with waiting times for appointments with GPs

Some patients wait longer than others to get an appointment and nearly one in five patients feel that they should have been seen sooner.

Source: Ref. 7
44. Encouragingly, a recent review of evidence suggested that socially disadvantaged groups are able to access primary care as easily as other population groups with similar health needs (Ref. 20). Similarly, a review of the relationship between equity and access found only one example of systematic evidence of inequities in access to primary care, except for preventive services – which tended to be used least by those with greatest need (Ref. 21).

45. Fifteen per cent of respondents in the National Patient Survey were not using general practice because it was inconvenient – this was again higher for younger people (26 per cent of those aged 18-24 compared with only 3 per cent for the over 65s), those from minority ethnic groups (26 per cent) and those living in London (21 per cent).

46. In response to patient concerns about time to get an appointment in general practice, new targets were set in the NHS Plan (see BOX C), to enable patients to see GPs and other health professionals more quickly (Ref. 17). In addition, NHS Direct and Walk-in Centres have been set up to provide prompt advice and treatment. These initiatives all assume that patients do not mind who they see, as long as they are treated quickly. What is the evidence for this?

47. The National Patient Survey found that, of those registered with a group practice (92 per cent of the total) three-quarters were willing to see any GP. However, there were no further questions to examine this more closely, for instance under what circumstances seeing your own doctor was important. In 2000 the Consumers’ Association carried out a survey of 1,224 adults in which they asked respondents about their preference for seeing their own GP with an immediate, one-off problem versus an ongoing illness or condition.¹ Over one-half (58 per cent) said that they would take the first available appointment with whichever doctor was free for a one-off, but only 30 per cent for an ongoing condition. Indeed, 35 per cent stated that, for an ongoing condition, they would wait for the next appointment with their own GP, however long it took. People aged over 65 were more likely to wait for their own GP, whatever the nature of the problem.

¹ Results of IPSOS-RSL Omnibus Survey – 16080 NHS Direct commissioned by the Consumers’ Association and reported in Health Which? August 2000.
48. The trade-offs between continuity and convenience or ease of access are important and complex. Continuity is probably more important for some patient groups – for example those with chronic disease such as diabetes or asthma, or mental health problems. These conditions require knowledge of the patient’s lifestyle, circumstances and ongoing management of the disease or problem. Personal, continuous care taking account of patients’ individual needs has been shown to be cost-effective – ‘the integrative, relationship-centred approach explains why generalists use fewer resources than specialists while producing similar health outcomes for patients with chronic disease’ (Ref. 22).

49. In larger practices, patients might exercise some choice, for instance to see a female doctor or nurse for a cervical smear or to see a GP with manipulation skills for back pain. The development of GPs with specialist interests makes this element of choice more likely. In the light of this, some practices have developed the notion of continuity for an episode of care, where patients are encouraged to see the same doctor over time for a particular problem (Ref. 23).

50. But patients do not presently have the necessary information to make these choices. Recent policy contained in Delivering the NHS Plan (Ref. 10) directs each PCT to provide an annual Patient Prospectus on the choice of services available in primary care. This is a welcome initiative and it will be interesting to see whether it results in more informed decisions by patients about where they are treated. The other problem is whether patients will be able to exercise their choice. At present, in addition to having a right of access to general medical services, everyone in theory can change their doctor within or between practices. In fact, it can be difficult to register with the practice of one’s choice. As with schools, popular practices tend to be over-subscribed and in some areas, most or even all practices may have closed their lists to new patients. The NHS Confederation on behalf of the NHS and the BMA, are continuing negotiations on the system of patient allocation, which is the current mechanism for securing each person’s right of access to general medical services. It is vitally important that any replacement system ensures that everyone can access the full range of primary care services delivered to national standards.
Improving access

51. In the meantime, practices will have to meet the ambitious Government targets for patients to see a GP within 48 hours and a health professional within 24 hours. Results from local audit data showed that at the end of 2001 40 per cent of PCTs were finding it hard to meet interim targets – particularly to see a health professional within 24 hours. This is perhaps not surprising given that the current ratio of practice nurses to GPs is 1:2.3. By 2003, 90 per cent of practices will have to meet these targets and PCTs will be answerable for them. There is some concern about whether this target is appropriate for all patients, including routine follow-up appointments, and whether it might lead to staff having less time to spend with patients at risk. But it is clear that the waiting time to see a GP or nurse is a major cause of patient dissatisfaction.

52. The Primary Care Collaborative, run by the National Primary Care Development Team (NPDT), has been very successful in improving access and in changing practice culture to do this. The Collaborative was started in June 2000 with 20 PCG/Ts, each selecting five to seven practices in their area, followed by three further waves of 20 PCGs/Ts. The last wave of practices joined in September 2001. By the end of 2001, 1,000 practices (one in eight) covering 7 million patients, were engaged with the Collaborative. The lessons from these practices are being rolled out through regional networks.

53. Effort is being concentrated in three areas: improving access; coronary heart disease; and capacity and demand management (for secondary care). On access, practices have been asked to measure the time until the third available appointment offered to patients – ‘advanced access’. This is a more exacting target than the NHS Plan measure for the first available appointment to see a GP (48 hours) or nurse (24 hours).

54. Results from the Collaborative show a dramatic improvement in access rates, with more rapid learning in successive waves. There was 53 per cent improvement in the time to see a GP (from 3.7 days to 1.7 days) and 43 per cent improvement in the time to see a nurse for all practices involved (from 3.3 days to 1.9 days). I

I See www.npdt.org/
55. The methods for improving access are:

- Understand demand: map the demand for appointments on different days of the week and times of the year.
- Change how demand is handled: reduce the demand for face-to-face appointments by offering telephone appointments, email consultations, patient self-help (websites, patient-staffed desk), group consultations, or a different healthcare team member.
- Match capacity to demand: balance the capacity of the appointment system with the demand profiles.
- Plan for contingencies: prepare for planned and unplanned changes in both demand and capacity.

56. The programme has some national support, with a project manager from the PCT and links with the Collaborative, but the emphasis is on getting self-generating improvements within existing resources. Learning workshops are held and time is protected for practice teams which include all staff, from receptionists to GPs, to work together to devise solutions. The process of working together to achieve improvements may in itself have transformed the way in which practices work (CASE STUDY 1, overleaf).

57. Is quality of care improving?

57. This chapter has focused so far on patients’ views of general practice and those aspects of the organisation of care that need improving. But what about the actual care patients receive? It is very difficult to measure quality in general practice. Many studies use process measures such as premises standards or immunisation targets, in the absence of reliable data on the quality of care that a patient receives. As one commentator notes, it is important to ‘balance the need for measuring that which is measurable and measuring that which is meaningful’ (Ref. 24). However, given the problem in providing reliable measures of quality, there are still a number of examples of improvements in care during the last decade.

58. The coverage of population health screening increased during the 1990s, when incentive payments for GPs were introduced. Cervical cytology coverage has changed over that period (Ref. 25) (EXHIBIT 7, overleaf). It is notable that not only has overall coverage increased, but inequities between affluent and deprived populations have been substantially reduced. Similar data are available showing progressive improvements in immunisation coverage.
A Focus On

CASE STUDY 1 Collaborating practice under the NPDT initiative

A practice in Southern England recently introduced advanced access. The practice has a list size of 11,600 patients, and 6.24 whole time equivalent GP partners and it joined the NPDT initiative in March 2001. It initially had an average 12-day wait for a GP appointment and a shortfall of approximately 200 doctor appointments each week. In June and July, 2.75 WTE doctors left the practice.

The practice leads for the initiative, a GP and a nurse, began addressing the situation in a number of ways. They encouraged the partners to review systematically the frequency and nature of follow-ups and to agree protocols for common conditions. The practice introduced a way for nurses to manage same-day demand over the telephone, and a system for doctors to consult over the telephone. During the summer, the practice agreed to clear the backlog of appointments and recruited a locum to cover part of the GP vacancies. On 1 October a new partner started and the practice implemented advanced access.

The impact has been that:

- less than 1 per cent of patients fail to turn up for appointments;
- the weekly consultation rate is lower than for the same period in the previous year;
- 95 per cent of patients see the doctor of their choice;
- 99 per cent of patients see a doctor on their day of choice; and
- 90 per cent of patients see a doctor at their time of choice.

Source: National Primary Care Development Team
Evidence on trends over time are sparse for other aspects of care. One longitudinal study has been carried out of the management of patients with chronic disease in general practice looking at changes from 1998 to 2001 (Ref. 26). These showed general improvement, which was statistically significant for angina (EXHIBIT 8, overleaf).
The same study showed other improvements in care from 1998 to 2001. In the 20 practices studied, these included:

- increase in access to translators from 29 to 53 per cent;
- patients’ access to phone information from 82 to 100 per cent;
- improvements in mental health services and in services for older people.

The Government’s strategy of clinical governance has led to extensive quality improvement activity in primary care groups and trusts, with quality now high on the agenda (Ref. 27). National standards have been produced in key clinical areas such as coronary heart disease and diabetes, which are likely to improve standards generally and remove some of the unacceptable inconsistencies in practice. Apart from the results summarised above, it is at present too early to say whether these initiatives have resulted in direct improvement to patient care in general practice, although early evidence from the Primary Care Collaborative suggests marked improvements in targeted areas, such as care for coronary heart disease.¹

¹ See www[npdt.org/](http://www[npdt.org/)]
Variation in quality

62. But although there has been overall improvement since 1990, the baseline is one of different standards. Evidence suggests that different practice populations have access to different levels and quality of services in general practice. There is a dearth of good data in this field, as quality is notoriously difficult to capture. There has been only one systematic review of quality of clinical care in general practice (covering UK, New Zealand and Australia) (Ref. 28). This suggested significant areas of concern – for instance, even in the highest achieving practices, only 49 per cent of patients with diabetes had had the back of their eyes examined for retinal damage in the previous year and only 47 per cent of eligible patients had been prescribed beta blockers after a heart attack.

63. Few studies have attempted to measure quality of care in a representative sample of practices. The National Primary Care Research and Development Centre has done this. Sixty practices in England were randomly selected to take part in a detailed review of a sample of patient records (Ref. 29). Expert panels composed mainly of GPs defined aspects of care for diabetes, angina and asthma, which they regarded as necessary both to carry out and record. This study showed considerable variation in the quality of care, for instance one-third of practices failed to record half the ‘necessary’ items on the notes for people with asthma (EXHIBIT 9, overleaf).
EXHIBIT 9  Quality of care in general practices

There is considerable variation in the quality of care.

*Percentages are averaged across a sample of patients’ notes; a higher percentage indicates more items are recorded.

Source: Data provided by National Primary Care Research and Development Centre and summarised by Campbell et al 2001 (Ref. 29)
64. The major areas in which general practitioners generate costs are in prescribing drugs and referring patients to hospital. These both show substantial variation between practices. On the whole, it has been difficult to relate these directly to quality markers. Some prescribing indicators can be a reliable source of data on cost-effectiveness, such as the proportion of less effective and non-generic drugs used locally, and the spending on drugs of limited clinical value. For instance, while most areas are now meeting the national standard for 72 per cent of all items to be prescribed generically, a few practices in some areas are reaching less than 40 per cent¹, and spending on drugs, which are considered to have little or no lasting therapeutic value, varies six-fold (from 19p to £1.27 per weighted patient).²

65. While there is undoubtedly an element of inefficient prescribing, for some diseases, such as heart disease and asthma, high quality prescribing probably increases prescribing costs. However, it is interesting that increased spend on statins, used for secondary prevention of heart disease by lowering blood cholesterol, is not evenly spread across the country. The latest data derived from the Prescription Pricing Authority Toolkit³ show that those areas with the greatest increases in statin prescribing, after the CHD NSF was published, were not always those starting from the lowest base (EXHIBIT 10, overleaf). Prescribing of statins is variable and it is unclear whether it is related to the needs of the population, or to the behaviour of practices. But the extent of the variation indicates that there may be some inequalities in the standards of care that patients receive.

¹ Data derived from Department of Health, Common Information Core, 2000/01.
² Personal communication with the Prescribing Support Unit.
³ A set of used to analyse prescribing data from the Prescription Pricing Authority. The data are presented as nationally defined standard data sets and reports.
Overall, there are no simple conclusions about levels of prescribing and quality of care. The same is true for hospital referrals (Ref. 30). While high-referring doctors may be wasting resources, low-referring ones may be depriving their patients of beneficial treatment. This is illustrated by the probable ‘under-referral’ by GPs of older people with dementia in some parts of the country, as indicated in a recent Audit Commission study (Ref. 31).

In 2001 the Government proposed in its national Performance Assessment Framework that the quality of GP care could be indicated from hospital admission rates for a number of conditions that could be managed in primary care (Ref. 32). However, around half the variation in these admission rates can be explained by socio-demographic factors, demonstrating the dangers of making naïve assumptions about performance in this area (Ref. 33). In addition, the relationship between

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**EXHIBIT 10 Growth in use of statins compared with baseline position**

PCG/Ts with the highest rates of growth in statin prescribing were not always those starting from the lowest base.

*Source: Audit Commission – data derived from the Prescription Pricing Authority Toolkit*
general practice and other parts of the health service is not always clear. At a health authority level, we found no correlation between the resources available to general practice and variables such as rates of outpatient referrals, emergency admission or elective procedures. Care needs to be taken in using referral activity or prescribing to make generalisations about the quality of general practice. Studies that have reviewed the quality of care tend to use a ‘basket’ of indicators that together give some sense of the range of services and quality of care experienced by patients at different practices (Ref. 29).

Does type or location of practice matter?

68. A number of studies have looked at the question of whether particular types of practice provide good or poor quality care (Refs. 29, 34, 35, 36 and 37).

69. Some generalisations can be made about factors associated with better care, including:

- Chronic disease management tends to be better in larger practices.
- Access to care, continuity of care and some aspects of communication tend to be better in smaller practices.
- Uptake of preventive services tends to be better in affluent areas.

- Some aspects of care tend to be better in those practices approved to train GP registrars.

70. It is important to appreciate that these generalisations conceal large variations in standards of care between practices. For example, the largest study of a representative sample of practices showed that, on average, chronic disease management was better in larger practices, but small practices were represented among those providing both the best and the worst care. Current evidence suggests that ‘no practice type has a monopoly on quality of care’ (Ref. 29). There are therefore good arguments for preserving a diversity of practice sizes and types. But at the same time, the PCT has to ensure that these are meeting minimum quality standards and satisfying local needs, rather than simply arising from historic patterns of care. One challenge is to ensure that the trend towards larger practices does not mean that patients lose out on some of the advantages that smaller practices currently offer.
71. This chapter has shown considerable variation in the quality of services for patients. Some patients have to wait longer to see a doctor or nurse and some health needs are not being met. There have been concerted efforts by patients, professionals and policymakers to improve quality standards in recent years. Quality improvement is a key component of the proposed new GP contract. There is now more rigorous monitoring of patients and more exacting standards of clinical care and the pressure to achieve more consistent quality in general practice is one of a number of pressures. The next chapter explores the reasons for increased demands on general practice and considers how practices are coping with these pressures.
4 Pressures, demands and workload

Summary

72. Despite the perception of a marked increase in general practice workload, there is little hard evidence to confirm this. Data for the last decade show increased consultation times, smaller patient lists and reduced out-of-hours working. While there has been a slight increase in recorded hours of patient care, this does not reflect the other activities now demanded of general practice, including liaison with a range of external bodies such as PCTs and social services. Also, these data do not reflect the real change in the complexity of the GP workload over the same time, demonstrated by the shifting workload from hospitals to primary care, patients’ growing health and social care needs, including more complex drug regimens and exacting national clinical standards, and greater scrutiny. Evidence from focus groups of GPs convened by the Audit Commission supports the increased complexity of caseload and ‘decision density’ in general practice.

73. There is more that can now be done for individual patients and patient consultation times need to be increased to do everything necessary. Evidence shows that longer consultation times are associated with better outcomes for patients.

74. NHS Direct and Walk-in Centres have not, so far, reduced demand for conventional family doctor services; they offer extra convenience rather than substitute services. The next ten years are likely to see a continuing increase in the complexity and volume of workload in general practice. Every practice needs to review how it can manage its workload more effectively, those working with the Primary Care Collaborative show what can be achieved by teams redesigning their work.

Pressures on general practice

75. General practice staff work in an increasingly complex world. Advances in technology and clinical care, changes in the organisation of healthcare, policy initiatives and increased patient expectations have resulted in greater demands on staff (EXHIBIT 11, overleaf).
There are many forces acting upon general practice in 2002.

Source: Audit Commission
76. The population as a whole is ageing (EXHIBIT 12) and the number of people aged 85 or over will rise from 1 million in 2000 to 1.4 million in 2024. This will lead to more demands on general practice, as older people (those aged 65 or over) tend to consult their GP more (six times a year compared with the average of four visits). Those aged over 75 years account for 40 per cent of all GP home visits (Ref. 38) and for one-half of NHS expenditure on drugs.

**EXHIBIT 12  Forecast population change**

Growth in the numbers of older people has resource implications for general practice.

*Source: Office of National Statistics, 2000-based population projections*
77. Other changes have dramatically affected the general practice teams’ workload. Changes in models of care have transferred the location of much healthcare from hospital to general practice, in particular care for older people and those with severe mental health problems. The number of long-stay NHS beds reduced by 38 per cent between 1983 and 1996 – a loss of 21,300 beds\(^1\). In addition, the average stay for ordinary admissions more than halved, from 16 days in 1990 compared with 7 days in 1999. Upon discharge from hospital the GP resumes primary medical responsibility.

78. The last 15 years have also seen dramatic changes in the management of many chronic diseases, driven by better drug therapies and knowledge, and is now routinely done in general practice rather than in hospital. For example, people with diabetes used to be under the care of a hospital physician. A national survey of GPs in 1997 showed that 75 per cent of patients with diabetes were managed largely outside the hospital (Ref. 39). Changes in morbidity mean that there are much greater numbers of people who need treatment – the number of people with diabetes is likely to double in the next ten years. Care has also shifted out of hospital in other areas (EXHIBIT 13).

79. Clinical staff are under greater scrutiny, with new requirements for professional accountability and national standards of access and quality. The implementation of national standards has huge implications for general practice. National Service Frameworks (NSFs) have been introduced for coronary heart disease (CHD), mental health, cancer, diabetes and older people. For example, to comply with the NSF on CHD, practices have to set up disease registers and clinics, draw up treatment protocols and be more proactive in the way they manage people with CHD and those at risk of it. In terms of the information alone, this has big workload implications.\(^{II}\)

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\(^1\) There was an increase of 141,000 beds in private nursing and residential homes over this period. The GP assumes the main responsibility for care.

\(^{II}\) One study analysing the workload implications of the NSF estimated that an average practice would need to regularly record 2,221 items, some of which would not previously have been collected (J Hippisley-Cox and M Pringle, ‘General practice workload implications of the national service framework for coronary heart disease: cross-sectional survey’, *British Medical Journal*, Vol. 323, 2001, pp269-70).
To take another example, the NSF for older people includes a module on managing medicines as older people have higher use of medicines generally, and are more likely to experience adverse drug reactions (Ref. 40). Clinical staff are asked to carry out more detailed risk assessment and reviews of medication. This all adds considerable time to patient consultations and increases the burden of decision-making, if GPs are to adhere to the standards for appropriate prescribing, against which they may be audited (BOX D, overleaf). But the quality and cost savings that can be achieved are immense, improving healthcare outcomes and safety, and preventing adverse drug reactions and avoidable hospital admission. These examples illustrate both the demands on general practice from new national standards and the difference that improved standards can make.

EXHIBIT 13  Shifts in organisation of care and their impact on general practice

Significant areas of healthcare are no longer provided in hospital, placing more demands on general practice.

Source: Audit Commission

80. To take another example, the NSF for older people includes a module on managing medicines as older people have higher use of medicines generally, and are more likely to experience adverse drug reactions (Ref. 40). Clinical staff are asked to carry out more detailed risk assessment and reviews of medication. This all adds considerable time to patient consultations and increases the burden of decision-making, if GPs are to adhere to the standards for appropriate prescribing, against which they may be audited (BOX D, overleaf). But the quality and cost savings that can be achieved are immense, improving healthcare outcomes and safety, and preventing adverse drug reactions and avoidable hospital admission. These examples illustrate both the demands on general practice from new national standards and the difference that improved standards can make.
81. Another possible indicator of an increased workload for GPs is the amount of items prescribed. Between 1995/96 and 2001/02 the number of items prescribed increased by 24.6 per cent (TABLE 1). The rise was more pronounced in the last year or two, due to a range of factors including national policy (for instance, the greater use of statins in the management of heart disease or the policy shift to make nicotine replacement therapy available on prescription); new drugs becoming available (both new therapies, such as Relenza for prevention of flu, and new indications for existing drugs, such as the use of taxanes for a wider range of patients with cancer); and pressure from patients and the pharmaceutical industry.

Source: Ref. 40
**TABLE 1 Changes in the number of drugs prescribed (mainly by GPs)**

The number of items prescribed has increased steadily over the last seven years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of items prescribed (million)</th>
<th>Percentage increase in number of items prescribed</th>
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<tbody>
<tr>
<td>1995/96</td>
<td>468</td>
<td>–</td>
</tr>
<tr>
<td>1996/97</td>
<td>480</td>
<td>2.6%</td>
</tr>
<tr>
<td>1997/98</td>
<td>498</td>
<td>3.5%</td>
</tr>
<tr>
<td>1998/99</td>
<td>509</td>
<td>2.3%</td>
</tr>
<tr>
<td>1999/00</td>
<td>527</td>
<td>3.5%</td>
</tr>
<tr>
<td>2000/01</td>
<td>553</td>
<td>4.9%</td>
</tr>
<tr>
<td>2001/02</td>
<td>583</td>
<td>5.4%</td>
</tr>
<tr>
<td>1995/96 to 2001/02</td>
<td>–</td>
<td>24.6%</td>
</tr>
</tbody>
</table>

*Source: Prescription Pricing Authority, 2002*

82. Within this overall increase in prescription items, the number of prescriptions for specialist or ‘amber’ drugs, that is those initiated by specialist consultants in secondary care, has increased by 70 per cent over three years (**TABLE 2, overleaf**). Prescribing responsibility is passed to GPs once the patient is stabilised on an appropriate dose. These amber drugs tend to be expensive, such as beta interferon for patients with multiple sclerosis, and require regular monitoring by the GP to ensure patient safety and benefit. GPs are unlikely to withdraw treatment or modify doses without advice from the secondary care consultant; however, they are expected to monitor the effect of the drug regularly. There are recommended protocols for GPs to monitor patients on amber drugs, but many are not yet agreed or in use, adding to the pressures on GPs.
TABLE 2 Changes in the number of specialist drugs prescribed

The number of specialist drugs prescribed, which will impact on GPs’ workloads, has increased dramatically in recent years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of items prescribed (million)</th>
<th>Percentage increase in number of items prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>1.9</td>
<td>–</td>
</tr>
<tr>
<td>1998</td>
<td>2.1</td>
<td>10.5%</td>
</tr>
<tr>
<td>1999</td>
<td>2.5</td>
<td>19%</td>
</tr>
<tr>
<td>2000</td>
<td>3.3</td>
<td>32%</td>
</tr>
<tr>
<td>1997 to 2000</td>
<td></td>
<td>74%</td>
</tr>
</tbody>
</table>

Source: Prescription Prescribing Authority, 2001

83. Patient expectations have also risen, with greater access to information about health and healthcare. For instance, there are around 10,000 health information websites, and the number of new health-related sites in the EU is increasing by 300 a month (Ref. 6). In addition, the number of conditions officially classified as illnesses continues to grow and more options are available to treat each patient.

84. Increased expectations, more complex caseloads and greater scrutiny have all added to the strain on general practice staff (BOX E).
General practitioners describe their workload as more complex

‘Now there’s this concept of decision density, you’ve got to fit so many more decisions into that individual consultation, therefore you can’t be the listening ear.’

‘But there have been some actual shifts as well, the drug monitoring – that’s the rheumatoid, rheumatic diseases, [now] we try to do as much as we can of the monitoring of patients on disease modifying rheumatic drugs. But that’s an extra job that didn’t used to be done in general practice. It was hardly done at all. Because again it’s about the whole goal-post shifting, and the evidence showing a much more complex bit of care for patients, who previously needed support and pain management and very little else [from me].’

‘And patient expectations, the fact that they come in with their print-out from the internet. I have patients coming in and saying “why haven’t you got me on a statin?” because of what’s written in the Daily Telegraph. And patient expectations are going up and up and up.’

‘We feel like the filling in the sandwich, patient expectations are increasing all the time and the public messages reinforce this and the chronic state of play in hospitals means we get squeezed from all sides.’

‘[We are] overwhelmed by evidence base change in all areas, all of which affect general practice. In the rigidity of targets, everything else gets lost.’

‘And the clinical governance – every patient who’s got a clinical governance disease area – you’ve got to do a checklist – are we up to date with the various checks that should be done? And the net result is that the consultations are taking longer and longer and longer. I do think the patients value that, but in terms of the number of patients you can get through, it is getting more and more difficult.’

‘We sort of viewed disasters as coming from out there, not created from within. But to some extent, they are more likely to be created from within now that we are handling more complex drugs …’

‘I mean, ten years ago someone had high blood pressure. They’d come; you’d measure the blood pressure. “Your blood pressure’s fine, now go away.” Now the checks, has he had an ECG, what about their cholesterol, shall I check their ten-year CHD rating on my Excel [spreadsheet]?’

Source: GP focus groups convened for the Audit Commission, 2002
85. The last 20 years have seen significant changes in where and how patients are managed, particularly those with longstanding and complex needs. Some of these changes have brought real benefits to both patients and staff. For instance, the development of GPs with specialist skills in areas such as dermatology has enabled patients to be seen quicker and nearer to their home, while allowing individual GPs to develop their skills. This will be discussed more fully later in the report, when considering how the whole team and their skills are used. But the general shift of activity and responsibility in many areas of patient care, particularly for those with chronic problems, should be noted.

Measuring workload

86. But while the caseload is more complex, what evidence is there of quantitative changes to workload in general practice? It is very difficult to measure workload, since a working life cannot be reduced to simple measures of activity, let alone quality. But it is useful to consider some traditional measures, to understand more fully the present picture of general practice. These include the numbers of hours worked, and the number and length of consultations. These in turn are influenced by list size and composition. Some of the main trends in workload over the last ten years are summarised in Table 3.

87. One factor accounting for demand on general practice is the patient list size. There has been a reduction in the average list size due to increases in the number of GPs. Between 1988 and 2001 the average list size in England reduced by 8 per cent, from 1,999 to 1,841 per GP principal (headcount). Going further back, list sizes have decreased by around one-third, from a UK average of 2,506 in 1951 to 1,778 in 1999. Although average list size has reduced there are wide variations between practices.

88. The most recent evidence points to some increase in the average number of working hours – from 37.01 hours in 1989 to 39.21 hours in 1998 (6 per cent). At the same time, home visits have become less common – from 13 per cent of all consultations in 1989 to 5 per cent in 2000 (excluding out-of-hours work) (Ref. 38).
GPs were asked to record for each half-hour period all activities undertaken throughout the survey week. GMS activities included surgery (including telephone consultations), home visiting (including travel time), clinics, patient casework, practice administration, attending education courses and teaching. Number of hours worked also includes an apportioned amount of time spent on professional reading and seeing pharmaceutical or medical representatives. In 1989 and 1993 hours include out-of-hours worked but are excluded from the survey in 1997.

<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>Changes in GP workload</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average number of patients per GP principal</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1,999</td>
</tr>
<tr>
<td><strong>Average number of GMS hours worked per week</strong>&lt;sup&gt;b&lt;/sup&gt;</td>
<td>37.01*</td>
</tr>
<tr>
<td><strong>Average number of hours personally on-call per week</strong>&lt;sup&gt;b&lt;/sup&gt;</td>
<td>23.48</td>
</tr>
<tr>
<td><strong>Average number of GMS hours worked out of hours per week</strong>&lt;sup&gt;c&lt;/sup&gt;</td>
<td>n.a.</td>
</tr>
<tr>
<td><strong>Average length of consultation (minutes)</strong>&lt;sup&gt;b&lt;/sup&gt;</td>
<td>8.8*</td>
</tr>
</tbody>
</table>

*Great Britain, **England, n.a. – not available

Source: (a) Ref. 65; (b) Department of Health (1994) General Medical Practitioners’ Workload Survey 1992-93, Joint Evidence to the Doctors’ and Dentists’ Review Body from the Health Departments and the GMSC; (c) Review Body on Doctors’ and Dentists’ Remuneration, Twenty-sixth Report (1997)
89. But these figures do not include time spent liaising with other agencies and other non-clinical activities (which are likely to have increased significantly in the last ten years). The number of agencies and individuals – such as PCTs, mental health teams, patient groups and colleagues in other practices – with which GPs and practice nurses now have to work, has grown. The other un-quantified demands on staff time are clinical governance and audit activities.

90. Evidence points to average consultation time increasing from 8.8 minutes in 1989 to 9.36 minutes in 1998. This marks a considerable increase from the six to seven minutes on average in the 1960s, but it may still be insufficient. Anecdotal evidence from our GP focus groups suggest that many doctors feel they do not have enough time to spend with their patients. A recent systematic review confirms that longer consultation times provide higher-quality care. Doctors with longer consultation times prescribe less and give more health promotion advice, and longer consultation times are associated with better outcomes for those with chronic disease (Ref. 41). The previous section outlined the ways in which more is now expected from the patient consultation – from opportunistic health promotion advice to more complex treatments and discussion of options with the patient.

91. One burden on GPs is the 24-hour responsibility for their patients. Traditional arrangements included rota arrangements or deputising services, with a small number providing care themselves. Recent improvements to out-of-hours services have now eased this burden considerably for doctors. GP co-operatives have been established, largely as bottom-up initiatives, where groups of GPs (from 20 to 500) share responsibility for out-of-hours care of the registered patients of all participating practices. The BMA 2001 survey of over one-half of all practising GPs in England and Wales showed that 67 per cent belonged to a co-operative and 92 per cent of respondents had some co-operative or deputising service available in their patch. Improvements in out-of-hours arrangements have probably made a great difference to GP morale – one study of GPs before and after the setting up of an out-of-hours co-operative reported significantly lower stress levels (Ref. 42).

‘What has made an enormous difference to our work over the last five years is no longer doing night calls...’

Source: GP focus group convened for the Audit Commission 2002
92. Patients are less satisfied with out-of-hours care – only three in ten respondents in the MORI poll commissioned by the Audit Commission in 2001 claimed to be satisfied with their local GP out-of-hours services (although one-half of those expressing an opinion said they had never used the service). Recent scores from more than 45,000 patients showed only 47 per cent satisfaction with after-hours services, compared with 77 per cent who were satisfied with a routine visit to the doctor. Data from the National Patient Survey also showed slightly lower dissatisfaction, although this was still relatively high for those using the service (82 per cent satisfied with their last visit compared with 90 per cent for daytime consultations). The proposals for a new GP contract will remove the mandatory responsibility of the GP to ensure out-of-hours cover – instead, PCTs will be responsible. More work needs to be done to assess the impact of these changes on patients.

New providers of care

93. Some new primary care providers have been introduced in the last few years – NHS Direct and Walk-in Centres. These are designed to provide greater access to patients (24 hours, 7 days a week in the case of NHS Direct) and to ensure that patients make more appropriate use of both primary and emergency services. Have these initiatives reduced the demand on general practice?

NHS Direct

94. NHS Direct, a national telephone helpline providing information and health advice for people in England and Wales was first announced in 1997 and became available to the whole population by the end of 2000 at a cost of £80 million (Ref. 43). This is significant for general practice because of the potential to improve the appropriate use of GP consultations. The nurse advises the caller whether they can manage the problem themselves, should make an appointment to see a doctor or other professional, or visit A&E or other emergency service.

I See footnote to para. 41
95. A recent evaluation of the scheme in England by the National Audit Office suggested that it achieved a high level of satisfaction and a good safety record (Ref. 43). It concluded that there was not yet a visible effect on demand for NHS services overall, with volume still being relatively small – 3.5 million calls in 2000/01 (EXHIBIT 14). Numbers are likely to increase substantially as people become more aware of the service, with 7 million calls predicted in 2001/02. A further four-fold increase – 30 million calls a year – is expected by 2008 (Ref. 10).

96. In terms of the present impact of NHS Direct on the demand for GP services, analysis in the NAO report showed that 54 per cent of callers were actually advised by an NHS Direct nurse to see a GP compared with 72 per cent who said that without this service they would have contacted a GP (although no data were available on the actual outcome of the call). This means that 18 per cent of callers were advised how to care for themselves instead of contacting their GP – indicating a reduction in the demand on general practice, although perhaps not as dramatic as envisaged.

97. Criticisms of NHS Direct overall include the appropriateness of advice, lack of awareness of the service among the most needy population and the capacity to meet increasing demand, given that it currently employs 970 WTE nurses. Although this is only about 0.4 per cent of all registered nurses working in the NHS, it is significant given their level of skills and experience and the projected increase in numbers required to develop the service (Ref. 43) to 1,150 WTE by March 2002 (a 19 per cent increase).

98. An earlier evaluation of the impact of NHS Direct on emergency services concluded that there had been no significant change in the use of A&E or ambulance services, but a small but significant change in the use of GP out-of-hours services (Ref. 44). In the future, NHS Direct will act as a gateway to all primary care out-of-hours services, either through people calling NHS Direct or by automatic call transfer from a GP practice. Initial evaluations of these early pilot schemes, which cover 10 million people, show a general reduction of the number of night-time call-outs for GPs although, as call-outs become much more appropriate, intensity of workload may increase. The most significant impact of NHS Direct on general practice may in future be in being the entry point for out-of-hours care.
EXHIBIT 14  Volume of activity within primary care

New primary care providers’ activity is marginal compared with activity in general practice.

General practice provides a very large volume of weekly patient consultations within primary care...

**GP consultations = 5 million**

**District nurses = 625,000**

**Health visitors = 317,000**

**Community psychiatric nurses = 98,100**

**NHS Direct = 67,300 telephone calls**

**Walk-in centres = 590 attendances**

... in addition to these, 10 million prescription and over-the-counter items are dispensed by community pharmacists each week, as well as advice and information to patients.

**NHS Direct = 1 call to 75 GP consultations**

**Walk-in centres = 1 attendance to 8,510 GP consultations**

Walk-in Centres

99. By April 2002, 41 Walk-in Centres were approved with up to £30 million made available in the first year as part of a central initiative. These centres were to be nurse-led and offer primary care services (essentially treatment for minor illness and injuries) without an appointment, with long opening hours. Early assessments suggest that they are well used by younger people, who find general practice less convenient. But because consultation times are relatively lengthy, and volume is still relatively small, the cost effectiveness of Walk-in Centres has been questioned. Other criticisms focus on the lack of integration with other services, particularly general practice, and ‘little evidence to show that service delivery was planned in response to formal assessment of local needs’. Indeed, the location of Walk-in Centres were determined centrally with little control by local primary care organisations, making them difficult to integrate with other services.

100. PCTs have to ensure that 90 per cent of the population can see a GP within 48 hours or health professional within 24 hours by March 2003. Recent guidance states that if this is not possible by traditional general practice, PCTs should consider using NHS Walk-in Centres and other means. Walk-in Centres to date have had a limited number of attendees, although some patients find them convenient. At present, they are not making a significant impact in easing the pressures on general practice.

101. Despite these new initiatives, there is still likely to be a significant problem for general practice in meeting current demands. In order to deliver all that is demanded of the 21st century practice, each practice team will have to carry out a fundamental review of the way it works. As one commentator, David Mechanic, has observed:

‘Now there is so much more doctors can do, there are many more external forces impinging on their practice, and patients and the public have raised expectations. Oversight has increased and autonomy has diminished. The solutions are less likely to be in a doctor’s workload and more likely to be in the redesign of practice.’

(Ref. 48).

GP support varied across the nine London centres. Their WTE contribution ranged from 0 WTE in one centre to 1.5 WTE at another (Ref. 45).
The next chapter considers the way that resources are currently used. It highlights inequalities across the country and looks in particular at problems in recruiting and retaining staff. Even to meet current workload, current capacity is stretched. Better use needs to be made of all parts of the primary care team and practices need to review how they work. This is the only way in which practices can do all that is expected of them in the new NHS.
5 Resources and supply

Summary

103. Since 1948, much of general practice spending has been outside the control of the local primary care organisation. Resources have in the past been driven by GPs’ investment decisions. Historic patterns of funding and staff have resulted in inequities across the country. The highest-resourced areas have twice as much funding and more than double the number of GPs as the lowest-resourced areas. Areas with fewer GPs are not compensated by having more practice nurses and these ‘under-doctored’ places tend to be in deprived areas with greater health needs. Recent policy changes on resource allocation and the arrangements proposed in the new GP contract will empower PCTs to allocate resources according to the health needs of practice populations.

104. In some places, the quality of general practice is compromised by failure to attract and retain staff. The overall vacancy rate for GPs (there are no data available for practice nurses) is approaching 3 per cent. But the picture is much worse in certain areas, for example, in one inner city area, one in five GP posts is vacant.

105. One in three GPs is over 50 and in 10 per cent of PCTs more than one-half of GPs are over 50. Higher proportions of older GPs are in areas of greatest need. On current figures, it may be difficult to replace those leaving, particularly in more deprived areas. There are very limited data for practice nurses, but a similar picture emerges of an ageing workforce. However, a positive feature is that the practice nurse and GP population is relatively stable, with many remaining in the same post for a number of years.

106. While recent trends are encouraging, with an increasing uptake of GP registrar posts, at present, the number of those joining general practice is only marginally higher than the number of those leaving. Given these rates of growth it will be difficult for the Government to meet its targets for expanded staff numbers, particularly given the increasing proportion of those working part-time.

107. It may be difficult to sustain traditional models of general practice, and the profile of general practitioners is changing, with more women, more GPs working part-time, and more working in non-principal posts and PMS schemes. Many GPs are also taking up opportunities to diversify into research and specialised areas of clinical practice. These changes are positive, but the culture and organisation of general practice has sometimes been slow to reflect them. The
notion of a GP principal working full-time in a practice for all their working life and providing almost all the clinical care for their patients is no longer the dominant model. These trends are likely to continue – a survey of 1995 medical graduates showed that two-thirds of those wanting to join general practice were women, and all respondents wanted more flexibility to pursue other interests and combine work with family. Workforce planning by PCTs should reflect these trends.

108. Better use could be made of other members of the practice team to improve patient choice and standards and to relieve some of the GPs’ workload. More than eight out of ten practice nurses work part-time and PCTs should devise strategies to maximise their use. There are no reliable figures on the number of nurse practitioners in general practice, but there appear to be very few. Nurse practitioners have specific training and can work autonomously, diagnosing and treating patients. As generalists they have the potential to take on some of the GPs’ caseload and they also have a role as specialists, particularly in managing people with chronic disease, such as diabetes. Studies have shown that some nurse-led services offer the same or better quality of care as GPs, but not necessarily at lower costs. But there will not be enough GPs to meet the growing demands of the service and to meet patient expectations. More will need to be done by others, and the last ten years has seen a missed opportunity in developing a sound infrastructure of skilled nurse practitioners in primary care.

109. Spending on drugs locally varies two-fold and cannot be explained by differences in health needs alone. Local management of the drug budget is increasingly important, given growth in drug spending overall. Pharmacists are a crucial part of the primary care team and have not always been used to best effect. As well as high street pharmacists who dispense drugs to patients and offer advice, pharmacists are increasingly being employed by PCTs or practices to advise staff, improve prescribing practice in line with new national standards, and to help manage the drug budget. There is currently a shortage of trained pharmacists, with vacancy rates for NHS trust and community pharmacists about three times higher than that for GPs. Discussions about a new contract for pharmacists and local development schemes will potentially enable the better use of pharmacists as a key primary care resource.
The Primary Care Collaborative shows the impact of applying some basic management techniques in practices and more needs to be done to improve local management. Currently, the role and activities of the practice manager vary widely from practice to practice, with no recognised national standards.

The quality of practice infrastructure, including premises and information systems, varies greatly. A small minority of premises do not meet basic standards. Of more concern, eight out of ten have limited space – although practices need more room to allow large teams to work together and to train more staff. Also, most practices are not readily accessible by disabled people. The special initiative in London in the 1990s to improve standards in primary care showed that targeted investment in premises can make a real difference. Premises have been identified by the Government as a key area for improvement and the proposed new GP contract framework outlines some regulatory changes to encourage investment. Progress in this area should be monitored.

Understanding flows of money

Spending on general medical services (GMS)

GMS (including prescribing costs) accounts for three-quarters of family health services (FHS) expenditure (EXHIBIT 15). The funding of GMS is a complicated mixture of reimbursements, fees and allowances, which are set out in national regulations. The big picture is that expenditure on GMS is divided into two parts: non-discretionary and discretionary (previously known as non-cash-limited and cash-limited). The non-discretionary part accounts for about 78 per cent of all GMS spend, and relates mainly to reimbursement of practice expenses, including GP remuneration. Much of the funding is directly related to each GP, so that in areas with a relatively high number of GPs, GMS resources are higher, and vice versa for areas with relatively few GPs.

Prior to the Primary Care Act in 1997, which enabled primary care organisations to agree local contracts with practices via Personal Medical Service schemes, investment in setting up practices rested with GPs and not the local primary care organisation (FHSA or health authority). Areas which were pleasant to live and work in tended to attract GPs and, conversely, GPs were less likely to invest in unattractive areas. Once a GP set up
a practice, GMS non-discretionary funds followed and so an uneven pattern of resources was established.

114. The discretionary part – less than one-quarter of GMS expenditure – is intended to reimburse 70 per cent (normally) of the costs of practice staff, including some training, as well as some costs for computerisation and premises. But in some areas the amount reimbursed can be less than or more than this proportion. PCTs have some control over the discretionary monies, although most is already committed for staffing and other costs. A new and increasing proportion of funds is now committed to Personal Medical Services (PMS) schemes – local contracts between a PCT and a practice or other provider for the delivery of services for a pre-determined budget replacing the national GMS arrangements. Local enhancements to practice funding for particular services can also be delivered via GMS Local Development Schemes.

EXHIBIT 15 Expenditure on Family Health Services, 1999/2000

Discretionary expenditure on general practice is very small.

Source: Ref. 78
115. Historically the vast proportion of GMS has been outside the control of the local primary care organisation – the Family Health Service Authority (FHSA), Health Authority and now the PCT. This contrasts with all hospital and community funding, which is cash-limited and within the control of the local health commissioning body. In practice, most health service funds for local services are committed to continuing to run current hospitals and other services and pay staff, so the difference can be exaggerated.

116. For the first time in 2002/03, GMS non-discretionary monies form part of the capitated funding system. This should enable those PCTs with historically under-resourced general practice to invest more to redress the balance. Changes proposed in the new contract for GPs mean that practices will receive a global allocation, calculated on patient need, allowing them to plan resources in advance.

Spending on drugs

117. Prescribing of drugs represents about 45 per cent of Family Health Services expenditure (see EXHIBIT 15) and is increasing by more than other areas of health expenditure. In the last six years (since 1995/96) spending has increased by over 60 per cent (TABLE 4). This reflects in part the need for practices to comply with national standards – for instance the greater use of statins in the secondary prevention of coronary heart disease. In the last year, spending on statins increased by 31 per cent and accounted for one-third of the overall increase in drug expenditure. PCT’s overall spending is cash-limited and the increase in prescribing expenditure is likely to put pressure on other parts of the budget and other services locally.

In 2001/02, where PCTs were operational, formal responsibility for the drugs budget rested with them. In the rest of England, formal responsibility rested with health authorities, who delegated responsibility to primary care groups (PCGs).
Prescribing expenditure has increased by more than three-fifths since 1995/96.

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual prescribing expenditure (£m)</th>
<th>Percentage increase in prescribing expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995/96</td>
<td>3,455</td>
<td>–</td>
</tr>
<tr>
<td>1996/97</td>
<td>3,767</td>
<td>9.0%</td>
</tr>
<tr>
<td>1997/98</td>
<td>4,091</td>
<td>8.6%</td>
</tr>
<tr>
<td>1998/99</td>
<td>4,346</td>
<td>6.2%</td>
</tr>
<tr>
<td>1999/00</td>
<td>4,810</td>
<td>10.7%</td>
</tr>
<tr>
<td>2000/01</td>
<td>5,045</td>
<td>4.9%</td>
</tr>
<tr>
<td>2001/02</td>
<td>5,585</td>
<td>10.7%</td>
</tr>
<tr>
<td>1995/96 to 2001/02</td>
<td>–</td>
<td>61.6%</td>
</tr>
</tbody>
</table>

*Source: Prescribing Support Unit, 2002*
118. The amount spent by PCG/Ts on prescribing for every patient varies two-fold – from £15.80 to £33.70 per weighted patient per year (EXHIBIT 16). One formula developed for predicting prescribing spending based on need (including long-standing illness) can explain 60 per cent of the variation in expenditure between practices (Ref. 49). More detailed morbidity measures may account for more of this variation, but it is still likely that some elements of it are attributable to differences in individual clinicians and practices rather than health needs.

119. The unexplained variation in spending and the significance of that spending for the whole budget underlines the need for good prescribing practice and ensuring appropriate pharmacy advice to the primary care team.

Distribution of resources

GMS spend

120. In 2001, average spending on non-discretionary GMS by health authorities was £51 per head of population but there is wide variation; for example, spending in Oxfordshire Health Authority was £63 per head of population compared with £33 per head in Gateshead & South Tyneside Health Authority (EXHIBIT 17).

Distribution of staff

121. The variation in expenditure reflects the unequal distribution of GPs around the country. In 2001, there were more than double the number of WTE GPs per 100,000 population in Oxfordshire Health Authority

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EXHIBIT 16 Variation in prescribing expenditure between PCG/Ts

Prescribing expenditure varies two-fold between PCG/Ts.

Source: District Audit analysis of Prescription Pricing Authority data, 2000/01
than South Derbyshire; 69.2 WTE and 32.4 WTE respectively. Variation is less marked among practice nurses – 31 WTE per 100,000 in Cambridge Health Authority compared with 14 WTE per 100,000 population in Enfield & Haringey Health Authority (EXHIBIT 18, overleaf). A recent study showed that the number of GPs was the most significant predictor of practice nurse provision – and there was no evidence that nurses made up for the shortfall of GPs in areas with the greatest healthcare needs (Ref. 50).

122. The number of patients registered with a GP principal varies four-fold across England (EXHIBIT 19, overleaf). Very high list sizes may be partly accounted for by staff vacancies and some principals choose to have a small number of patients. But they may also reflect historical inequities in the way resources are allocated.

123. Areas with the greatest resources – the greatest number of doctors – are not those with greatest need. Analysis of Jarman underprivileged area scores – an indicator of social deprivation – and the number of GPs per 10,000 population shows almost no relationship between the two – a picture virtually unchanged since 1991 when the Audit Commission reviewed general practice in their study of FHSAs (EXHIBIT 20, overleaf).

I The data show patients per GP principal in post. These ignore the contribution from GPs who are employed as assistants, deputies and retainers.
EXHIBIT 18  WTE numbers of GPs and practice nurses 2001

The number of GPs and practice nurses varies but where there are fewer GPs, this is not compensated by more practice nurses.

Source: Department of Health, Common Information Core (England) 1999-2000; Ref. 65
But more sophisticated studies, which adjust for health need, as opposed to general deprivation, show an ‘inverse care law’ – areas with greater health needs have fewer GPs. This inverse relationship is more pronounced for other primary care staff (Ref. 51). When adjusting for longstanding illness, areas in the top decile (with lowest health needs) have four times as many practice nurses and two-thirds more GPs than those in the bottom decile. Overall, these differences are much more marked in general medical services than in other health sectors – for instance, spending on hospital and community health services only differs by one-tenth between the top and bottom deciles.

**EXHIBIT 19  Number of patients per GP principal, 2000**

The number of patients per GP varies widely.

*Source: National Primary Care Research and Development Centre – National Database for Primary Care Groups and Trusts*
Deprivation payments were introduced in 1990 to increase the resources of practices with significant numbers of patients who lived in deprived areas, to allow for the greater workload. The impact of deprivation payments may have been limited; a review by Sir Donald Acheson concluded that ‘the GP deprivation payments system... whilst well-intentioned, has neither been effective in attracting GPs to these [deprived] areas, nor in increasing access to effective services for disadvantaged populations’ (Ref. 52).

In 2001, a package of ‘golden hellos’ was introduced with differential payments to attract new GPs to deprived and ‘under-doctored’ areas, the impact of which should be monitored.

EXHIBIT 20  Relationship between Jarman under-privileged area scores and number of GPs

There is no relationship between deprivation and the number of GPs – a picture virtually unchanged since 1991.

Source: Ref. 1; National Primary Care Research and Development Centre – National Database for Primary Care Groups and Trusts
Inequities in resource distribution have been recognised for a long time as a problem. The Medical Practice Committee (MPC), which was established in 1948, was responsible for overseeing the geographical distribution of GPs. The MPC would approve new practices, partnerships and mergers, and identify areas which were ‘over-’ or ‘under-doctored’, mainly through average list sizes. The MPC was recognised to have had a significant effect in making things fairer, but has been criticised for not being proactive enough and working through ‘a process of negative direction’ (Ref. 53). The MPC was abolished in 2002 and its responsibilities given to PCTs.

The actual relationship between the number of healthcare professionals available and health outcomes is unclear. It might be expected that areas with higher levels of GPs would achieve better preventative health performance, for instance on child immunisation or cervical screening. It could also be hypothesised that higher levels of general practice would reduce avoidable hospitalisation – for instance, the proportion of older people admitted to hospital as emergencies or the number of hospital admissions for (largely) preventable acute asthma and diabetes crises. In fact, analysis showed no relationship at health authority level between the number of GPs (used as a proxy for general practice resources) and measures of preventative health on the one hand and demand for acute services on the other. This may be partly because it is difficult to isolate the impact of general practice resources from other factors that might affect demand on secondary care or uptake of preventative services. For instance, evidence (and common sense) shows that practices with more mobile populations are less likely to reach immunisation targets, because of factors outside the control of the GP (Ref. 54).

Current guidance from the Department of Health has set a target of 53.2 WTE GPs per (weighted) 100,000 population for each PCT; this is based on the most recent average figure for England (Ref. 55). The target for 2004 is 55.7 WTE GPs, in line with the 6 per cent growth in GP numbers set out in the NHS Plan. As yet there are no guidelines for the desirable numbers of practice nurses per head of population.
As for doctors generally, the number of GPs per head of population in the UK is relatively low – 61 per 100,000 – compared with other developed countries. In the US, for example, there are more than 75 ‘GPs’ per 100,000, in Germany more than 100 and in France more than 140. But the role of the general medical practitioner may differ between countries. I Within the UK, England has the lowest number of GPs per head of population – 58 per 100,000 – compared with 62 in Northern Ireland, 64 in Wales and 80 in Scotland (Ref. 9).

While it is difficult to say what the desirable level of staff is to achieve certain outcomes, it is clear that some areas have markedly fewer doctors and nurses working in general practice than others. There are problems in recruiting and retaining staff, which affect all areas, deprived or affluent. In response to the Audit Commission consultation on the specification for this study, recruitment and retention was the most commonly cited barrier to delivering high-quality care. In considering resources for general practice, we now need to look in more detail at the issue of capacity – are there enough doctors and nurses to do the work?

**Staffing capacity**

Many factors influence the number of GPs available to provide primary care services (EXHIBIT 21). These include the number of vacant posts, the profile of the workforce, working patterns and the take up of vocational training schemes.

In order to maintain current levels of staff, the wastage rate (those leaving general practice) has to be lower than the growth rate. Between 1999 and 2001, the wastage rate fluctuated between 3 and 5 per cent. Note that this compares favourably with some other public sector professions – for instance the wastage rate for police officers was 4.8 per cent (Ref. 56) and approaching 8 per cent for full-time teachers (Ref. 57). Although the numbers of GP principals joining general practice exceeded those leaving there was a net increase of only 252 principals (a 0.9 per cent increase).

A GP is defined here as a medical practitioner working in primary care services. In the UK this will include GP principals and non-principals.
EXHIBIT 21 Workforce flows of general medical practitioners

The supply of GPs is dependent upon many factors.

133. The NHS Plan in England set a target for an increase in GP numbers (headcount) by 2,000 above the 1999 level by 2004. This assumes average growth at 1.4 per cent and that wastage from general practice remains at or below its current level. But growth has fallen below that to 0.9 per cent and if it stays at that low level, we will only see an extra 628 GPs above the 1999 level by 2004.

Furthermore, the WTE number of GPs is likely to be lower as an increasing proportion work part-time.

134. More recent targets for 2008 promise a net increase of 15,000 GPs and consultants above the 2001 level. It is not clear whether this number includes the additional 2,000 GPs and 7,500 hospital consultants outlined in the NHS Plan (Ref. 17). If it is in addition to these...
In the same ratio of 1:3.75 GPs to hospital consultants, then the GP workforce would be expected to increase by 3,150 between 2004 and 2008. Current figures suggest that the Government is going to find it difficult to ‘grow’ enough GPs to meet these targets.

**Those entering general practice**

The low rate of growth is partly due to an earlier trend of declining numbers of people joining general practice. The number of first-time joiners declined from 1,313 in 1990 to 958 in 2000, reflecting reductions in the number of GP registrars between 1990 and 1996, a decline in general practice as a career choice among newly qualified doctors and a reluctance among those completing vocational training schemes to enter general practice straight away as principals (Ref. 58 and 59). The situation is now improving – for instance, the number of GP registrars following decline in the early 1990s then increased, rising by 44 per cent between 1996 and 2001 to 1,883. Initially the NHS Plan pledged an extra 450 posts for GP registrars, and subsequently a further 100 posts were announced by the Department of Health, which should accelerate this trend. However, the service may continue to feel the effects of the earlier decline for some time.

In addition, the future growth of qualified GPs depends on the availability of accredited GP trainers and practices. However, data from the NPCRDC database show that in two-fifths of PCTs, 10 per cent or less of GPs are accredited to supervise GP registrars. The proportion of trainers is even lower in PCTs with greatest health need and 12 PCTs have no GP trainers. The Government has promised 400 new training practices, but restrictions of space, time and trainers may make this difficult to implement.

The number of practice nurses more than doubled between 1988 and 1990, possibly in anticipation of changes to the 1990 GMS contract. Since then the number of practice nurses has increased steadily, on average by 2 per cent a year (see EXHIBIT 3). Much of the work specified in the 1990 GMS contract, for example health promotion and chronic disease management, could be delegated to nurses who could increase the income potential of general practices.
In nursing, there is no qualification similar to the GP vocational training scheme, which might limit the number of suitably qualified and experienced nurses entering general practice. However, there is competition for experienced nurses between new providers of primary care, such as Walk-in Centres and NHS Direct, specialist community services and nursing homes. All these competing demands make it difficult for practices to attract nurses, particularly in deprived areas.

**Those leaving general practice**

About one-third of GPs who leave general practice do so because of retirement (Ref. 60) in comparison with one-quarter of teachers (Ref. 57), perhaps reflecting wider dissatisfaction levels among teachers. There is a problem in the age profile of general practice staff. One in three GPs and practice nurses is over 50 – compared with one in five of full- and part-time teachers\(^1\) (EXHIBIT 22, overleaf).

Since 1995, GPs have been able to retire at 50 with an abatement of pension and since 1997 practice nurses have been able to join the NHS pension scheme. A recent survey found that 45 per cent of GPs planned to retire between the ages of 50 to 59 and 45 per cent between the ages of 60 and 70 years (Ref. 61). One in ten PCTs will have to face the impending retirement ‘bulge’ sooner as more than 50 per cent of GP principals are aged 50 or over. This problem is concentrated in deprived areas (EXHIBIT 22, overleaf). In many of these areas, this reflects the recruitment to the NHS of a cadre of doctors who qualified in south Asia and came to practise in this country thirty to forty years ago – many working in more deprived areas (Ref. 62).

\(^1\) Data derived from the DfES Database of Teacher Records.
EXHIBIT 22  Age profile of GPs and practice nurses, 2001

One in three GPs and practice nurses is aged over 50. In some PCTs the number of GPs nearing retirement is higher, particularly in socially deprived areas.

Source: Ref. 65; RCN membership survey 2001; National Primary Care Research and Development Centre – National Database for Primary Care Groups and Trusts
141. Devising strategies to manage general practice as part of wider primary healthcare is crucial, given the age profile of community nursing staff. For example in 1997 more than three-quarters of qualified district nurses were aged 50 or over (Ref. 63).

142. It is worth noting that the ‘problem’ of an ageing workforce can also be construed as a strength, in an experienced and relatively stable workforce. A recent survey of GPs showed that 70 per cent had been in general practice for more than ten years (Ref. 61). Similarly, data from the 2001 RCN membership survey found that more than two-thirds (70 per cent) of practice nurses had been in post for more than five years, and half had been there for more than ten years. This was confirmed by a recent survey of practice nurses in Sheffield which found that they tended to remain in their first practice nurse post and remain for a long period – one-half had been in post for ten or more years (Ref. 64).

Vacancies

143. Albeit a crude indicator, the numbers of ‘joiners to’ and ‘leavers from’ the GP principal workforce suggest that the vacancy rate has remained relatively steady since the late 1990s (Ref. 65 and 66). But the number of vacancies doubled last year, partly reflecting recent initiatives to expand the workforce, for example through PMS pilots (Ref. 60). But recruitment to posts is taking longer, with only about one-half (53 per cent) of vacancies being filled within three months, while the number of applicants per post is falling.

144. The vacancy rate for GP principals is reportedly low at any one time and thought to be less than the three-month vacancy rate for hospital consultants – currently 3 per cent. This is higher than for some other public sector workers – for instance, the rate for teachers is around 1.3 per cent (Ref. 67) – but much lower than for others, such as the vacancy rate for field social workers at 16 per cent (Ref. 68). Vacancy rates for practice nurses are not available nationally.

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I See www.doh.gov.uk/public/vacanciesurvey.htm

II Advertised vacancies for full-time permanent appointments of at least one-term’s duration.

III Vacancy rate refers to the number of funded posts with no employee in post and for which a replacement was being sought at 1st April 2000.
The GP vacancy rate appears quite low, but masks real problems in different parts of the country in attracting staff to posts. Although data are hard to obtain locally, in one inner city area at the end of February 2002 there were 11.5 WTE vacant GP principal posts out of a total of 58.25 WTE posts across 21 practices – a vacancy rate of 20 per cent. The number of vacant practice nurse posts was smaller – 2.81 WTE out of 29.26 WTE posts, equating to a vacancy rate of 9.6 per cent (EXHIBIT 23). There is clearly no room for complacency in the need to attract and retain doctors and nurses in general practice.

EXHIBIT 23  Numbers of GPs and practice nurses in one PCG (end February 2002)

Some practices have difficulties recruiting GPs and practice nurses; for instance, Practice E has no practice nurse and only one out of three GPs in post.

Source: Audit Commission visit to one PCG
Changing profile

146. The profile of general practitioners is changing (EXHIBIT 24, OVERLEAF). Between 1988 and 2001 there was an increase in the number and proportion of women and part-time GPs – one in three GP principals is a woman and one in five GP principals works part time. More GPs are now salaried and are choosing to work flexibly, without the responsibilities of partnerships. There are 2,014 (headcount) GPs working in this way as assistants, associates and retainers. Many of these ‘non-principals’ work part-time, reflecting changes to working practices and changing attitudes to career and lifestyles (Ref. 69). Non-principals make up 7 per cent of doctors currently working in general practice; four-fifths of whom are women (Ref. 65). The growth of doctors joining PMS schemes has been rapid, from a zero start in 1997 to more than one in eight GPs by September 2001. And latest figures for April 2002 show that about one in five GPs has now opted for local PMS contracts.¹

147. The proportion of doctors working flexibly is likely to increase. A BMA cohort study of 1995 medical graduates showed that 32 per cent of respondents wanted to enter general practice, which was greater than that at graduation (18 per cent); more than two-thirds choosing general practice were women (Ref. 59). Nearly all those undertaking vocational training (92 per cent) wanted to become a principal and those who wanted to become associates or assistants wanted more flexibility for other interests or to have a family. Respondents wanted to find a balance between work and family; these factors often coincided with a career change to general practice and the end of on-call commitments.

148. Most (85 per cent) practice nurses responding to the 2001 RCN membership survey reported working part-time, on average 26 hours per week. In 2001 there were 19,846 practice nurses in England or 11,163 WTE staff. This means that the strategy for increasing the input of practice nurses to general practice should include attempts to increase current staff’s working with support from family-friendly initiatives and other inducements.

149. Opportunities to appoint salaried GP assistants have been in place since 1948, and the 1997 Primary Care Act provided the opportunity to appoint salaried general practitioners with personal lists, sometimes as part of a PMS pilot. But this proportion is still quite limited – for instance, by 2001 only 8 per cent of GPs working in PMS practices had opted for salaried status (Ref. 70).

¹ See www.doh.gov.uk/pricare/pca.htm
EXHIBIT 24  The GP profile

The profile of the GP workforce is changing, with more women GPs, more part-time working, an increasing number of non-principals and the growing popularity of non-GMS schemes.

Increasingly, more flexible ways of working will be needed at different points in an individual’s career. The traditional model of general practice, based on a GP becoming a principal and staying in one practice for most of his or her career, appears to be waning. A survey of three cohorts of doctors completing vocational training schemes suggests that one-half of non-principals are unlikely to increase their hours, because of work commitments outside of general practice (Ref. 69). The proposed new GP contract, if agreed, will provide a framework for GPs to exercise much greater flexibility in their work, with regard to both hours and content.

‘There’s nothing I’d rather do than be a partner, be settled, see the same patients, know you’re going to be there, start forming your world … it’s better for patients and for me … but the costs of partnership are far too high for me.’

‘I think we’re at the very end of the generation that would behave like we behave. Those that are coming in afterwards are not interested in what we would put importance on.’

Source: GP focus group convened for the Audit Commission 2002

GPs now have greater opportunities to develop skills in a number of areas outside general practice. These include research, management, working for PCTs, clinical governance, appraisal, post-graduate education and teaching GP registrars. But increasingly GPs are developing clinical skills in specialist areas.

GPs with special interests

It has long been a tradition that individual partners within group practices take a lead in areas of their own special interest, such as dermatology, sexually transmitted diseases or women’s health. Their interest and skill in a particular specialty has often been maintained through a weekly clinical assistant post in a local hospital. Other partners within the practice would then use the additional skill in requesting second opinions, often calling in a partner during a consultation to see the patient there and then, and so avoid an outpatient appointment. These developments were professionally led and there was little or no attempt to co-ordinate professional interest with patient need in any given population. Remuneration for clinical assistant posts in hospitals did not keep pace with BMA sessional rates and so, in many places, GPs could not afford to pay locums to cover their general practice work.
153. As part of the NHS Plan, the Government aims to revitalise the system whereby GPs take referrals from colleagues from within and outside the practice. It has set a target of 1,000 GPs with specialist interests by 2004, although it is well known that many more GPs would already fall into this category by continuing to do the work they are already undertaking. There is no national register of GPs with special interests, although some information is available by specialty.¹

154. There are different drivers for this trend. One is to help to manage secondary care demand and reduce outpatient waits in key areas such as orthopaedics and dermatology. The second is to enable GPs to take on varied and interesting work. There are some concerns that these schemes may be driven by individual enthusiasms, rather than the needs of the population. Another perhaps more fundamental concern is that, if specialisation continues to develop informally, who will do the work of general practice? Some feel that it may devalue the specialism of general practice, if all GPs are encouraged to develop an interest in a particular area.

‘There’s a sort of a trend that it’s a little bit unfashionable to be just a good basic general practitioner. I mean, you have to have special interests outside.’

Source: GP focus group convened for the Audit Commission, 2002

155. There is genuine enthusiasm among individual GPs engaged in this work and some exciting examples (such as Bradford South and West PCT) where the planned development of GPs with special interests is contributing to improved performance, for example reducing waiting times for outpatient appointments. Care needs to be taken that this enthusiasm can be exploited without jeopardising the ‘core’ business of general practice.

156. Much of this chapter has been concerned with general practitioners, as the main resource (and the subject of most data). The opportunities for individual GPs to develop special interests and adopt a portfolio of activities, such as research and teaching, has been explored. It is now worth considering possibilities for developing other members of the practice team, as well as ways to make best use of the key resources of practice premises and information systems.

¹For example, there is a network of about 50 GPs with a special interest in ENT services (personal communication with the Modernisation Agency).
Extended role for nurses

157. The 1990 GMS contract provided new opportunities for practice nurses, particularly in preventative work and chronic disease management. There are limited data on the activity and skills of the GP, the practice nurse and other members of the primary healthcare team. A national survey of practice nurses in 1995 showed wide variations in practice nurses’ activities. Those working in larger or training practices were more likely to be engaged in tasks requiring more advanced training, diagnostic skills and clinical judgement (Ref. 71).

158. While there has been a large increase in the number of practice nurses, there is still no national strategy to support their progress and development. The numbers have therefore continued to expand in a piecemeal fashion with varied job descriptions depending on the local policy of the practice. There is no consensus on the scope of practice nursing or the degree of specialisation. The role of practice nurses can overlap with that of district nurses, for example, in the management of leg ulcers. Terms and conditions vary widely between practices, as do access to training and development and clinical supervision. Practice nurses make up a very small proportion of the total nursing workforce – less than one in twenty qualified nurses (WTE) work in general practice. By contrast, one in three medical practitioners is a GP.

159. It has been suggested that more of the day-to-day work of general practice could be devolved to practice nurses and that their roles could be developed, for example in developing triage in primary care. The BMA suggests that in general practice nurses could see the patient first and recommend whether he or she should be seen by the GP or other professional such as pharmacist, social worker or counsellor (Ref. 72). A MORI poll of 1,972 adults commissioned by the BMA in early 2002 found that 87 per cent of people would be happy to see a nurse rather than a doctor, if their conditions were not serious.¹

¹ See www.bma.org.uk/ap.nsf/Contents/Doctors+-+Public+confidence+in+doctors
Not every practice nurse could take on these extra responsibilities. Those taking on an expanded role are called ‘nurse practitioners’. At present, there are no agreed national standards for the role or the skills, competencies and training required by nurse practitioners. Consequently the title ‘nurse practitioner’ is not recognised by the Nursing and Midwifery Council and there are no data centrally held on the number of nurse practitioners in primary care. But numbers appear to be small. There is inconsistency in the use of the term, with some overlap with the role of the nurse consultant and nurse specialists. A recent review defined them as nurses ‘who have undergone further training, often at graduate level, to work autonomously, making independent diagnoses and treatment decisions. In this way, they may potentially substitute for doctors’ (Ref. 73). The review examined the use of nurse practitioners in providing first point of contact care for patients with undifferentiated health problems in a primary care setting. It concluded that they provided a quality of care that was as good as, and in some ways better than, doctors. However, the review did not look at the cost-effectiveness of these arrangements.

Care needs to be taken in assuming that substitution of care will mean cost savings. Evidence suggests some nurse-led services offer the same or better quality, but not necessarily lower costs (Ref. 74). As Iliffe states in his overview, ‘On average, nurses have longer consultations, arrange more investigations and follow-up, provide more information and give more satisfaction than general practitioners. Primary care nurses are not cheaper than general practitioners, but they are as safe in managing self-limiting illnesses’ (Ref. 75).

The RCN estimates that there are between 3,000-3,500 nurse practitioners in all sectors in the UK, that is graduates from nurse practitioner, personal communication with the RCN and programmes meeting the RCN’s criteria (see Nursing Times, 30th April 2002 issue, p7).
The PMS pilots set up from 1998 represented a real opportunity to experiment with new workforce models and included nine ‘nurse-led’ pilots, where nurses provided primary care services with much ‘first contact’ work with patients and provided clinical and managerial leadership. In these pilots, nurses routinely referred patients directly to hospitals to see a consultant or for diagnostic tests and, in some, employed GPs in the practice to provide some clinical sessions. Evaluations suggest that nurse-led care is popular with patients and seems to have achieved a great deal. However, these pilots ‘faced difficulties and resistance, particularly from local medical colleagues’ (Ref. 15). This may partly be due to professional demarcations and expectations and tensions between the ‘old model’ of general practice, where the GP provided almost all the clinical care, and a more recent model of a multidisciplinary practice in which the GP is one part of the team. But other barriers to effective deployment of nursing staff are more basic. One survey of GPs showed that lack of space was the factor most frequently reported (by 76 per cent of respondents) as limiting the expansion of the practice nurse’s role (Ref. 76) – premises and the physical environment are crucial factors to the quality of care.

There are competing demands for the limited pool of registered nurses to take on the increasing demands of general practice. The NHS Plan pledged 20,000 more nurses in post by 2004 but no figure was earmarked for general practice (or primary care). Recent announcements suggest that by 2008 there will be 35,000 more nurses, midwives and health visitors in post than there were in 2001 (Ref. 10). Again, the growth in numbers required for the delivery of primary care services has not been established. There needs to be a concerted national programme to nurture, develop and train a cadre of skilled primary care nurses to meet the demands of the next ten years.

Pharmacists

In the same way that nurses could do more within the practice, there is also scope for an extended role for pharmacists. A study conducted in one medical practice in a deprived area of Merseyside substituted community pharmacist expertise for medical intervention in the treatment of 12 minor ailments. Findings suggest that this was acceptable to health professionals and most patients and resulted in a reduction in GP minor ailment workload (Ref. 77). This project has now been implemented across the PCT, and replicated and developed in other areas of the country.
165. There are three types of pharmacist that support general practices directly:

- community pharmacists;
- practice pharmacists; and
- prescribing/pharmaceutical advisers.

**Community pharmacists**

166. Community pharmacists work in high street chemists dispensing drugs to patients, mainly as a result of GP prescriptions. A prescription is the most common health intervention experienced by patients – over 540 million prescriptions were issued in 2000 (a rise of 40 per cent in the last ten years (Ref. 78)). On average, patients visit a community pharmacist about 12 times a year (Ref. 79) (compared with four visits to their GP), not only for their prescriptions, but also for non-prescription medicines and general and specific advice. Since chemists are normally open at weekends and for longer hours than GPs, community pharmacists often provide first-line support direct to patients without an appointment or a charge.

167. While dispensing is the predominant focus for pharmacists, some community pharmacists deliver locally agreed additional services. However, the community pharmacist is still an underused resource of information and advice to general practices and patients. But they are increasingly being recognised as valuable members of the primary healthcare team, often working directly with general practices. The publication of *Pharmacy in the Future* (Ref. 80), the Government’s review of the role of pharmacists in helping to implement the NHS Plan, reflects a growing recognition of the vital role pharmacists can play in making services more accessible to patients and reducing demands on GPs. There are a number of ways in which the role of community pharmacists can be extended (BOX F).

**Practice pharmacists**

168. Practice pharmacists may be employed by a PCT or directly by a practice. They are either full-time or part-time and often combine this role with posts in other settings – portfolio roles combining community and general practice are increasingly common. Practice pharmacists are not employed to provide dispensing services. They will, however, carry out some of the activities outlined in Box F, working directly with patients, as well as supporting practice staff. Currently there are about 100 practice pharmacists in England. However, about 2,000 practices (one-quarter of all practices) have pharmacies on site (Ref. 81) that provide standard pharmaceutical services.
Prescribing/pharmaceutical advisers

169. Prescribing advisers work at PCTs and some work in strategic health authorities. The majority give advice to GPs on how to prescribe more accurately and effectively, and encourage them to follow national guidance. They tend to manage the drugs budget for PCTs. Increasingly they may have a more strategic role developing and commissioning services, perhaps leading a small team of pharmacists and support workers who deliver the prescribing advice. A few community pharmacists will also be part-time prescribing advisers. Whereas there used to be one pharmacist working as a prescribing adviser in a health authority, there is now at least one in every PCT. Their numbers increased from around 150 in 1997 to about 700 in 2001.

BOX F  Extended roles of the community pharmacist

Community pharmacists provide some or all of the following additional services:

- Supporting general practice by advising on quality, taking part in prescription reviews, supporting intermediate care, and devising local formularies and protocols.
- Delivering repeat dispensing services.
- Referring patients to their GPs.
- Directly prescribing certain drugs and managing minor ailments following agreed protocols, for example, head lice, coughs and the ‘morning after’ contraceptive pill.
- Visiting and liaising with patients after episodes in hospitals to avoid ‘the pill muddle’ – the patient can become confused about which medications to continue or stop, particularly if different names are used for the same drugs.
- Maintaining patient medication records.
- Inspecting and advising staff in nursing homes.
- Health promotion and health development, for example, smoking cessation support services.
- Promoting concordance in medicine taking and supporting partnerships in medicine taking.

Source: Audit Commission
There is a reported shortage of pharmacists to meet all these demands and those of the secondary care sector. The vacancy rate is around 10 per cent,¹ about three times that for GPs. The shortage was exacerbated by lengthening the pharmacy degree from three to four years, so that in 2001 fewer new pharmacists registered.

National policy changes are being introduced that are likely to have an impact on the pharmacist profession. The introduction of pilots of Local Pharmaceutical Services (LPS) schemes are aiming to deliver services in new ways (as the pilots for PMS schemes did) and the plans for a new national contract for pharmacists should encourage greater expansion of their roles. The discussions include how to reward high-quality services (in a similar way to those outlined in the proposed new GP contract). There is no timetable for negotiation of the contract as yet, but the decision to renew it is timely.

Practice Managers

The role of practice manager in primary care is vital. The activities and responsibilities vary greatly from practice to practice (BOX G).

This is a wide variety of responsibilities and few practice managers will be carrying out all of these tasks. But most will have to deal with strategic issues (what is the future direction of the practice? Should we try to recruit another GP?), financial issues (what is the practice’s current financial position? Can we afford another receptionist?) and operational management (are we meeting access targets? Who is on reception tonight?). The pay, grading, experience and qualifications will vary as much as responsibilities. In some practices, the practice manager may be the practice director, who is a partner and receives a share of the practice’s profits. In others, the practice manager chairs multidisciplinary team meetings and takes an active role in shaping the practice. By contrast, some practice managers (particularly in smaller practices) are effectively the senior receptionist.

¹ Hospital pharmacy survey carried out by NHS Pharmacy Education and Development Committee, July 2001 estimated vacancy rate at 14 per cent; in 2002 IPMI survey of community pharmacy personnel found vacancy rate of 10 per cent; and Hospital Pharmacists Group found NHS hospital pharmacies vacancy rates was 8 per cent.
These variations almost certainly have an effect on patients’ experience of the practice. Many practice managers have management qualifications accredited by the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR) or other organisations, such as the Institute of Healthcare Management. Similarly, health authorities and PCTs have provided training for practice managers and have involved them in decision making. What is now needed is a national approach to developing this valuable group of staff and using them to best effect in the primary care focused NHS. The new GP contract proposes to incentivise an expanded role for practice management and deliver 100 per cent funding of the costs associated with practice management (Ref. 18).

**BOX G** The practice manager’s role can involve some or all of the following:

<table>
<thead>
<tr>
<th>Financial management</th>
<th>Staff management</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing the practice’s finances, including payroll and liaison with accountants.</td>
<td>Submission of GMS claims.</td>
<td>Data protection act responsibilities.</td>
</tr>
<tr>
<td>Purchasing practice supplies, for example, dressings, medical gases, vaccines, equipment.</td>
<td>Liaison with private sector suppliers, for example, computer system supplier.</td>
<td>Dealing with complaints.</td>
</tr>
<tr>
<td>Managing any contracts related to the practice, for example, agreements on the practice premises.</td>
<td>Liaison with drug reps.</td>
<td>Ensuring that health and safety regulations are complied with.</td>
</tr>
<tr>
<td>Preparing bids for additional finances.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning practice activities and finances.</td>
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<tr>
<td>Negotiating with the practice’s bank.</td>
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<td></td>
</tr>
</tbody>
</table>

*Source: Audit Commission*

General practice in England 87
The work of the Primary Care Collaborative indicates the impact that basic management techniques can have in improving the way a practice works. This is an area where PCTs should be reviewing each local practice’s standards of management and ensuring that appropriate training and development is commissioned. PCTs also have to ensure that practices have adequate premises and information systems in place. These are crucial resources which, at present, are some way from meeting the demands of the 21st century.

**Other resource inputs**

**Premises**

175. One of the most fundamental aspects of general practice is the building in which the service is delivered. A severe limiting factor is space; currently around 80 per cent of all premises are below recommended size for new buildings and 14 per cent are judged to be cramped (Ref. 82). The Government’s vision is for larger teams of primary care professionals working together, but this requires facilities which at present may be lacking. One survey of GPs showed that lack of space was the factor most frequently reported (by 76 per cent of respondents) as limiting the expansion of the practice nurse’s role (Ref. 76). Space is also a limiting factor for expanding the number of training practices, to meet demands for more doctors, because GP registrars need consulting rooms.

176. Accessibility is also an issue. By 1 October 2004 all existing premises will need to be fully accessible to disabled people to comply with the 1995 Disability Discrimination Act. In 2001, four-fifths of areas providing the information revealed that only 23 per cent of premises overall met the standard (although the proportion for each area ranged from none to 100 per cent).!

177. Some premises do not meet the most basic standards, which include facilities such as washbasins in treatment rooms, or rooms to ensure patient privacy. Overall, 9 per cent of practice premises do not meet these standards, but these sub-standard premises are unevenly spread across the country (EXHIBIT 25).

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1 Data derived from the Department of Health, Common Information Core (2000/01).
London is particularly badly served by premises – in 2001, seven out of ten of the health authorities with the highest proportion of practices below minimum standards were in London. This is despite the London Initiative Zone boost to investment to improve primary and community care facilities in the wake of policy reviews such as the Tomlinson Report (Ref. 83 and 84). A large sum of money – £400 million – was made available, of which 41 per cent was spent on premises. This made a significant impact, reducing the proportion of inadequate premises in every health authority by an average of 28 per cent (ranging from 4 to 44 per cent (Ref. 85).
The Government is aware of the inequities of premises across the country. The NHS Plan states that over 3,000 practices (nearly one-third) will be substantially refurbished or replaced by 2004 and there will be 500 new one-stop primary care centres. The most recent survey of ownership carried out by the NHS Executive’s valuation office in 1995-96 showed that 63 per cent of practice premises were owned by general practitioners, 16 per cent by the NHS, and 21 per cent were rented from the private sector (Ref. 82). The proportion of privately financed premises is likely to be accelerated by the NHS Local Improvement Finance Trust (LIFT), set up in 2001 to develop a new market in investment in primary care and community-based facilities and services. LIFT is a joint venture between the Department of Health and Partnerships UK plc (PUK). Public monies are used to pump-prime private investment, in an attempt to develop new facilities, particularly in inner city areas, although some critics have doubts about the feasibility of this as a mechanism to redress inequalities (Ref. 86). The impact of this scheme should be monitored over the coming years.

**Information systems and use**

‘One of the practices is a mess, the other is fantastic, computerised, patient details on the screen, you’re not trying to find the letter, and that’s at a smaller practice where they’ve managed to do quite a lot.’

‘[Premises] vary so much. And computers. I’m actually baffled. How can you do all these target and audit things, how can you do it when the practices are not computerised?’

Source: GP focus group convened for the Audit Commission, 2002

Modern information systems are essential to improve patient care and to meet the NHS Plan targets. But a recent influential report stated ‘The health service makes very poor use of ICT... systems have typically been developed and installed in a piecemeal fashion’ (Ref. 6). The NHS has often invested more money in the systems without ensuring investment in staff time and training to make use of them. And there has probably been under-investment overall. A recent comparison of a US healthcare provider (Kaiser Permanente) with the NHS stated that Kaiser plans to invest about 2 per cent of its total budget over the next five years in IT, while the NHS plans to spend about 0.5 per cent (Ref. 81). The 2002 budget pledged more resources for the NHS and stated explicitly
that ‘a greater share of the new funding will be used on...modernised information technology’ (Ref. 10).

181. The Government has also set specific targets for improving information as part of the NHS Plan (BOX H). Nearly all general practices were connected to the NHSnet by March 2002.† But some of the other targets will prove more difficult to realise. Recent data from the Audit Commission’s NHS Plan Implementation Review showed that, of the PCTs assessed as high risk in relation to waiting times in primary care, one-half lacked adequate monitoring systems in general practice.

182. Within general practice, electronic information systems are now particularly important because:

- Practices house ‘cradle to grave’ records for each patient, which provide good population health information as well as comprehensive records for each individual.

† See www.nhsia.nhs.uk/nhsnet/pages/connecting/nhsconnect/connections

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**BOX H  Targets for IT in general practice**

The NHS Plan’s targets for IT in general practice are:

- By 2002, all GP practices to have access to NHSnet;
- By 2004, electronic prescribing of medicines;
- By 2005, all GP practices to be computerised;
- By 2005, all bookings from GPs to outpatients or from outpatients to elective daycase or inpatients to be made electronically. All patients and their GPs will be able to book appointments at both a time and a place that is convenient to the patient; and
- By 2008, all patient records in PCTs and trusts will be electronic.

Other targets include:

- Patients will be provided with timely, comparable information on practices and hospitals; and
- PCTs will provide independently validated information to the public through their annual patient prospectus about the availability, quality and performance of local health services. The prospectus will also contain details on the choice of services available in primary care – such as female GPs or specialist services.

*Source: Refs. 10 and 17*
• The increased complexity of healthcare, described in the last chapter, can be managed more easily with electronic information systems.

• New national standards (in coronary heart disease and other areas) make it more important to have easy ways of recording and accessing health information to monitor patients at risk and review their management.

• Selection by the patient and their GP of the time and place of hospital appointments, and the consultant, will be much easier with electronic systems.

• The new GP contract framework emphasises quality targets which will need monitoring – again, this will be easier with electronic systems.

• The new GP contract framework suggests that some services may now be provided outside the practice, making continuity of patient information more important. For instance, a person with diabetes might need to see their GP in the practice but a specialist nurse in another location.

183. The new GP contract framework proposes that responsibility for funding and managing information systems rest entirely with the PCT, rather than the practice. The Audit Commission’s next phase of work in general practice could examine how PCTs are handling their new responsibilities for ensuring that all practices meet modern information standards.

184. This chapter has considered general practice resources, particularly staff, and how they have been distributed across the country. There are areas in which practices are having real problems filling posts and keeping staff and are finding it difficult to give patients an adequate service, in the context of rising demands and increasing expectations. There is a limited supply of trained GPs and nurses to do this work and it will be difficult to meet Government targets for more staff. There needs to be better use made of all members of the team, including nurse practitioners and pharmacists, to ensure that patient expectations are met. Every practice needs adequate premises, modern information systems and good management to meet the demands of the 21st century.
6 Conclusions

185. General practice is one of the most highly valued public services. It is diverse and dynamic, and many practices have shown an ability to adapt to meet modern demands. Overall the quality of care is improving and more can now be done for individual patients. Many patients have greater choice over where they go and who they see for particular health problems. Inconsistency in services between practices is likely to be greatly reduced by the introduction of new national standards, which reinforce the key role of general practice in preventing and managing diseases such as coronary heart disease and cancer and introducing new quality standards, as proposed in the framework for the new GP contract. At the same time, changes to the funding system and the new levers that can be used by PCTs should remove some of the unacceptable differences in resources and facilities between practices. It is interesting to note the remarks of a commentator from the US – ‘I was struck by the paradox that, despite the sense that general practice is in crisis, it is meeting fundamental needs and is vastly improved…’ (Ref. 87). This all represents good news for patients.

186. In many ways, it has never been a better time to work in general practice. There are new opportunities for individual doctors and nurses to develop specialist skills and to make a difference to the quality of care for patients. The proposed new GP contract, if agreed, will offer considerable choice for GPs over the kind of work they do and where and when they do it.

187. Our report has shown that there are problems in recruiting and retaining staff – some of which reflect general trends in the public sector. The traditional model of a GP principal providing most of the clinical care for 1,800+ patients is increasingly difficult to sustain, given increasing expectations by patients and the workforce. Our analysis shows problems in filling current posts, particularly in the areas of greatest need. The Government is struggling at present to deliver the (relatively) modest target of 2,000 new GPs by 2004 – a 7 per cent increase from 1999 figures.
The problems of an ageing workforce and limited supply are equally true of nurses as doctors in primary care. The potential for nurse practitioners to take on some of the workload of GPs has not yet been realised and the present numbers are small. It is essential to train and develop these staff, both as specialists to manage patients with chronic diseases actively and to act as skilled generalists providing first point contact for patients with undifferentiated needs. Evidence suggests that suitably qualified nurses can provide high-quality care and meet patient needs, although not necessarily resulting in the cost savings that some may anticipate. But there are competing demands for skilled nurses – particularly with the advent of new agencies, such as NHS Direct and Walk-in Centres – and it is a limited market. The last ten years have seen a missed opportunity to develop a sound infrastructure of skilled practice nurses and nurse practitioners. The Government needs a concerted strategy, with more training centres and opportunities to develop nurse practitioners in primary care, who can take on some of the workload traditionally done by GPs. But this is a medium- to long-term strategy. What can be done immediately?

One tactic is to exploit more fully the bank of GPs working in non-principal posts. These include locums, salaried doctors and those working part-time to accommodate family commitments, engaging in teaching, research and other activities. This is a growing and important part of the general practice workforce, and that needs to be nurtured and developed by the professions and Government. At present, these developments have happened piecemeal and have not been sufficiently planned. Increasingly, portfolio working is likely to be a feature of all our working lives. A framework for remuneration is needed that recognises the contribution that can be made by these portfolio GPs, while retaining, as far as possible, the benefits of traditional general practice, including the list and continuity of care for the patient.
190. Some of the tensions (see EXHIBIT 4) have been explored in some detail in this report – such as the drive to improve access which can, at times, conflict with the personal, continuing care offered by the family doctor. Evidence suggests that patients themselves are making decisions and balancing these tensions, sometimes choosing to wait longer to see their ‘own’ doctor and, at other times, wanting to be seen quickly by any member of the team. Those choices are likely to be available in larger practices. But smaller practices have their own strengths – providing higher patient satisfaction against some markers and providing local services to dispersed populations, for example in rural areas. There is no single blueprint for what makes a good general practice. The difficult task for the PCT is to ensure that national standards are met, without losing the benefits of heterogeneity in general practice. This might mean, for instance, employing skilled nurses to provide diabetes care to a number of small practices. GPs are now, rightly, more accountable – to their peers, to the wider NHS (via PCTs) and to patients. Effective management, with good information systems and good use of staff, is essential if the diversity of general practice is to be sustained without compromising quality standards.

191. Practices should be supported to take time as a team to review critically what they do now and how they could manage their work better to rise to the challenge of growing demands and national standards (EXHIBIT 26, overleaf). The Primary Care Collaborative has shown how practices can transform themselves through reorganising their workload and making better use of existing staff. Doctors, nurses, practice managers and receptionists need to work together to give patients the care they need. And the other members of the wider primary care team, including community nurses and pharmacists, need to be involved in improving services for patients locally.

192. Some practices are seizing opportunities to transform themselves and are working on the change agenda with neighbouring practices and their PCT. Box I illustrates some ways in which a practice might have improved its facilities and ways of working in recent years. Each change is individually quite small but could have significant impact on the quality of care for patients or the efficiency of the practice. Changes to the appointment system or targeted extra help at peak times can have a dramatic impact in reducing waiting times and freeing up doctors and nurses to spend more time with those with greatest needs.
EXHIBIT 26 A managed practice can achieve better outcomes for patients

Many general practices are demonstrating the benefits of a managed practice.

Source: Audit Commission
193. But if general practice is to continue to build on these improvements, it needs proper resourcing. Growth in GMS revenue expenditure has been significantly lower than that on hospital and community health services (EXHIBIT 27, overleaf). While spending on general medical services has increased in real terms by 20 per cent in the last ten years, spending on hospital and community health services (which is dominated by hospitals) has increased by more than 60 per cent. Similarly, while the number of hospital medical and dental staff grew by 36 per cent between 1990/91 and 1998/99, the number of GPs grew by only 5 per cent over the same period.

194. While unified budgets held by PCTs offer real opportunities for planning integrated services and new developments, there are also fears that the needs of general practice and primary care will be swamped by continual crises in the acute sector. There are also genuine concerns that too much is being asked of primary care too quickly, given relatively low investment in this sector over time.

**BOX 1 Some practices are seizing opportunities to transform themselves**

A sample practice that has introduced new features to provide a better service for patients.

New features include:

- Part-time GP for gynaecology and women’s health.
- GPs carrying out telephone consultations for one session a week.
- GP with special interest in dermatology working across several practices.
- Monthly practice board meetings for whole primary healthcare team (chaired by practice manager).
- Nurse practitioner for asthma and diabetes clinics.
- Patient and carers’ group meetings held monthly.
- Paperless practice, with electronic links to hospital from all professionals.
- Regular training and development and personal development plans for all staff.

*Source: Audit Commission*
General practice remains a dynamic service, whose diversity is one of its greatest strengths. Further evidence is needed to understand the way that practices use resources, to ensure that lessons are learned about what works best. The Primary Care Collaborative shows that the introduction of management techniques can make a real difference to patients’ service. PCTs now have greater responsibilities to ensure that patient needs are met.

In the next phase of work on general practice, the Audit Commission will be recommending good practice to help PCTs to shape general practice. We will seek comparative data to help to identify areas for improvement. The Audit Commission will also examine the economy, efficiency and effectiveness of the use of key resources, such as information systems, premises, team working and practice management. The way in which practices have adapted to recent initiatives suggests that there is a real drive for improvement and that, with the right support, general practice can meet the challenges of the 21st century.

**EXHIBIT 27 Growth in expenditure across health sectors, UK**

Revenue expenditure in hospital services and staff continues to outstrip that in primary care.

Source: Ref. 9
## Glossary

<table>
<thead>
<tr>
<th><strong>Discretionary GMS expenditure</strong></th>
<th>Expenditure subject to cash limit controls such as reimbursement for practice staff (previously known as cash limited).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Medical Services (GMS)</strong></td>
<td>A nationally determined contract for most GP services, which covers basic general practice services available to patients. A new contract is currently being negotiated.</td>
</tr>
<tr>
<td><strong>GP non-principal</strong></td>
<td>A GP non-principal is a general medical practitioner who provides general medical services. They do not hold a contract with the health authority or primary care trust to provide services for a list of patients. Instead they work as assistants, associates or retainers under the direction of the GP principal.</td>
</tr>
<tr>
<td><strong>GP principal</strong></td>
<td>A GP principal is a general medical practitioner who is in contract with a health authority or primary care trust to provide a full range of general medical services for a registered list of patients.</td>
</tr>
<tr>
<td><strong>Jarman score</strong></td>
<td>The Jarman under-privileged area score is the weighted total of eight transformed and standardised census variables such as the proportions of elderly people living alone and unemployed people. The score is used as a proxy measure of social deprivation. An area with a larger score is more deprived than one with a lower (including negative) score.</td>
</tr>
<tr>
<td><strong>List</strong></td>
<td>The ‘list’ is the number of patients registered with a GP principal and for whose treatment the GP principal is responsible. Under the terms of the proposed new GP contract, the list will, in future, be held by the practice and not an individual GP.</td>
</tr>
<tr>
<td><strong>National Primary Care Development Team (NPDT)</strong></td>
<td>The NPDT was established in February 2000 to run the National Primary Care Collaborative. The team provides support to participating practices and PCTs involved in the Collaborative.</td>
</tr>
<tr>
<td><strong>National Service Framework (NSF)</strong></td>
<td>In the late 1990s a range of measures were introduced to raise quality and decrease variations in service including National Service Frameworks (NSFs). The NHS Plan re-emphasised the role of NSFs as drivers in delivering the Modernisation Agenda. NSFs set national standards and define service models for a defined service or care group; put in place strategies to support implementation; and establish performance milestones against which progress within an agreed timescale will be measured.</td>
</tr>
<tr>
<td><strong>Non-discretionary GMS expenditure</strong></td>
<td>Expenditure that is not subject to a cash limit but is mainly 'demand-led'. It covers allowances and expenses of general medical practitioners including their remuneration (previously known as non-cash-limited).</td>
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<tr>
<td>--------------------------------------</td>
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<tr>
<td><strong>Nurse practitioner</strong></td>
<td>The term ‘nurse practitioner’ is used inconsistently. There is much debate about the role because of overlaps with other nursing staff in the UK. The introduction of the title ‘nurse consultant’ also adds to this ambiguity. Generally nurse practitioners work autonomously, making independent diagnoses and treatment decisions. A recent review defined them as nurses ‘who have undergone further training, often at graduate level to work autonomously, making independent diagnoses and treatment decisions. In this way, they may potentially substitute for doctors’ (Ref. 73).</td>
</tr>
<tr>
<td><strong>Out of hours</strong></td>
<td>GP services provided outside the ‘normal’ working day, that is the hours from 7 p.m. on weekdays to 8 a.m. the following morning and from 1 p.m. on Saturdays to 8 a.m. on the following Monday morning. The proposed new GP contract defines out of hours as 6.30pm to 8am, Monday to Friday, at weekends and on Bank Holidays.</td>
</tr>
<tr>
<td><strong>Personal Medical Services (PMS)</strong></td>
<td>The NHS (Primary Care) Act 1997 allows for the piloting of different arrangements for delivering primary medical services as an alternative to the national GMS contract. A PMS Pilot can be a GP, a GP practice (which could be nurse led), a group of practices, GPs employed by an NHS Trust or a PCT, who have agreed to provide a range of primary care medical services to a defined population for an agreed sum of money. It is a locally negotiated agreement.</td>
</tr>
<tr>
<td><strong>Practice nurse</strong></td>
<td>A registered nurse usually employed by a general practitioner to provide a range of nursing care.</td>
</tr>
<tr>
<td><strong>Primary Care Collaborative</strong></td>
<td>The Primary Care Collaborative commenced in June 2000 to promote improvements in primary care across three topic areas; access to primary care, the management of patients with coronary heart disease and capacity and demand management between primary and secondary care. The Collaborative aims to introduce changes slowly and incrementally and to share examples of learning and what works among collaborating practices and PCTs (see <a href="http://www.npdt.org/">www.npdt.org/</a> for more information).</td>
</tr>
</tbody>
</table>
**Primary Care Groups (PCGs)**

PCGs were the predecessor bodies of PCTs, but with fewer powers, acting as subcommittees of health authorities from 1997. These enabled groups of general practices to work together to identify health needs, commission health services for a local population, and to develop primary care.

**Primary Care Trust (PCT)**

PCTs are free-standing, legally established, statutory NHS bodies. They will be responsible for 75 per cent of the NHS budget from 2003/04 and are the main local NHS body assessing all healthcare needs. At April 2002 there were 302 PCTs providing, commissioning and monitoring healthcare services for an average population of 180,000. PCTs have responsibility for the management, development and integration of all primary care services including medical, dental, pharmaceutical and optical as well as hospital and community services.

**Statin**

A cholesterol lowering drug or lipid regulating drug.

**Whole time equivalent (WTE)**

Term used to describe calculations that express the hours of part-time workers as a proportion of a full-time post.
Appendix 1: Membership of the Advisory Group

The study team is grateful to the valuable contribution provided by Advisory Group members:

Mr Ray Appleby, Association of Community Health Councils in England and Wales
Mr Peter Berman, National Association of Lay People in Primary Care
Ms Pam Bishop, Lay member, Mansfield & District Primary Care Trust
Mr John Bullivant, Audit Commission Wales
Dr Andrew Burnett, Medical Director, Barnet Primary Care Trust
Dr John Chisholm, Chairman, General Practitioner Committee, British Medical Association
Dr Judy Curson, Commissioner
Ms Sue Faulding, Senior Pharmaceutical Adviser, Leeds Health Authority
Ms Adrienne Fresko, Commissioner
Dr Steve Gillam, Director of Primary Care, Kings Fund, GP (Bedford)
Ms Sally Gorham, Chief Executive, Walthamstow Primary Care Trust
Dr Sian Griffiths, President, Faculty of Public Health Medicine
Sir Graham Hart, Commissioner

Professor David Haslam, President, Royal College of General Practitioners, GP (Huntingdon)
Mr Tony Hurrell, Chief Executive, Carmarthenshire Local Health Group
Mr Tim Jones, Primary Care Development Manager, Vale of Aylesbury Primary Care Trust
Dr Paul Lewis, Chair of Executive Committee, Maidstone & Malling Primary Care Trust, GP (Maidstone)
Dr Richard Lewis, Visiting Fellow, Kings Fund
Mr John McKenzie, Association of Medical Secretaries, Practice Managers, Administrators and Receptionists and Practice Manager (Reading)
Mr Lindley Owen, Chief Executive, Restormel Primary Care Trust
Professor Martin Roland, Director National Primary Care Research and Development Centre, University of Manchester
Ms Yvonne Savage, Community and District Nursing Association
Ms Sue Skewis, Chartered Society of Physiotherapy
Ms Liz Smith, Head of Nursing, East Devon Primary Care Trust and Community Practitioners and Health Visitors Association
Dr Peter Smith, Chairman, National Association of Primary Care, GP (Kingston-upon-Thames)

Mr Michael Sobanja, Chief Officer, NHS Alliance

Dr David Colin Thome, National Clinical Director for Primary Care, Department of Health, Visiting Professor MCHM, University of Manchester, GP (Runcorn)

Mr Rob Webster, Head of Personal and General Medical Services, NHS Executive

Ms Diana Whitworth, Chief Executive, Carers UK

Ms Cathryn Williams, London Borough of Barking & Dagenham Social Services

Ms Lynn Young, Primary Care Officer, Royal College of Nursing

The study team comprised Tara Lamont, Lucy McCulloch and Gabby Smith, under the direction of Wendy Buckley. Virginia Morley (independent consultant – facilitator of GP focus groups), Richard Freeman (District Audit) and Diane Ridley (District Audit) contributed as team members or consultants and Sonia McKenzie and Catherine Cawley provided secretarial support. A literature review on the quality of services in primary care was carried out by Professor Martin Roland, Director of the National Primary Care Research and Development Centre. Dr John Oldham, GP and Head of the National Primary Care Development Team, provided data on improving patient access and Dr Michael Greco, University of Exeter, provided patient data from the Improving Practice Questionnaire. Sue Ambler (Royal Pharmaceutical Society) provided advice on data concerning pharmacists and the Royal College of Nursing provided unpublished data from their 2001 Membership Survey.

The Audit Commission is grateful for help and guidance during the course of this review, but responsibility for the contents and conclusions of the report rests solely with the Audit Commission.
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This paper is one of a series of Audit Commission products looking at primary care. It considers the state of general practice in England in 2002, reviewing evidence on current strengths and weaknesses. It highlights concerns for patients and looks at ways of making the best use of all members of the practice team. This paper will be followed by other reports that discuss general dental services, primary care trusts and general practice resources.

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