Royal College of General Practitioners

# The Future Direction of General Practice

## A roadmap

Royal College of General Practitioners
London | 2007

BMA COGPED Committee of General Practice Education Directors napc nasgp national association of sessional gp nhs alliance SAPC THE SOCIETY FOR ACADEMIC PRIMARY CARE SPA Small Practices Association


RCGP

# The Future Direction of General Practice

## A roadmap

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Royal College of General Practitioners

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**The Royal College of General Practitioners was founded in 1952 with this object:**

*'To encourage, foster and maintain the highest possible standards in general practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same.'*

**Among its responsibilities under its Royal Charter the College is entitled to:**

*'Diffuse information on all matters affecting general practice and issue such publications as may assist the object of the College.'*

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## for a general practice-based healthcare system

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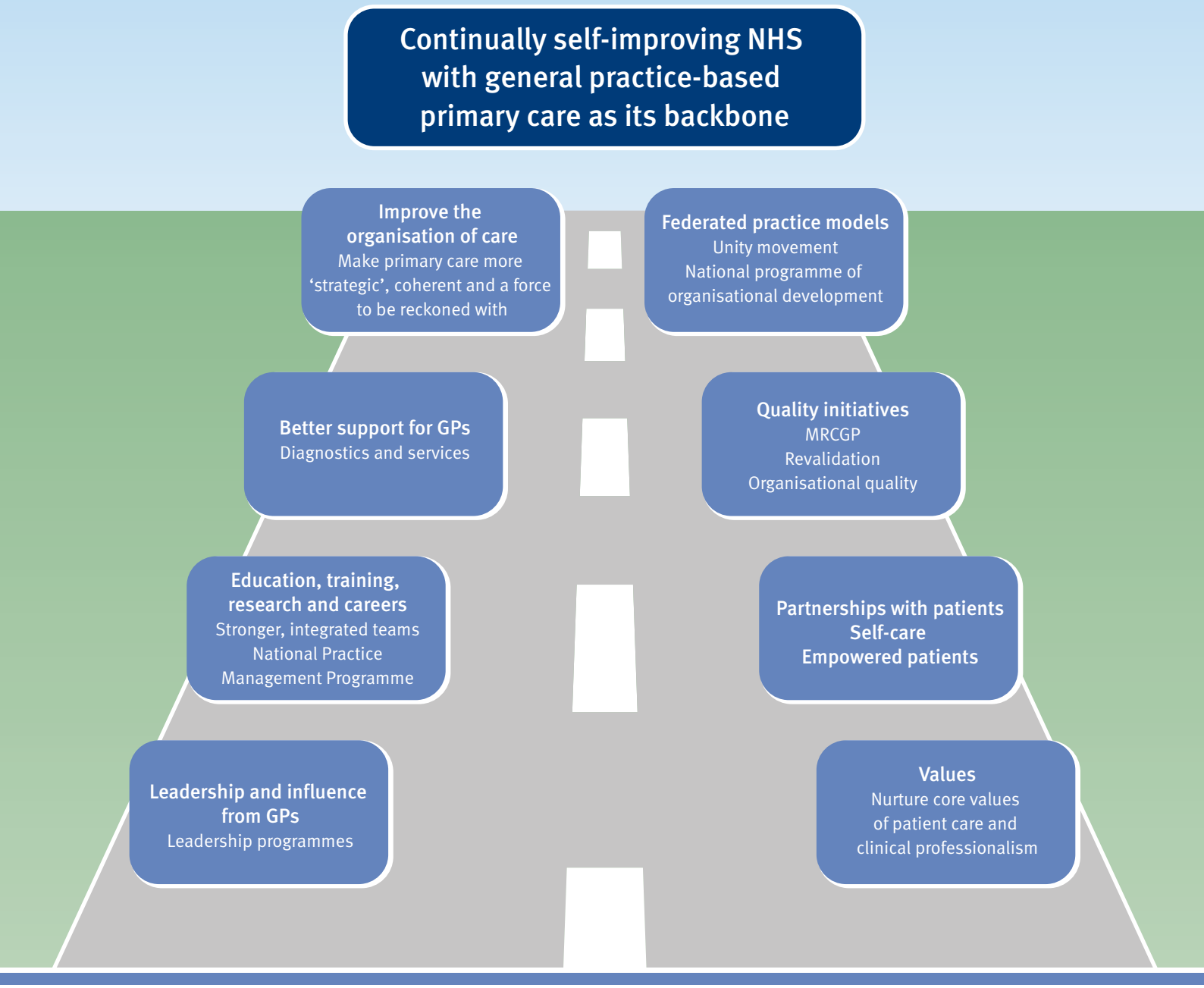

# Preface



General practice is truly at a crossroads. It is facing many pressures and challenges but also opportunities. The expectations for health care are changing from all points of view, including patients, policymakers, the NHS and GPs themselves. There is no shortage of analysis. It is knowing what to do next that matters.

Some people have expressed uncertainty about the future of general practice. Choices have to be made about the direction of health policy. There are those who believe that the profession does not have solutions to the problems that the health system is facing. The College believes that they are wrong.

This document – the product of intense deliberation and discussion – offers a vision for better patient care in the NHS. The RCGP believes that it is essential for GPs to put forward their own ideas for improving patient care. Sometimes we are so busy in our active day-to-day clinical work that it is hard to step back and consider strategic issues. But this is precisely what we have to do. This *Roadmap* can be used to challenge policymakers, and to support business cases for the development of services that build on the values we espouse here.

The status quo is not sustainable. Fragmentation of care, health inequalities and urgent care must be addressed. Furthermore, if we are to meet the health needs of patients over the coming years, we will need to bring about a radical change in the quality, organisation and delivery of services.

We believe it is possible to deliver improvements using a variety of models that build on the strengths and values of general practice. Using a 'federated' approach with primary healthcare teams and practices working together, virtually all health problems – including mental health – could be dealt with in primary care.

This document maps the way forward and demonstrates how the enormous potential of primary care can be maximised to bring about major improvements in patient care. The College's *Roadmap* is supported by all the major general practice organisations and represents an unrivalled opportunity for GPs to unite. The *Roadmap* is the blueprint for the future.

We urge that GPs organise themselves into a force to be reckoned within their local health economies. We hope that this document will be used by GPs and others as a basis for declaring an ambition to improve their local NHS. We believe that every effort must be made, and support given, to implement this *Roadmap*.

**Professor Mayur Lakhani** CBE FRCP FRCGP
Chairman of Council, Royal College of General Practitioners

RC GP Royal College of General Practitioners

# Forewords



UK general practice is still recognised throughout the world as one of the most cost-effective, high-quality deliverers of care. Despite changing contracts, the aspirations of a changing workforce and increasing patient expectations, the core principles underpinning UK general practice remain constant and valued.

Despite recent unwarranted media criticism, there is still clear evidence that the British public value and trust their family doctor. However, we must never take this for granted and this document helps to emphasise these values and the leadership that will be needed to sustain and develop general practice over the coming years.

The General Practitioners Committee of the British Medical Association is pleased to have been involved with the development of the College's *Roadmap*, which describes a clear direction of travel in an increasingly confusing and contradictory health environment. We are committed to working with our colleagues in the College to ensure that the *Roadmap* helps to keep UK general practice along the path of providing our patients with the best-quality primary care.

**Dr Hamish Meldrum** FRCGP
Chairman, British Medical Association

BMA

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At a time of rapid change, general practice badly needs strong leadership and a sense of direction. This excellent, well-argued and balanced piece of work provides both in abundance and NHS Alliance is delighted to be associated with this important enterprise.

Behind this document is a belief that change should be led by GPs themselves, who see patients on a daily basis and know only too well the difficult balances that have to be made. There are things that we must keep, such as the ethos of a public service driven by values and vocation with an emphasis on personal care and continuity, and with a focus on the whole person. Equally, there are new roles that general practice must now undertake, which range from many of the services currently offered in acute hospitals to an amplified role in self-care, personal health and the health of the whole local community.

While proposing a clear direction, this document avoids some mistakes of recent years, where real change has been subjugated by endless organisational restructuring. It states quite rightly that future change should be organic and thus sensitive to the needs and views of patients, evidence of outcome and the experience of frontline GPs and managers. If general practice is allowed to develop along the lines suggested, its increasing self-confidence and cost-effectiveness will play a major part in enabling the 'primary care-led NHS' to fulfil its true potential as a sustainable world-class service.

**Dr Michael Dixon** OBE FRCS FRCGP
Chairman, NHS Alliance

nhs alliance

It is extremely important in these times of great change and unrest throughout the whole of our NHS that we have a clear direction and vision for the future of our patients and frontline staff, and none more so than for those of us who deliver primary care services to our registered populations. Our College has produced a thought-provoking and supportive document that starts to shed light on how primary care services and, in particular, how general practice will deliver care in the future. I commend this document produced by the College, which puts in place the first tranche of much needed building blocks.

**Dr James Kingsland**
Chairman, National Association of Primary Care

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The Committee of General Practice Education Directors (COGPED) welcomes this *Roadmap* as a document to fuel the debate on the future direction of general practice. We would like to emphasise the role of education and training as a lever for change, as clinical and managerial developments in general practice have often originated in training practices. Educational environments frequently lead in service delivery with educational and clinical governance working together. The role of education in the development of what is the most complex clinical area cannot be understated as we move towards the GP as the new generalist of the NHS. COGPED and the RCGP will work together to deliver GPs with the capacity and capability of engaging with the debate and delivering the services for the patients of today and tomorrow.

**Dr Arthur Hibble** FRCGP
Chair, Committee of General Practice Education Directors

The Society for Academic Primary Care (SAPC) welcomes this document as one that will support primary care services in the UK in delivering and improving patient care. All efforts to make primary care of the highest quality are part of our shared mission with the RCGP, and this is the ultimate goal of our organisation, which prioritises excellence in primary care research and teaching.

**Prof. Amanda Howe** FRCGP
Chair, Society for Academic Primary Care

SAPC
THE SOCIETY FOR ACADEMIC PRIMARY CARE

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We are delighted to give the endorsement of the Small Practices Association (SPA) to this enthusiastic and worthy document. In particular we are pleased that the traditional values of patient focus, holism and continuity of care are to remain an important part of the bedrock of our shared future. We will work with any and all groups to make real these aspirations.

**Dr Michael Taylor** MRCGP MICGP
National Chairman, Small Practices Association

SPA
Small Practices Association

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*The Future Direction of General Practice: a roadmap* is based on the core values of general practice – quality, education, primary care development and workforce. It thus comfortably solves the paradox that, by underpinning these professional values of general practice, gives us the remit to place patients at the centre of our map. Sessional GPs – whose opinions for many years have been given insufficient credence – can now feel that their important contribution is being recognised.

**Dr Richard Fieldhouse** MRCGP
CEO, National Association of Sessional GPs

nags national association of sessional gps

# Acknowledgements

We would like to thank Professor Richard Baker, Professor Helen Lester, Dr Paul Hodgkin, Dr Orest Mulka, Dr Agnelo Fernandes, Dr Steve Mowle, Ailsa Donnelly, Professor Chris Van Weel, Dr Andy Spooner, Dr Mike Dixon, Professor Nigel Mathers and Dr Imran Rafi.

# 1 Executive summary

1 NHS reforms have created pressures, challenges and opportunities for general practice. Expectations of patients, society, the wider health community and GPs themselves are changing.

2 The Royal College of General Practitioners (RCGP) and the General Practitioners Committee (GPC) of the British Medical Association (BMA) believe that the profession must put forward its own ideas for the development of general practice and patient care. This document is designed to promote discussion about the future direction of general practice. It draws on discussions with patient groups, general practitioners and other key stakeholders.



3 We hope that this document will be used to map a way forward for improving patient care using the enormous potential of primary care. It provides a framework for bringing together key improvements in quality, education, primary care development and workforce. The document can be used to influence, support and challenge policymakers at national and local levels.

4 We do not believe that the status quo can enable GPs to deliver everything that patients need in the 21st century. A new model of health and social care is required that builds on the needs of patients and the strengths and values of general practice.

5 General practice is a key element of all healthcare systems in Europe and is recognised by health service providers as being of ever-increasing importance. It is valued by patients and contributes to an effective and efficient health system. Policymakers must build on the existing strengths and values of general practice and avoid policies that might fragment care.

6 Our vision is for a stronger and more vibrant general practice-based primary healthcare system that is patient centred, which provides consistently high-quality, safe, needs-based care. This can be achieved by expanded – but integrated – primary health teams offering a wider range of services in the community with expanded access to diagnostics. We suggest that virtually all health problems in the population – including mental health – could be dealt with in primary care with short-term referral as needed, to maintain comprehensiveness. The role of the acute hospital is for more serious clinical problems, specialist interventions, care and procedures.

7 Our model is based on good clinical generalists working in the community. The therapeutic doctor–patient relationship must continue to be the cornerstone of future health care, and models of care should enable relationship continuity for the many patients who seek it. The expert generalist has a pivotal role in tackling co-morbidity and health inequalities.

**8** To achieve optimal care, the strategic and organisational development of general practice must be increased. This will include the development of collaborative groupings or federations of practices. GPs need to become more united as a professional group. In this way, it should be possible to improve access and provide an extended range of services. The practice and the primary healthcare team must remain the basic unit of care. This federated model of general practice, championed and led by GPs, is essential to counter the challenges of a 'market' approach in the NHS, a particular concern in England. A 'one size fits all' model is not recommended or possible. We recommend that local GPs and health economies should determine their own evolution. An organic approach to change is recommended, involving citizens in the dialogue.

**9** We caution against the development of 'polyclinics' that focus purely on diseases and technical care but commend the value of co-location of services to reduce fragmentation of patient experience. Whatever models are adopted, the cardinal values of general practice such as interpersonal care and continuity based on care for defined populations and registered lists must prevail.

**10** The implementation of better models of care will require strong clinical and professional leadership from GPs. We urge GPs to organise themselves locally into a force to be reckoned with. A progressive and dynamic approach is needed. Education and training will be fundamental to delivering change. Investment of resources will be necessary to support the new model of care including the development of premises and the underpinning workforce and training requirements.

**11** The new MRCGP exam means that all new GPs will be eligible to become members of their standard-setting body on a voluntary basis. Having a single professional body for GPs provides opportunities for more strategic governance of the profession, more 'joined-up thinking' and improved long-term professional development.

**12** We believe general practice should become a major contributor to preparing the future NHS workforce. Current constraints to this (such as inadequate premises) must be identified and rectified.

**13** The future is exciting for general practice. GPs must adapt and grow to meet new challenges. There are many opportunities to work with patients to improve patient care and for GPs to develop enticing portfolio careers. In a complex healthcare environment, the future GP will be offering patients advanced relationship-based, primary medical care. We recognise that our aspiration will require considerable investment, reform and support for implementation but feel that it is a much needed and achievable model to improve patient care.

# 1 Introduction



**1.1** The state of general practice has become an important national issue in the eyes of the public and the media. Hardly a day goes by without general practice featuring in the headlines and not always in a positive manner. The quality of services, particularly access to GPs and urgent care, is high on the agenda of both patients and policymakers. In addition there is concern about the 'cost' of the Quality and Outcomes Framework and whether it represents the most effective use of scarce resources.

**1.2** There is no doubt that the NHS faces rising public expectations and demands, and that there is a growing emphasis on 'value for money' in a resource-constrained environment. The expectations of general practice are also changing from the point of view of the wider health community and GPs themselves. Although general practice is consistently well-rated, and trust in GPs remains high, some people have expressed uncertainty about the future of general practice. Will general practice be able to continue to respond to the legitimate clinical needs of citizens?

**1.3** We consider it essential that the profession addresses the concerns of patients and puts forward its own ideas for improving patient care in the 21st century. The RCGP recognises the importance of this and has undertaken a number of initiatives to explore the issues. These have included a public meeting (Appendix 1), a consultation with RCGP faculties and members about the future of general practice (Appendices 2 and 3) and a seminar with key stakeholders (Appendix 4). These were not designed to be systematic statistical surveys but were intended to capture key issues and a range of perspectives. In 2006, the RCGP also took part in an international colloquium on renewal in family medicine.[1] Our document also refers to the work of the General Practitioners Committee (GPC),[2,3] the NHS Alliance[4] and the National Association of Primary Care (NAPC).[5]

**1.4** Using the findings from these initiatives and considering other documents this paper outlines key questions for debate about the future of general practice. Although the current system has considerable strength, which must not be lost, we feel that the existing arrangements will not enable us to deliver the care that we are capable of, particularly given the rising expectations and increasingly complex needs of patients and the aspirations of healthcare professionals themselves.

**1.5** Although this paper relates to the Department of Health in England, we hope that it will be of interest to other parts of the UK, and indeed internationally. To ensure that the differences in health systems within the UK are addressed, we have included a perspective piece from each of the home countries.

**1.6** The purpose of this document is not to describe in detail the philosophy or values of general practice – the RCGP has already published several documents on these issues.[6,7,8] Rather, the purpose of this document is to offer a framework for a future federated model of care to help set the direction of general practice in the 21st century.



**1.7** In the document we use the following definitions:

**1.7.1**. *General practitioners (GPs)/family doctors* are expert physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing generalist care to every individual seeking medical care irrespective of age, sex and state of health.[9]

**1.7.2.** *General practice* is defined as: 'an academic and scientific discipline, with its own educational content, research base and clinical activity, orientated to primary care and built on fundamental principles'.[10]

**1.7.3.** *Primary care* is defined as: 'the first level contact with people taking action to improve health in a community. In a system with a gatekeeper, all initial (non-emergency) consultations with doctors, nurses or other health staff are termed primary care as opposed to secondary healthcare or referral services.'[11] General practice is the building block of primary care in the UK, so we prefer to use the phrase 'general practice-based primary care'.

**1.7.4.** We also use the terms generalist and specialist in this paper.[12] The language of 'primary' and 'secondary' care is becoming increasingly redundant. Care traditionally provided in the community may now be provided in hospitals and vice versa. However, we strongly believe that access to specialists should normally be through generalists in view of their experience and broad knowledge base.

**1.7.5.** We begin by considering the drivers of change. We then set out how we can serve patients better and emphasise the values that must underpin development of the discipline. The organisation of care is clearly the key to improvement as is effort to tackle fragmentation of patient experience and improve patient safety.

# 2 General practice in a changing world

**2.1** A large number of developments will affect the future of general practice. These include changes in public expectations, society, the NHS and in the profession itself.

## 2.2 Societal changes

**2.2.1.** Society is continually changing and the role of patients in shaping the nature and provision of health care has increased. A doctor's opinion is no longer regarded as sacrosanct and a new dialogue is developing between healthcare consumers and providers. The expectations of patients, the interest of politicians and the media, the impact of new information systems such as the internet, and the increasing cost and complexity of healthcare delivery have all resulted in a climate of continual change. Such change has been with us for decades but is accelerating in pace and scope.[13] The result is that patients expect increasingly sophisticated and responsive health care.[14]

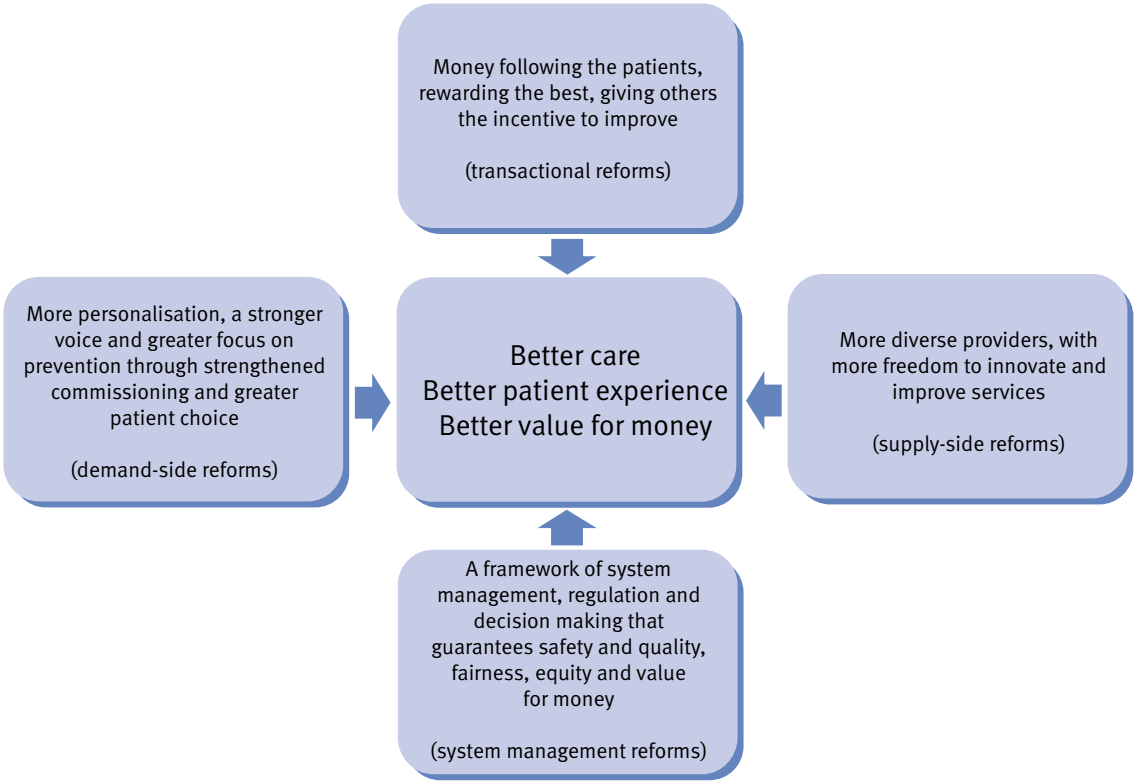
**2.2.2** Changing lifestyles, with associated problems such as obesity, alcohol dependency and cancer, will continue to have a major impact on demand for health care. An ageing population will pose major challenges on health and social care services. Advances in medical science, technology and drug discovery are constantly affecting the way health care is delivered.

## 2.3 NHS reforms in England

**2.3.1** A major, rapid and controversial programme of modernisation of the NHS is underway.[15] It is not the purpose of this document to offer a detailed critique of this process but to examine its influence on general practice and to determine what opportunities and challenges it offers GPs to improve patient care.

**2.3.2** The three goals of health system reform are 'better care, better patient experience and better value for money'. These are to be delivered through four programmes: supply-side reforms, system management reforms, demand-side reforms and transactional reforms (Figure 1).

**Figure 1:** **Health system reform in the NHS in England**




**2.3.3** The key policies within transactional reforms are Practice-Based Commissioning (PBC) and Payment by Results (PbR). The new health and social care white paper *Our Health, Our Care, Our Say*[16] proposes a major reshaping of the NHS by shifting appropriate care out of acute hospitals and into the community. It is proposed to transfer 5 per cent of the acute sector budget into the community over the next decade. Specific initiatives include a programme of care close to home in six specialties, aggressive management of long-term conditions and the targeting of health inequalities. The new policies pose a formidable implementation challenge for local health communities.

**2.3.4** The key policy within supply-side reforms is contestability and plurality of provision. This has proven particularly controversial amongst professional groups and trade unions as it allows new entrants from the commercial sector to deliver a wide range of services in primary care using the Alternative Provider of Medical Services (APMS) contract model. This option is also being used by some 'entrepreneurial' GPs.

**2.3.5** The purpose of system management reform is to guarantee quality and safety, fairness, equity and value for money in a pluralistic NHS. The implication for providers in the NHS is that they will be expected to demonstrate their performance against these indicators.

**2.3.6** The key policy in demand-side reforms is emphasis on health and wellbeing, a more personalised service and patient choice.[17] Whilst opportunities to increase patient involvement in clinical decision making and treatment choice are welcomed, the practice of provider choice – such as choice of hospital – has not been accepted widely by healthcare professionals, and there are concerns about the application of *Choose and Book (C&B)*. It is important to separate problems with the booking system (C&B) from the broader underlying principles of patient empowerment and involvement. There is no doubt that patients want increasing choice about treatment options and information about their care. A survey by the BMA[18] showed that patients placed a high priority on choice of GP. Whilst there are concerns that choice might worsen health inequalities, there is also evidence that patients from lower socio-economic groups want to exercise more choice.[19] There is also evidence that trust increases when people actively choose a professional on the basis of having information about him or her.[20] Whilst care must be patient centred and responsive, it should not be at the expense of the clinical needs of the individual or of other patients.

## 2.4 GP contracts

**2.4.1** The introduction of the new GP contract[21] and the Quality and Outcomes Framework has radically altered the way GP practices work. The Quality and Outcomes Framework has delivered improved clinical standards for patients with chronic diseases. Some are, however, concerned that it may have created a 'tick box' mentality and created tension between the doctor's agenda and the patient's agenda,[22] and may distort clinical priorities. There is also concern that it may cause 'crowding out' – that is, reducing the intrinsic motivation or professionalism of highly skilled healthcare professionals.[23,24] GPs are concerned about their future ability to deliver high-quality patient care in the face of budgetary constraints, a focus on value for money and complex, possibly changing, contract arrangements.

**2.4.2** Out of hours: the new contract has enabled GPs to 'opt out' of 24-hour contractual responsibility for patients. GPs have generally welcomed the flexibility that this offers. Early indications are that this change has helped GP morale, recruitment and retention.[25] However, whilst the new arrangements have been supported by many doctors, some GPs, the media and patients have viewed them negatively, with the result that the state of out-of-hours care has become an issue of major concern in the UK.

## 2.5 Medical professionalism

**2.5.1** An important challenge for health reform is to ensure that excessive regulation does not reduce medical professionalism. The Royal College of Physicians has defined medical professionalism as: 'a set of values, behaviours, and relationships that underpin[s] the trust the public has in doctors'.[26] *Doctors in Society* states that: 'Medical professionalism lies at the heart of being a good doctor.' This and related developments such as patient-centred professionalism,[27] a BMA report on professional values[28] and the revised *Good Medical Practice* from the GMC[29] are important influences on modern medical practice, indicating the need for doctors to develop good working partnerships with patients. We need to build on this to ensure approaches to medical regulation genuinely support and sustain professionalism.



## 2.6 Postgraduate medical education and training

**2.6.1** Major reform of education and training through Modernising Medical Careers (MMC)[30] has led to an important debate about the needs of patients, future plans, and the role of doctors within this. The Postgraduate Medical Education and Training Board (PMETB) has recently approved the new RCGP Curriculum for Specialty Training for General Practice. This aims to improve patient care through better GP training. Although vocational training presently has many strengths, some GPs at the end of their training do not feel fully prepared for their role in the NHS.[31]

**2.6.2** Serious problems have been experienced by junior doctors applying for specialist training schemes using the Medical Training Application Service (MTAS). A major review of the application process is being undertaken together with a more fundamental review of the overall scheme. It is worth noting that general practice has a validated, competence-based selection system for doctors applying for GP training and that the scheme has operated relatively successfully. The strategic review must offer an opportunity for doctors to design improvements and for a stronger, pivotal role for professional bodies in postgraduate medical education and training. This is to address major concerns expressed by doctors about both MMC and PMETB.

**2.6.3** The new specialty training curriculum has been defined by the RCGP together with an improved training model. The key features of these are: three-year schemes that will be competence based; educational supervision from general practice even for hospital placements; a series of short (for example, four-month) attachments in settings outside general practice; and, finally but most importantly, spending a minimum of 18 months training in a GP practice. We also recommend that GPs have a programme of higher professional education following the current three years of specialty training. Our aspiration is for a five-year formal training programme.

**2.6.4** A new licensing assessment will be recommended to PMETB by the RCGP and will constitute the new MRCGP examination from 2007. This means that there will be only one standard for entry to general practice and that, for the first time, all new GPs will be eligible to become members of their standard-setting body.

## 2.7 Public perceptions of GPs and general practice

**2.7.1** There has recently been an unprecedented level of media interest in GPs.[32] Although surveys repeatedly show high levels of satisfaction with the NHS and general practice among patients,[33,34,35] concerns about access and urgent care remain. This, coupled with stories of increasing GP earnings, can give the impression of a diminution of service and poor value for money. In some areas GPs are opting out of providing key services such as immunisations.[16] The profession must take great care to maintain the high regard and trust in which it is held by the public, and this document suggests ways of doing this.

## 2.8 Changes within the profession

**2.8.1** Currently 30 per cent of care is delivered by sessional GPs (formerly called non-principals). Many GPs want to work in different ways and find the traditional arrangements frustrating. Flexible, salaried working is now common but partnership opportunities are increasingly scarce. The influx of women into the GP workforce has brought increasing requirements for flexible working and/or GPs to return to work following career breaks for whatever reason. However, despite the growing proportion of female GPs, there is evidence of a gender divide since most GP partners are men while most salaried or sessional GPs are women. The possibility of becoming a GP with a special interest (GPwSI) has been welcomed by some but there is concern about its effectiveness and impact on generalism. There is, as yet, no clear career pathway or model for GPs. The challenge is how to build fair and accessible career opportunities for GPs who want to work in flexible ways in a fast and changing NHS at the same time as meeting the needs of patients and the service. Interest in training to be a GP is high. There is an urgent need to devise models of care that make the best use of the talents of all GPs.

## 2.9 Proposed changes to medical regulation and quality assurance

**2.9.1** In 2006 Professor Sir Liam Donaldson published his report *Good Doctors, Safer Patients*.[36] Proposals for implementing this have been published by the UK Government in its white paper, *Trust, Assurance and Safety: the regulation of health professionals in the 21st century*. The twin-track model of revalidation (relicensing and recertification) is to be introduced with an enhanced role for medical royal colleges. GPs and practices will need support to fulfil their obligations.



## 2.10 Overall impact

**2.10.1** Clearly, there are many drivers of change. It is therefore not surprising that some GPs feel unsettled about the impact of these changes on their ability to deliver patient care. Change presents both challenges and opportunities. Most people's contact with the NHS is with general practice and 90 per cent of care is delivered there. This places general practice in a strong position to improve overall clinical care for patients.

**2.10.2** How can GPs thrive in such an environment? A study of the history of general practice shows that the generalist is adept[37] at changing and evolving, and that solutions can be generated from what appear to be crises.[38] If we have a vision of what general practice should be, it becomes possible to identify from among the current transient policy preoccupations those innovations we must develop and build on.

# 3 The nature and values of general practice



**3.1** We need to understand the nature and values of general practice in order to understand its pivotal role in current and future models of health care.

**3.2** General practice is a key element of all healthcare systems in Europe and is recognised by health service providers as being of ever-increasing importance. In the UK, general practice has been a fundamental element of healthcare provision since the inception of the National Health Service in 1948. In 2004, UK GPs carried out 259 million consultations. On average, patients consult their GP five times a year.

**3.3** Every citizen has the right to be registered with a general practitioner. Personal registration brings a number of key characteristics of general practice, including personal and organisational continuity of care, comprehensiveness (including medical generalism and the multiple functions of the primary healthcare team), and coordination. GPs also play a central coordinating role for patients with complex problems who must navigate increasingly complex health and social care systems.[39] There is a risk that, when patients receive different aspects of their care from different parts of the system, no one takes overall responsibility for their care. GPs accept this responsibility, and can often prevent expensive duplication of investigations or uncoordinated care from different providers. Other characteristics include longitudinal care, lifelong medical records, confidentiality, team-based care and the gatekeeping function.

**3.4** Clinical generalists providing care to patients with undifferentiated problems are critical to the clinical effectiveness and cost-effectiveness of the NHS, and are highly valued by the public. General practice offers a 'safety net' for patients including the old, the vulnerable, those with undifferentiated presentations, patients without established diagnoses or 'labels', and those with co-morbidity and complex conditions (covered in detail in later sections). The management of patients with multiple morbidities is a role almost unique in medical practice to the GP. Above all, GPs do not discharge their patients, but provide a lifetime of care, accompanying people through their illness pathways as guides and advocates.

**3.5** At the heart of general practice is the doctor–patient relationship, and the patient-centred clinical method in the consultation.[40] Values such as a commitment to interpersonal care are highly prized by patients and flow from relationship-based care and continuity.[41] The values of general practice must be nurtured and new ways of working should enhance them. In fact, such values may become more necessary as complexity in health care increases. Patients do not like having to repeat information to different providers, and they value the GP's role in coordinating care.[42]

**3.6** Patients want more information and involvement in their care.[31,43] General practice is notable for promoting the patient-centred clinical method during training and assessment, and this forms a significant component of the MRCGP professional examination. Recent research from the Picker Institute shows that, overall, UK general practice still has relatively low levels of patient centredness. One key to changing this is through improved training and education of healthcare professionals.[44] However, it is also notable that the length of consultations in the UK remains among the shortest in Western Europe – so change may be needed in consultation length as much as in consultation skills.

**3.7** We believe that patients should be equipped with the knowledge and skills to navigate a complex health and social care system, working with a trusted health professional, most often a GP. Some patients will need extra support because of specific difficulties in negotiating the service they need, for example people with poor English, people with learning difficulties, the homeless, etc.

**3.8** GPs increasingly need an approach to care that consciously adopts a patient's perspective.[45,46,47] Patients should be increasingly involved in planning health services, self-care, demand management, quality assessment, and in self-management and group education. Many good examples of GPs working closely with patients can be found in those GPs who manage patients with chronic diseases such as diabetes.

**3.9** The implications of patient centredness for doctors are succinctly captured in the patient principle: being a doctor involves adoption of a moral principle that commands the doctor to place the needs of patients before his or her convenience or interests.[48]

**3.10** We believe that service provision should move away from the needs of organisations to the needs of patients. In order to achieve a patient-centred organisation, patients' involvement in strategic planning must be increased. GPs need to work in close partnership with individual patients to determine the optimal treatment for them; similarly, practices and primary healthcare teams need to develop partnerships with patients or patient groups to involve them in planning service provision.

Dr Brian Fisher, a GP in London, says: 'In our practice, we enable patients to see their full GP record online. We also have a patient panel, which is a variant of the traditional patient participation group. We have also involved patients in the recruitment of GPs.'

## 3.11 The value of professionalism

**3.11.1** In its response to the Donaldson report, the RCGP stated: 'the most effective guarantee of patient safety is the professionalism of the staff working in the health service'.[49] Any system of regulation must ensure that this professionalism is celebrated and not undermined. The Royal College of Physicians stated that 'Professional values constitute the social capital of medicine.' It is essential that developments in health care do not 'crowd out' clinical professionalism. One aspect of professionalism in general practice is putting patient interests first, which often results in GPs doing more than is required in their contracts.

## 3.12 Conclusions

**3.12.1** A commitment to interpersonal care is highly prized by patients and flows from relationship-based care and continuity. The values of general practice must be nurtured and new models of care must enhance these values. The RCGP recommends that the basis of effective and efficient health care in the NHS must be primary healthcare teams responsible for defined and registered groups of patients. This should enable continuity and coordination, including call and recall systems for health prevention and promotion, which are critical in delivering effective chronic disease management.

**3.12.2** Within the NHS, general practice has a proven track record of providing personalised care and involving patients in decision making, which must be acknowledged. Efforts, however, must continue to bring about an overall change in the culture of the NHS to put the patient at the centre of care by countering organisational and professional paternalism.

**3.12.3** Modern clinical professionalism – emphasising partnerships with patients and accountability – must be celebrated, nurtured and respected by the NHS.

# 4 Improving the organisation of primary care



**4.1** Patient surveys have shown that patients want improved access and continuity of care, a greater range of services closer to home and improved care coordination. GPs themselves have also proposed ideas for primary care development (Appendices 2 and 3). The College's public event (see Appendix 1) showed that patients value general practice and want:

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

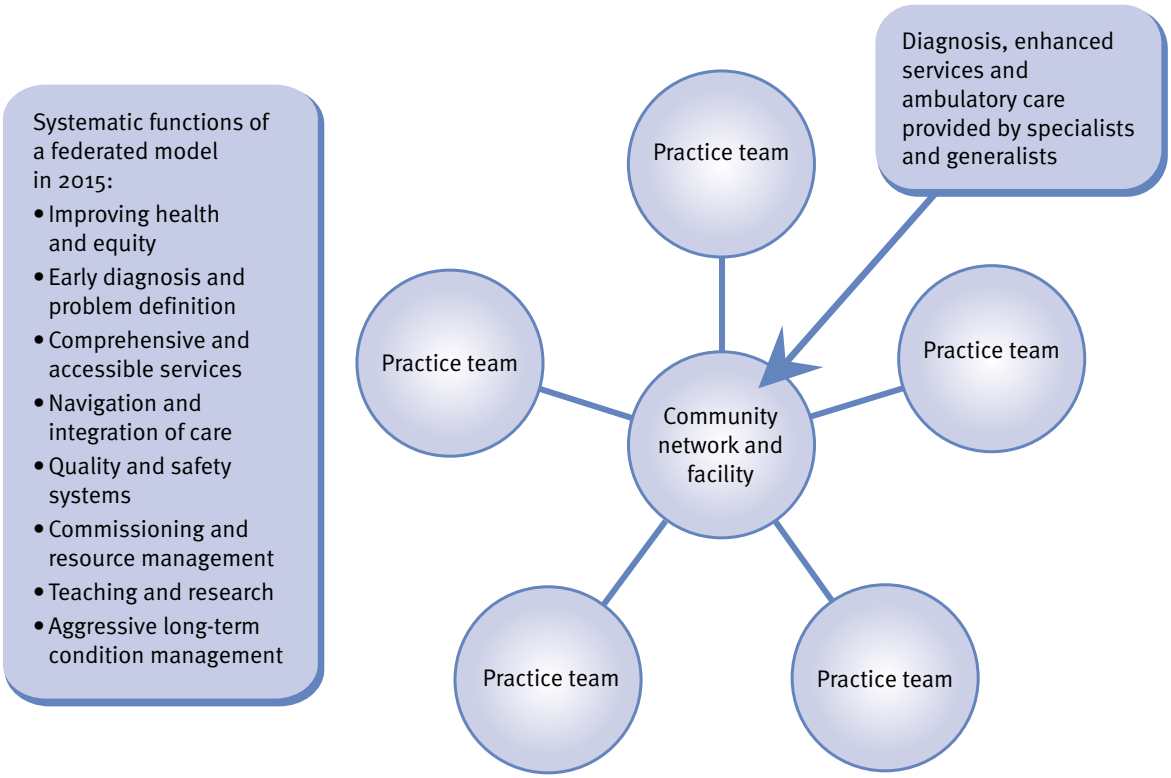
**4.2** The current infrastructure of general practice is well placed to deliver the services the public require and there is evidence that patients prefer consultations in practices to hospital visits. However, to give our patients everything that general practice is capable of we need to further increase its organisational development. It is unlikely that single practices or units of care could deliver a comprehensive range of services, although some larger units could. Patients continue to ask for services to be delivered closer to home. Technological advances – including near-patient testing – should help realise this demand.

**4.3** In some cases, the quality of GP premises limits the ability to deliver a wider range of services, and even the quality of existing services.[50] Inadequate premises will therefore need to be improved in order to deliver some of the changes proposed, including teaching and training. This will require a substantial injection of resources and innovative policies to support a systematic and ambitious programme of practice development.

**4.4** Practices working together in a variety of models, ranging from informal cooperation to formal legal entities, offer an opportunity to meet the clinical needs of patients. Practices could be the normal unit of care but work within a federation of care providers that could include social care. Although practices will be separate entities, by collaborating in federations they may be able to provide enhanced services such as extended chronic disease management and ambulatory care. Federations should be different from current primary care organisations in that they will be championed and led by primary care clinicians. They could be virtual and/or operate diagnostics and more specialised services from community hospitals. Figure 2 sets out the detail of this and the suggested functions. In section 8 we consider some of the functions in greater detail.

**4.5** The organisational development of general practice is essential. Models used elsewhere such as 'divisions' of general practice in Australia and New Zealand should be studied and built upon. Federation leaders would normally be GPs who would have a key role in driving up standards, improving services and supporting practices. Federations could also allow the bringing together of quality, education, teaching and training, and research by creating a critical mass. The exact size and make-up of federations is for local determination.

**Figure 2: Federated model of primary care championed by clinicians**




**4.6** The exceptional potential and power of practices working together can be illustrated by the example of GP out-of-hours cooperatives in the 1990s. The advent of GP cooperatives transformed on-call provision and improved the morale of GPs across the UK. In 1988 there were approximately 500 GPs in cooperatives; by 1998 there were 22,000.[51]

**4.7** The federations should be actively managed organisations with strong systems of leadership and governance (including adequate patient consultation and input) that will ensure quality of care, support clinical behavioural change, monitor resource use, and commission care using Practice-Based Commissioning (PBC). The federations will enable enhanced access to health care, particularly for urgent care.

**4.8** Change is already occurring

**Box 1: Working together whilst providing local accessible care**

GP Care Limited Liability Partnership is an innovative, flexible and inclusive organisation based around general practices in Avon. It was formed from a concept developed by local GP Dr Simon Bradley, and involves experienced members of the NHS community delivering quality family health care through a distributed network of local healthcare providers and premises. The organisation builds on the best of traditional general practice at the same time as innovating and extending the range and quality of health care available close to patients' homes. With general medical practices at the core of GP care, it provides an integrated range of health services that are patient centred and which will counter the fragmentation of NHS care that is threatened by the extension of the market in primary care. See www.gpcare.org.uk.

Principia Partners in Health in Rushcliffe, Nottinghamshire, is a coalition of GP practices, community professionals, community pharmacy and local people. Principia provides primary care, including extended-hours access and community services, to a population of 118,000. See www.networks.nhs.uk/183.php.

The Alliance in South Wiltshire, led by Dr Celia Grummitt, is a consortium of 15 practices that cross old PCT boundaries in order to best serve patients' needs. It is an association and is open to all groups of allied health professionals as well as GP practices, and serves around 100,000 patients. All practices have contributed funding to enable the work to be undertaken. A strong working relationship has been developed with the local PCT leading to the employment of local GPs in a new Urgent Care GP pilot. The arrival of GPs on the team has even allowed the commencement of community intravenous administration services, which were previously not possible.

**4.9** A 'one size fits all' model is not recommended or possible. It is for local GPs and health communities to determine their own future within a changing political framework. An organic approach to change is recommended, involving patients and other citizens in the dialogue. We caution against the development of 'super surgeries' or disease-focused 'polyclinics', which simply co-locate individuals without an underpinning philosophy or vision. However, we commend the value of co-location of services or close cooperation between GPs and community services, such as pharmacists, for reducing fragmentation of the patient experience and of federated general practice. Above all, whichever models are adopted, the cardinal values of general practice, such as interpersonal care and continuity of care for defined populations and registered lists, must prevail.

## 4.10 Conclusions

**4.10.1** To give our patients everything general practice is capable of we need to further increase its organisational development. It is unlikely that a single practice or unit of care could deliver a comprehensive range of services, although some larger units could. Local accessible care is essential. Patients continue to press for services to be delivered closer to home. Practices working together offer an opportunity to meet the wishes and clinical needs of patients. It is, however, also important to critically examine the evidence base that underpins service delivery and ensure new developments acknowledge and build on such information, and are subject to evaluation.[52]

**4.10.2** Advice and support should be made available to local GP communities to enable them to work together and develop models of governance and care that best suit the emerging multi-practice consortia and entities.[53] The College and other professional organisations could play an important role in developing such models of governance and care for PBC.

**4.10.3** Larger groupings of practices could allow the creation of legal entities that could then raise capital to promote the systematic development of infrastructure. Such initiatives could also be supported by properly resourced PBC.

# 5 Providing a greater range of services and diagnostics in primary care



**5.1** The provision of diagnostic and specialist therapeutic services is not generally a feature of UK general practice. There are, however, ongoing initiatives to transfer such services into appropriate primary care settings. GP surgeries are not specifically identified as the most suitable site for such services but regarded as one option, alongside 'one-stop shop' primary care centres and community hospitals. GPwSIs can perform some therapeutic procedures in primary care settings including ENT, gynaecology (e.g. investigation and management of menstrual disorders) and minor surgery (e.g. joint injections and removal of lesions). This must be done without compromising the essential roles and function of general practice. It can only be done with increased capacity, facilities and trained staff. This development should be influenced by the commissioning process. Not every practice will be expected to provide such services but, in the future, referral to another local unit or provider such as the community hospital should be possible. Examples of services that could be delivered closer to home are shown in Table 1.[54]

**Table 1: Services delivered closer to home**

| *Diagnostic test* | *Treatment and management* | *Rehabilitation/palliative care* |
|---|---|---|
| *For example:* | *For example:* | *For example:* |
| Blood tests | Extended minor surgery | COPD |
| Audiology | Dermatology | Cardiac rehabilitation |
| Plain film X-rays | Chronic pain | Orthopaedic |
| Ultrasound | Podiatry | Palliative care |
| 70% of pathology (non-slide based, non-specialist work) | Endoscopy | End-of-life care |
| | GUM | Stroke care |
| Echo-cardiology | Follow-ups of various conditions | |
| Endoscopy | | |
| Colposcopy | | |
| INR testing | | |

Dr Nav Chana, GP of Cricket Green Medical Practice, Surrey, operates a community deep vein thrombosis service and employs a physician's assistant.

## 5.2 Diagnostics

**5.2.1** At present, access to imaging and other tests is relatively restricted. In order to ensure smoother patient pathways and speedier diagnoses, GPs need increased access to diagnostics. The RCGP and the Royal College of Radiologists (RCR) have developed *The Framework for Primary Care Access to Imaging: right test, right time, right place*.[55] This framework supports GPs by indicating appropriate diagnostic imaging strategies for patients with a range of common clinical problems for which direct access to imaging should be available from primary care. It supports access to imaging by GPs equivalent to hospital doctors on the basis of the clinical needs of patients.

**5.3** In addition to improving access to imaging, there is also an initiative to improve access to so-called 'physiological measurements'.[56] Examples include 24-hour ECG monitoring, exercise ECG testing, audiology, endoscopy, ambulatory blood pressure monitoring, nerve conduction studies, *Helicobacter pylori* tests and lung function tests. This is to be welcomed.

**5.4** It is important to state that, whilst it is necessary to improve services and diagnostics in the community, primary care must not be seen merely as a 'conduit' to deliver secondary care-type services – the extra services must be integrated in a model that enshrines the values, philosophy and strategic function of general practice.

**5.5** Low-carbon health care: future health care should pay due regard to environmental issues. The *British Medical Journal* has urged doctors to play a leadership role in climate change[57] and has itself set up a *carbon council*. The carbon footprint of GP surgeries and healthcare activities should therefore be considered.

**Box 2: The future has to be better than the past: what better diagnostics and commissioning power could mean for patients**

**Now**

A 49-year-old woman presents with recurrent bouts of abdominal pain in the right upper quadrant. The GP suspects gallstones and requests an abdominal ultrasound, which is done after nine weeks. This confirms gallstones and the patient is referred to general surgery. After a wait of 13 weeks the patient is put on a waiting list for laparoscopic cholecystectomy. In the interim she has presented on two further occasions with similar pain to the accident & emergency unit of the local hospital. She has the operation six months later. She is discharged, develops a fever and presents to her GP. The practice has not received a discharge summary.

**The future has to be better than the past**

Patient has on-site, same-day liver function tests and other blood tests. An ultrasound is arranged for the same week at a local practice that has the facilities and a trained imaging specialist. This confirms the diagnosis and, using information about providers and surgeon, the patient elects to choose her hospital and is directly booked under a care pathway arrangement for a laparoscopic cholecystectomy. A patient adviser gives support and information of what to expect. On discharge a summary is delivered electronically.

**5.6** Relationship with specialists: the language of division embodied in the terms primary and secondary care is becoming increasingly redundant. For example, services traditionally provided in hospital (such as minor surgery or dermatology) are being delivered in general practice. GPs are increasingly co-located in accident & emergency departments and consultant-led clinics. We are used to the concept of the multi-disciplinary team in both hospitals and GP practices. In hospital there are many areas of good collaborative practice, for example cardiac surgery and cardiology, renal transplantation and nephrology, gastroenterology and gastrointestinal surgery.

Partnerships across the previously sacrosanct boundaries of primary and secondary care need to be explored.[10] Use of the terms 'generalist' and 'specialist' is preferred to primary and secondary care. The partnership between generalists and specialists needs to be focused within the community and not within the hospital, and must encompass service, education, research and audit. This should be more than just geographical co-location; a far more important issue is stronger interaction between specialists and generalists. Strong relationships and the development of trust should also encourage consulting patterns in which specialists give advice to generalists without requiring the patient to attend hospital.

GPs with a special interest (GPwSIs) should be grounded in generalism and maintain clinical practice in general practice. There should not be a hierarchy where GPwSIs are valued more than generalists. McWhinney stated that 'primary care should not become a mirror image of secondary care' as this will create a 'silo' system.[58]

There is an important question of how best to use this expertise of a GPwSI. One arrangement is that GPwSIs will serve as point of referral for their GP colleagues in the region. In this way, it can replace secondary care, but can also take important clinical problems away from mainstream general practice. A danger is that it consequently may deplete the expertise of fellow GPs. An alternative would be to use GPwSIs as coaches for their peers, leading the development of primary care–secondary care guidelines and collaborative agreements. This would enhance the expertise of mainstream general practice and enrich practice across the board.

## 5.7 Conclusions

**5.7.1** GPs are hampered in their efforts to provide best clinical care through a lack of access to diagnostics, many of which are only available through consultant referral. This creates bottlenecks and waiting lists.

**5.7.2** There needs to be a concerted effort by the NHS and commissioners to bring more diagnostics and better services into the community.

**5.7.3** New ways of providing services in the community must not be seen as a tussle between consultants and GPs. Collaborative approaches across the previously sacrosanct boundaries of primary and secondary care need to be explored, and examples of good practice built upon.[59]

# 6 Improving access and continuity of care



**6.1** The tension between access and choice has always been difficult. Changes designed to reduce the number of patients waiting more than 24/48 hours to see their GP have proven unpopular with practices and patients. We believe that this issue should be tackled more vigorously so that in the future we are more able to balance the requirements of immediate access and choice. There is no doubt that access continues to be a source of concern to the public, who also experience 'personal and system' discontinuity of care. Any document about the future direction of general practice must address this issue.

**6.2** This is exemplified by the following quote:

> *Last week I got up every day to make an emergency appointment, but then I thought 'no I won't be able to see Dr P, forget it', so I didn't, I'd rather wait.*
>
> (Female, 18–29, chronic health problem)[60]

**6.3** There is no doubt that speed of access has improved because of Department of Health guidance and support for PCTs to achieve the 24/48 hour access targets locally, but there have been severe consequences for other aspects of care. Patients commonly report the following difficulties:

- difficulty in booking in advance
- difficulty in booking with a GP of their choice (thus losing continuity)
- having to phone for appointments on the same day – and not being able to get through because lines are busy
- wanting more time with their GP than the standard appointment
- uncertainty about who to see.

**6.4** Appropriate access to primary health care is an important component of the quality of primary care. Better models of organisation of care and skill mix are needed to address this.

**6.5** Continuity of care

**6.5.1** Continuity has been defined as: 'the experience of co-ordinated and smooth progression of care from the patients' point of view'.[61] Continuity of care remains an essential element of modern general practice and is a prerequisite for high-quality consultations and effective management. There is also evidence that personal continuity, as opposed to organisational continuity, is associated with greater patient satisfaction with care and more efficient use of resources.[57] Continuity, especially inter-organisational continuity, is likely to be enhanced by the use of shared electronic patient records.

**6.6** To achieve continuity of care, services must provide:

- continuity of information: excellent information transfer that follows the patient
- cross-boundary/team continuity: effective communication between professionals and services, and with patients; closer liaison with social services
- flexible continuity: to be flexible and adjust to the needs of the individual over time
- longitudinal continuity: care from as few professionals as possible, consistent with other needs
- relational/personal continuity: to provide one or more named individual professionals with whom the patient can establish and maintain a therapeutic relationship.

**6.7** Sustaining informational, personal and longitudinal continuity across professionals and teams is difficult. If two or more healthcare teams are involved in the management of a single patient, there is a greater likelihood of breakdown in the coordination of care and 'hassles' for patients.[62] It is therefore essential that, in future models of care, the delivery of care by teams who can coordinate care effectively is encouraged.

**6.8** We strongly believe that good electronic patient records are essential for better models of care and to support informational and management continuity if confidentiality issues can be resolved.

**6.9** Patients are well aware of the tensions between continuity of care and rapid access to primary care.[42] Patients and carers have clear views on when they need personal continuity. Of concern is that disadvantaged patients such as those from ethnic minorities, the unemployed and the socially isolated are less successful in obtaining continuity than others. Baker and colleagues stated: 'that the NHS must balance access targets with an equally valued priority for relational continuity and that practices themselves need to prioritise relational continuity'.[63]

**6.10** Better models of organisation of care and skill mix are needed to address this problem. A great strength of the current general practice model is the pre-eminent role of the primary care team. Such team-based care allows patients to benefit from the range of skills that different professionals can provide in an integrated fashion and based at a convenient location. We believe that in the future the range and quality of skills available to patients should be even greater as professionals from different backgrounds are based within the primary care setting.

**6.11** Whilst there will be multiple points of first contact within the practice, it is essential that patients have a choice of seeing a GP[63] and a named GP. The GP will work as a part of a highly skilled and expanded multi-disciplinary team with clear lines of accountability and leadership.

## 6.12 Conclusions



**6.12.1** Access is an issue of continuing concern to patients. Personal and organisational continuity of care should be encouraged. However, most practices have tried different ways of improving access and many find it an extremely difficult issue to resolve. Further support is required. We believe that greater collaboration between practices using a federated model can enable access to be improved. An expansion of the GP workforce and professions allied to medicine is necessary to improve access and the consultation length. Patients should be given the choice of seeing a named GP. A federated model would enable practices to develop specific solutions to the identified needs of their local population in the area of access and urgent care.

**6.12.2** In future, care should be provided by expanded but integrated primary healthcare teams. The tension between access and choice has always been difficult, but improved skills mix, intelligent booking systems and patient empowerment will make it likely that in the future we will be better able to balance that equation.

Dr Donal Hynes, GP, says: 'We have a duty team in our practice that sees all patients who request same-day contact. The team is composed of nurse practitioners, general practitioners, practice nurses and support staff. All patients are seen by the team with consultation between team members as appropriate. It means that there is rapid access for minor problems (earache, infections) but also team work-up of more significant problems (e.g. chest pains are given full work-up by a member of the team according to a protocol and the GP is involved after full information). The routine team also work together with patients, having the opportunity for longer consultations and one-stop-shop assessments, diagnosis and treatment.'

Dr Clare Gerada is a GP partner in the Hurley Group, which comprises three GP surgeries across South London. The Hurley clinic offers extended opening hours twice a week from 7 am to 8 pm. The newest of the surgeries, Riverside, will also offer a commuter clinic and a Primary Care Resource Centre, which houses Lambeth PCT health providers, including a homeless team and a drug and alcohol team. The group shares services and resources, including a minor surgery clinic, gynaecology clinic, community midwifery team and mental health services.

# 7 Developing stronger integrated primary healthcare teams



**7.1** 21st century medicine in the community will be complex and technically demanding. Delivery will require highly motivated and multi-disciplinary teams of professionals. Teams remain the arrangement of choice for primary health care. Although team members may not always be co-located, they should be united through their common focus on the delivery of high-quality health care to all patients, facilitated by strong working relationships. There should be acknowledgement and acceptance that team goals and teamwork are more important than individual differences.

**7.2** The essential features of an effective primary healthcare team include:[64]

- the members of the team work on a common task
- the team has its own real or virtual working space or territory
- the team meets regularly
- good communication and cooperation between team members
- organisation of task allocation is conducted within the team
- multi-skilling is encouraged and organised
- work methods and time management are agreed within the team
- a leader or spokesperson is followed
- team members can influence recruitment to the team
- patient needs are put before individual/organisational needs or profit.

**7.3** There is considerable concern about how health visiting and community nursing are being marginalised from existing primary healthcare teams. This distancing will, we believe, work against delivering better patient care.

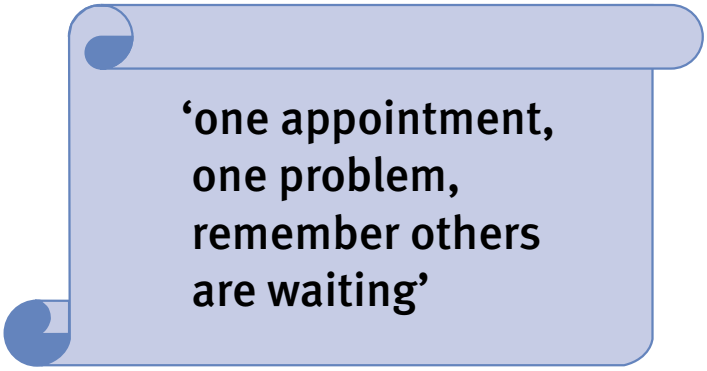
**7.4** There has been much talk about new roles in general practice such as physician assistants and nurse practitioners. We believe that these must not be seen as replacements for GPs but their role should be to augment and support GP medical care. We recognise that such support is essential to improve patients' access to their GP and increase consultation length where needed.

**7.5** GPs are increasingly reporting the difficulty of delivering sophisticated primary medical care, particularly in deprived communities, within a standard 10-minute consultation. This concern was strongly represented in the *Roadmap* consultation.

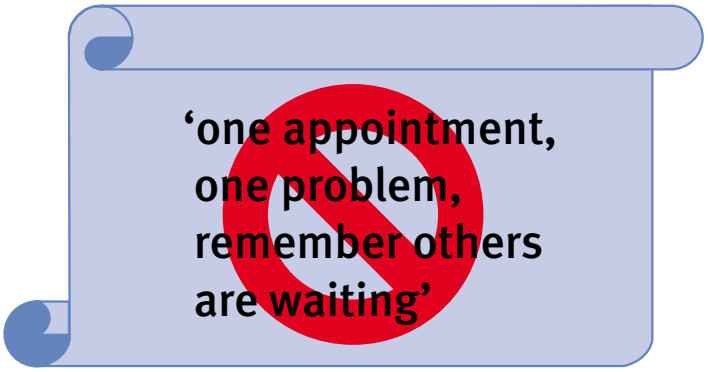
**7.6** Freelance GPs provide a vital role by supporting the primary healthcare team to provide flexible cover for holidays, illness, maternity/paternity, service and educational leave. In 2003 the National Association of Sessional GPs (NASGPs) undertook a survey suggesting that there were over 10,000 sessional GPs in the UK – the majority of whom were freelance GPs – providing 36 million NHS consultations a year. Traditionally, these freelance GPs worked as individuals within the NHS but, recently, 'teams' of freelance GPs have begun to evolve using a 'chambers' model that allows these individuals to work within a clinically governed, managed environment.

**Figure 3: Every minute makes a difference**

The distress of the profession can be summed up by this notice:




It is only through better skill mix, organisation and increased workforce that we can increase the consultation length and put an end to notices like this:




## 7.7 Conclusions

**7.7.1** Integrated primary healthcare teams, consisting of all healthcare professions delivering care in the community, can better address the challenges of an ageing population with an increasing burden of long-term conditions and co-morbidity than poorly coordinated teams or individual professionals working alone.

**7.7.2** The NHS must encourage this model of team-working. Services must be coordinated and delivered through integrated primary healthcare teams that are focused around primary care practices that provide effective professional leadership and information services.

**7.7.3** New ways of working that can create space for increased consultation times for GPs, particularly for patients with complex, co-morbid conditions, are needed. Effective teamworking can contribute significantly to better and safer patient care. GPs have a leadership responsibility to develop effective teams.

**7.7.4** The RCGP urges primary care organisations to adopt a policy of ensuring that both established roles (such as health visitors, midwives and community nurses) and newer roles (such as mental health therapists) are integrated within the existing primary healthcare team and primary care practice. Such teams require effective leaders who must fully understand the clinical needs of their patients. GPs have an important leadership obligation in developing and promoting sophisticated primary healthcare teams.

# 8 Developing the functions of general practice-based care



**8.1** Primary care needs to become more 'strategic' in its approach to meet the needs of patients. This means embracing a broader collective agenda. It does not mean every individual GP has to deliver each and every function but the broad agenda should inform the strategic collective function of primary care. The responsibility for this falls on primary care organisations, federations of practices, and commissioners. Figure 2 (see p. 14) sets out our proposed key functions of primary care as a sector; many of these are already occurring but need to be systematised.

**8.2** Starfield[65] has enumerated some of the challenges that face primary care. These include tackling health inequalities, protecting patients from over-investigation and inappropriate secondary care interventions, maintaining comprehensiveness, and detecting and managing adverse drug effects.

**8.3** *Co-morbidity* is the simultaneous presence of apparently unrelated conditions.[52] A focus on single conditions does not acknowledge or address co-morbidity across chronic conditions. Demographic changes in the UK, and elsewhere, are leading to an ageing population, with a concomitant increase in the prevalence of morbidity and co-morbidity. Co-morbidity is increasingly the rule rather than the exception.

**8.4** It has been argued that quality assessment focusing on single diseases may distort the provision of good health care by not addressing the potential interactions of different conditions, and therefore not appropriately assessing the management of chronic illness in the real clinical situation.[66] Optimising care for patients with multiple conditions requires a broader perspective of the overall quality of care in the individual patient context.[67,68,69]

**8.5** The unique skills of a GP are dealing with uncertainty and managing co-morbidity.[70] Given that socio-economically deprived communities have a higher incidence of co-morbidity problems, effective management of co-morbidity, together with greater ownership of the public health agenda, provides an opportunity for general practice-based primary care to make progress in reducing health inequalities. In the future, primary care will be providing care for increasingly diverse populations and the concept of cultural competence must be fostered in teams with support and training.

**8.6** *Health inequalities* remain widespread and in some cases are worsening; there is a real need to improve health care for those in lower socio-economic groups, or for those who are less articulate and vocal. The targeting of health inequalities mentioned in the white paper *Our Health, Our Care, Our Say* is welcomed.[16]

## Public health

**8.7** Practices are at the heart of their communities and could play a key role, with appropriate development and support, in tackling many aspects of the public health agenda. Already a significant amount of smoking cessation work takes place in GP practices. Methods should be found to deliver the public health agenda within new models of care.



**8.8** The work of Julian Tudor Hart shows the long-term benefits of coordinated primary care with a reduction in mortality from continuity of care, case finding and audit.[71, 72]

### Box 3: The importance of a strategic focus to the work of general practice: moving from reactive/perfunctory care to proactive care and focusing on health outcomes

**Focus on preventing avoidable deaths: scenario**

Working with public health specialists embedded in the primary healthcare team, Practice A (in an inner-city environment with a high number of South Asians) examines its mortality rates. Concern is raised about the high number of sudden deaths from coronary heart disease (CHD) at a young age. Preventable factors (undetected diabetes, hypertension and high levels of smoking) are identified and a plan is drawn up to tackle these. The aim is to reduce mortality over 10 years through aggressive risk factor identification and modification, and public health education. This plan, based on outcomes and reducing health inequalities, is agreed upon and supported by the local primary care organisation.

**8.9** Primary care professionals and public health physicians, embedded in practice teams, should provide leadership and take the health promotion agenda forward in schools and workplaces.

### Box 4: Public health: the broader role of primary care

**Mission statement**

The Homeless Health Service aims to provide the best possible primary health care for the homeless and vulnerably housed of Bristol and South Gloucestershire. Its vision is to develop a comprehensive, accessible service that can effectively advocate on behalf of its clients, and provide a high level of health care that respects their individual needs. The service works to support all the individual members of its team in order to fully utilise their existing abilities and enable them to develop new skills.

Since 1 April 2006 the service has been managed by a partnership between the Westbury-on-Trym GP Practice and homeless charity Emmaus Bristol. See www.bristolhomelesshealth.co.uk.

Dr Ian Greaves, lead partner of the Gnosall Health Centre, Staffordshire, says: 'We have created a register of patients who are most likely to develop vascular dementia. They are assigned to a health visitor who can give them specialist advice and guidance as well as support from specially trained volunteers from the Gnosall Patients' Forum. If medical intervention is needed the patient then sees Professor David Jolley, a "psychiatrist of late life" who visits the practice once a month. Professor Jolley works out a care plan for the patient, with action points for the whole primary care team.'

Dr Greaves's new health centre also includes a dentist and pharmacy, and runs outpatient clinics for psychiatry, obstetrics and gynaecology. It also has an operating theatre. Dr Greaves is passionate about breaking down barriers between primary and secondary care.

## Genetics Roadmap

**8.10** The RCGP, with genetics as part of its curriculum, recognises the importance of the advances being made in genetic research and how these may translate and impact on society, families and the individual. In preparing for the future, primary care teams will need to have a sound competence framework that includes taking a family history, knowledge of basic patterns of inheritance, making a genetic risk assessment, an understanding of referral pathways and developing a shared-care role in the management of chronic genetic conditions. New models of genetic service delivery within primary care and in collaboration with regional genetics units will be required. GPs in particular will be faced with ethical dilemmas relating to predictive genetic testing that will require an understanding of the clinical utility of genetic tests. Also of importance will be their understanding of the societal impact of genetics on employment, insurance and dealing with religious, ethnic and cultural sensitivities. GPs have the skills to deal with uncertainty and risk assessment, and provide the necessary support once they are empowered with up-to-date knowledge.

## Integration and coordination of care

**8.11** Modern health care can involve many healthcare professionals and providers in the care of a single patient (see Box 5).

### Box 5: Interfaces in health care

GP practice
Nurse triage
Out-of-hours co-op
Walk-in centres
A&E
NHS Direct
Alternative primary care providers
GPwSIs
Practitioners with a special interest
Intermediate care
Hospital care

**8.12** Interfaces can be dangerous places for patients[73] and systems need to evolve to ensure better coordination of care throughout the health and social care system, particularly for patients with co-morbidity. This will require robust models of clinical governance, supported by sophisticated IT systems – with appropriate safeguards for confidentiality. We believe that this is important to stop the worrying trend of fragmentation of care and to define, for patients, who is accountable for specific problems.[21,74] The coordinating role of GPs is crucial as patients experience disruption of care when crossing interfaces between primary, secondary and social care access.[75] However, very few systems achieve high levels of coordination of care. This is an important function of general practice, and opportunities for this may come through implementation of PBC and clinical care pathways.

**8.13** Management of long-term conditions

**8.13.1** About 17 million adults in the UK live with one or more chronic long-term conditions. Management of long-term conditions is a major component of the evidence-based Quality and Outcomes Framework of the GP contract. On average, practices achieved 96 per cent of the maximum score in 2005/6. The effective management of long-term conditions will continue to be an essential task for primary care involving diagnosis, management, prevention of complications and avoidable admissions, as well as patient education and empowerment to enable self-care. GPs have a unique role and expertise in managing care outside guidelines, which may be necessary when patients have several conditions that present competing clinical priorities.

## Teaching, training and research

**8.14** We do not believe that the full potential of primary care in teaching, training and research has been realised. If properly organised, unrivalled opportunities exist to make primary care a major contributor to preparing the future NHS workforce. Existing constraints to this must be identified and removed. One factor may be inadequate premises. Our vision is that, in future, the NHS workforce will be trained in primary care – from doctors to nurses and therapists.



**8.15** We would like to see more practices being supported to become education centres or learning organisations where a variety of skilled multi-professional teachers train the future NHS workforce. One-third of UK general practices are involved in teaching undergraduate medical students and therefore preparing tomorrow's doctors. There are approximately 3000 GP trainers. Practices and community networks should link formally to a medical school or university in their area to foster teaching, training and research. There also needs to be better liaison between providers of undergraduate and postgraduate GP education and training.

**Collingham Healthcare Education Centre (CHEC)**

CHEC is a not-for-profit primary care educational facility established to provide inter-disciplinary practice-based learning. It does this by designing and offering courses to meet the learning needs for a range of clinical and non-clinical primary care staff. It complements existing education and learning provision. Education and support is available to practice and community teams including nurses, healthcare assistants, GPs, practice managers and reception staff (www.chec.org.uk).

## Comprehensiveness

**8.16** Comprehensiveness means that all problems in the population should be cared for in primary care (with short-term referral as needed) except those that obviously require specialised management such as cancer. It is essential that new services established in the community are linked to primary care practices.



## Quality and safety

**8.17** In a complex primary care system with multiple providers and points of access it is essential that patients receive safe and high-quality health care. This requires mechanisms to assure the quality of care provided by primary care professionals, teams and provider organisations. Proposals for these have been published by the UK Government in its white paper, *Trust, Assurance and Safety: the regulation of health professionals in the 21st century*. The NHS is also proposing that clinical accreditation forms an important part of system regulation of NHS providers. However, micro-accreditation (i.e. multiple diplomas for specialist activities) should not detract from the core generalist role of the GP.

## Early diagnosis and problem definition

**8.18** Many problems that present in primary care do not lend themselves to a discrete diagnosis or label. The GP's task is to formulate a problem list or definition that can open the gateway to further management. Early diagnosis is critical for many conditions and we believe general practice must continue to address this problem systematically. This will mean the provision of greater diagnostics and support from specialists. Delayed or missed diagnosis is the commonest reason for successful litigation in primary care.

**8.19** Conclusions

**8.19.1** Primary care must develop a strategic approach and systematise functions to fulfil its true potential. This means embracing a broader collective agenda. It does not mean every GP has to deliver every possible function. The responsibility for this falls on primary care organisations, federations of practices and commissioners.

# 9 Making the best use of GPs' skills



**9.1** A key issue that emerged from our discussions is the role of the GP and how that might evolve to meet the needs of patients. Throughout the history of health care, generalists' roles have evolved:[76] from a time when GPs routinely administered vaccinations and dressings and took blood pressures to the current position where these functions are generally undertaken by other staff. GPs are now being asked to undertake roles and responsibilities that hitherto belonged to secondary care. This context is important – while there is increasing delegation and specialisation in general practice, care in hospitals is also becoming more specialised and delivered by a greater variety of specialists. The generalist who can provide holistic and patient-centred care is needed now more than ever.

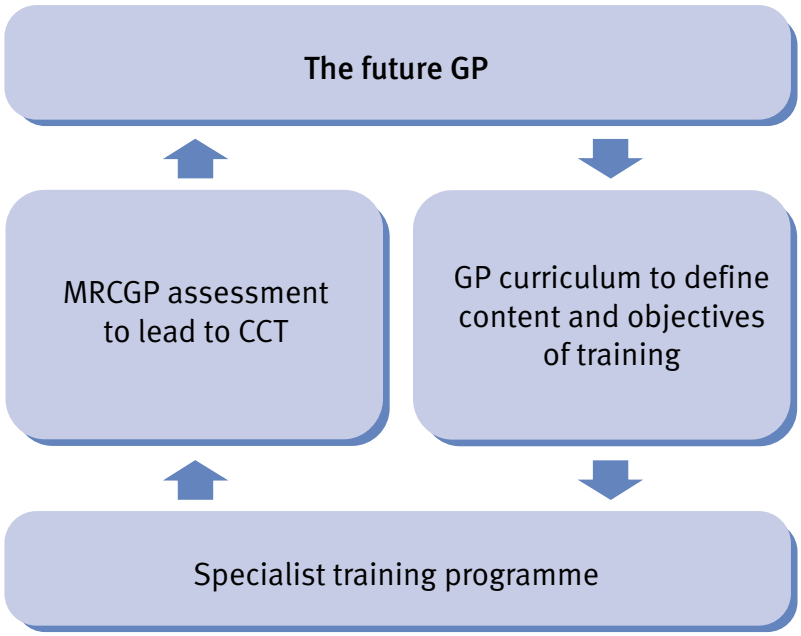
**9.2** What is a GP? Definition of a general practitioner

EURACT/WONCA provides the following definition:[10]

*General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health, preventing disease and providing cure, care, or palliation. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care.*

**9.3** The new training curriculum[77] has set out how the role of the GP needs to evolve. Preparing future GPs for this new role requires radical changes to education, training and assessment.[4] The outline can be set out as four key issues: What do we want GPs to do in the future? What should the educational content be for specialist training for general practice (the curriculum)? What sort of training model is required to be delivered by deaneries? Finally, what is necessary for a fit-for-purpose assessment programme that will confer the CCT (certificate of completion of training) [see Figure 4]?

**Figure 4:** **Link between GP role, curriculum, training and assessment**

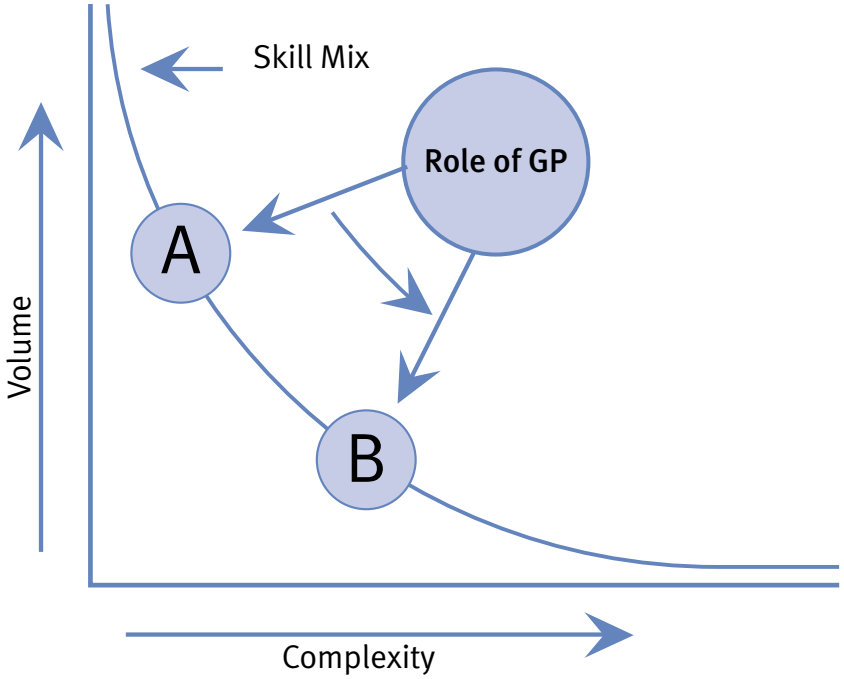



**9.4** An essential part of the strategy is to select the right doctors for specialist GP training programmes. There are two key questions for junior doctors who are thinking of a career in general practice: Is general practice the right career for me? And am I the right sort of doctor to be a GP?

**9.5** The key features of the new training arrangements are: three-year schemes following a national competence-based curriculum; educational supervision from general practice even for hospital placements; a series of short (for example, four-month) attachments in settings outside general practice; and, finally but most importantly, spending a minimum of 18 months training in a GP practice.

**9.6** The future GP will need to excel in the management of co-morbidity by operating at a high biomedical level focusing on diagnosis, prescribing and coordination of care including mediation between specialists. This is a strategic shift (see Figure 5) to be delivered by implementing the new GP curriculum through innovative training models.

**Figure 5: Strategic shift of the role of the GP to focus on complexity and co-morbidity**




Note: in addition to offering first-contact care as part of choice for patients, GPs will increasingly engage in more complex generalist roles in primary care.

**9.7** Much has been written about the distinctive features of what GPs do. The role cannot be fixed or static and will evolve. In Box 6 we set out the roles and functions of a GP that we believe are important and show how the synthesis of these functions makes the role effective.

**Box 6: Desired role and functions of a GP – 'ENRICH P2C2'**

E = ***Enablement*** *and patient centredness*
N = ***Navigates*** *the patient to the right section of health care where appropriate*
R = ***Reach a diagnosis***
I = ***Improvement***
*Clinical and quality* ***improvement,*** *narrow the gap between research and practice, healthcare governance; exceptional potential of the consultation*
C = ***Coordinator of care***
H = ***Holistic care*** *– relationship-based care*

P = ***Prescribing*** *and complex medicines management*
P = ***Patient safety*** *(uncertainty)*
C = *Managing* ***co-morbidity***
C = ***Clinical leadership role***

## 9.8 Conclusions

**9.8.1** GPs have a unique role in the management of uncertainty and dealing with complexity and co-morbidity. GPs remain the best managers of clinical risk, particularly of undifferentiated presentation of illness. GPs should be available for first-contact care as part of choice for patients.

**9.8.2** The role of the GP must remain that of the generalist. Narrowing the scope of practice through increasing specialisation must be avoided.

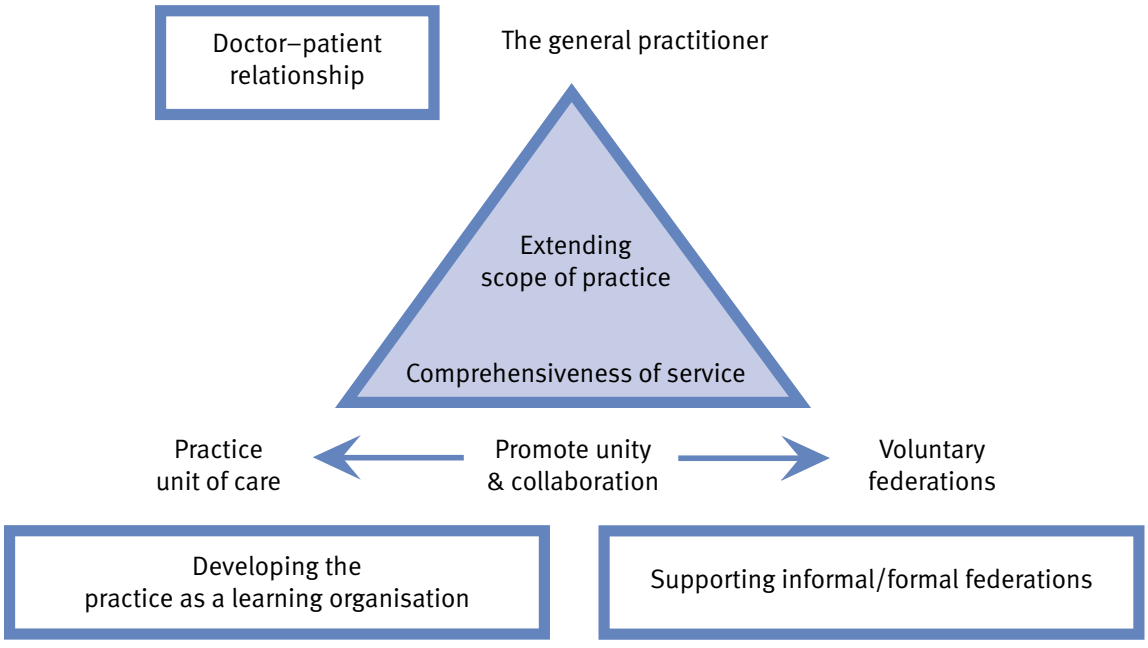
# 10 The future model of care
## Enabling the exceptional potential of primary care



**10.1** The future model of care will be GP led and include the development of collaborative groupings or 'federations' of practices (Figure 2, see p. 14) that together can provide the services patients want in the place they most want to receive it. This vision of a stronger and more vibrant general practice-based primary healthcare system will entail a concerted programme of development and support for GP practices. The quality and quantity of practice management requires considerable attention, particularly to deliver strategic functions. Strong clinical and professional leadership, particularly from GPs, will also be required. Education and training will be fundamental to creating this much needed strategic shift.

**10.2** To implement change, a clear descriptor of the model of care is needed. This is described below (see Figure 6). The journey to improvement is focused on three points: improving the quality of the doctor–patient relationship and interaction; developing the practice as a learning organisation; and encouraging collaboration between practices.

**Figure 6: New model of care**




Note: *unleashing the potential of primary care – focus on three points*. This is done by improving the quality of the doctor–patient relationship and interaction, developing the practice as a learning organisation and encouraging the development of collaboration between practices.

**10.3** GP practices must undergo major organisational development to become strategic learning organisations. A learning organisation is one that facilitates the learning of all its members and thus continually transforms itself.[78] Sylvester stated that 'The smallest organisational unit within NHS primary care is the general practice, yet it is in primary care where nine out of ten NHS patients are seen and where the largest number of patients will experience the success or failure of modernisation.'[78]

**10.4** There will need to be a step change in the quality and quantity of clinical engagement engendered by Primary Care Trusts with GPs. We urge PCTs to recognise the strengths and value of medical generalism to patients, and to encourage and support clinical leadership development and engagement. Positive and constructive relationships with primary healthcare teams are essential.

**10.5** There are three key questions for GPs and practices:

- What can I do individually as a GP to improve patient care and what training and support/skills do I need?
- What can the practice do to improve patient care?
- How can we work with other practices and other providers to improve patient care?

For each question a plan can be developed and support needs identified using the planning tool of a practice's professional development plan.

**10.6** Professional organisations at national and local level working with the NHS should consider developing programmes of support that GPs can access to implement the future model of care. We suggest that health economies working with professional organisations such as RCGP faculties and local medical committees develop programmes to support GPs. This could enable the concerted development of the scope of general practice and collaboration between practices, where appropriate, on a voluntary basis. This would all be delivered within a clear and transparent clinical governance framework.

The College of Family Physicians of Canada (CFPC) has recently issued a toolkit for family doctors to support them in the areas of governance, skill mix and organisation of care.[79]

**10.7** We believe that it is important to build partnerships with academia, e.g. local universities and medical schools. In this way a critical mass can develop to support primary care and the systematic development of teaching and training of the future workforce at undergraduate and postgraduate levels. Greater collaboration between undergraduate GP education and postgraduate training should also be sought. We believe that it is also essential to support the development of primary care research capacity and capability to underpin improvements in patient care and drive, not only the development of primary care but also the broader NHS. We fully endorse and support the vision set out in *New Century, New Challenges* by the Society for Academic Primary Care (SAPC).[80]

Strong and productive relationships are needed between academic GPs and local practices. Models that support such collaboration should be developed, e.g. academic health science centres.

Clinical leadership and engagement will be essential – there must be improved opportunities for training and support in this area, e.g. MBA programmes for GPs.

## 10.8 Implications for the RCGP

**10.8.1** The College's role is changing. The new MRCGP exam means that all new GPs will be eligible to become members of their standard-setting body. Having a single professional body for GPs provides opportunities for more strategic governance of the profession, more 'joined-up thinking' and improved long-term professional development. The College recommends the standards for specialty training for general practice and it has now been asked to develop proposals for recertification of GPs. Education and training will be the key to modernisation of primary care. The College should not only lead in setting standards for the profession but also champion innovation and post-CCT professional development. The College should stimulate a debate about a career structure for general practice to nurture a dynamic and progressive profession. This will require an innovative and sophisticated programme of lifelong learning and support for GPs. The College and its partner organisations such as the GPC should continue to consider how it can best meet the needs of GPs in a fast-changing general practice environment.

**10.8.2** Unity in the profession is an important part of the strategic development of the discipline of general practice and it is essential to put it on a par with other specialisms such as medicine or surgery where attaining membership of the appropriate royal college is mandatory to hold a substantive post in the NHS. *In the future*, the College will serve as the entry point for all new members to the profession through certification. Recertification may offer an opportunity for established GPs who are not members to become eligible for membership when a suitable mechanism is developed.

## 10.9 Conclusions

**10.9.1** Our vision of a stronger and more vibrant general practice-based primary healthcare system will require support for the implementation of better models of care including a concerted programme of development and support for GP practices. We believe that, if fully implemented, this *Roadmap* will lead to substantial improvements for patients.



**10.9.2** Professional organisations at national and local level working with the NHS should consider developing programmes of support that GPs can access to implement the future model of care.

**10.9.3** Both practices and collaboratives need to develop into strategic learning organisations. The development of a federated model of general practice could allow it to address the challenges of an increasing market approach in the NHS (a particular concern in England). This change is already occurring on the ground and many different arrangements are emerging from social enterprise organisations to public limited companies.

### Table 2: What will this mean for patients?

| *Old Way* | *New Way* |
|---|---|
| X-rays, tests and most investigations done by hospitals | Majority of X-rays, tests and investigations carried out in primary care at GP practice or shared community facility |
| Passive patients subject to clinical paternalism | Empowered patients in charge of their chronic conditions |
| Patients struggling to secure and book appointments | Streamlined and smooth access to appointment systems – including online and telephone support |
| Paper records or hybrid electronic records | Paperless shared electronic records |
| Small and fragmented primary healthcare teams, limited in scope | Expanded but integrated primary healthcare teams with leadership and accountability |
| Lack of continuity of care | Access systems promoting continuity of care with patients able to express preference |
| Variable management of health inequalities and co-morbidity | Systematic and widespread primary care programmes to tackle health inequalities |
| Significant proportion of care delivered in hospital | Most care close to patient's home – hospitals for highly specialised care or procedures |
| Paucity of clinical engagement | Healthcare organisations led and championed by doctors and nurses |
| Variable practice organisation and systems for quality | Highly systematised practice organisations with quality and patient safety culture |
| Training of workforce in hospitals | Future workforce trained more in primary care |

# 11 Overall conclusion



Our vision is for a stronger and more vibrant primary healthcare system that is patient centred, consistently of high quality, safe and accountable. GP practices should collaborate with providers in a model that will be championed by primary care clinicians. Values of interpersonal care and continuity will continue to be central and can be achieved by the use of registered lists (see 'The RCGP vision for a general practice-based primary healthcare system', p. i). GP practices will be highly developed strategic organisations with strong leadership and management. Good GPs will continue to be essential. The role of the GP will be that of the advanced medical generalist dealing particularly with co-morbidity, diagnosis and coordination of care. Patient-centred care will be delivered by expanded and integrated primary health teams offering a wider range of services in the community with access to a wide range of diagnostics. Facilities for public health, quality, safety and accountability should be routinely available to all primary care systems.

In our vision, access to specialists will normally be facilitated by the GP navigating and advocating for patients as they journey through the healthcare system. The building blocks of our vision are shown in Figure 7. We suggest that virtually all health problems in the population (including mental health) will be dealt with in primary care, with short-term referral as needed. Hospitals will be reserved for acute illness, specialised investigations and major surgery. In this model, generalists and specialists will work more closely together.

However, to achieve this, a major change is needed in the organisation of primary care and in the strategic management capacity of general practices. GPs need to influence the continuing development of the healthcare system. GPs should embrace new opportunities to develop primary care. If we are to champion the best possible standards of general medical care then leadership from GPs will be essential. This will require innovative and creative ways of working including business models to develop new services, raising capital and utilising economies of scale. The 'make up' and values of new general practice as advocated by the RCGP is shown in Figure 7.

**Figure 7:** **Building blocks of general practice-based primary care**

| | | | | | |
|---|---|---|---|---|---|
| Culture | Open and fair, learning | Quality and safety of care | Innovation | Clinical effectiveness | Education, teaching and training |
| Functions | First-contact care and diagnosis | Health inequalities | Co-morbidity and complex patients Long-term conditions | Health promotion, case finding | Commissioning, resource management and coordination of care |
| Infrastructure | Practice management and strategic planning | Practices collaborating and working together | Led and championed by clinicians | Access including urgent care Responsiveness | Technology and near-patient testing |
| Infrastructure | GP practice | Integrated and expanded multi-disciplinary teams | Information communication technology | Diagnostics | Major improvements in premises/ facilities |
| Values | Registered populations | Doctor–patient relationship | Patient-centred Self-care skills | Patient-centred professionalism | Trust and confidentiality |

We recognise that our aspiration will require considerable investment, reform and support for implementation but feel that it is a much needed and achievable model to improve patient care. We urge policymakers, primary care organisations and GP organisations to consider this report and to make recommendations for implementation. GPs and GP practices might also find this report useful when planning their practice and locality developments.

# 12 General practice in Northern Ireland, Wales and Scotland



With devolution, some significant differences have emerged between healthcare systems in the four countries of the UK. These reflect the different cultures, different historical provision and different priorities in each country. In Northern Ireland there is the added complication of the current political uncertainty.

## Current differences in Northern Ireland

Historically, there is a culture of high levels of health-seeking behaviour in the province as is evidenced by the high level of demand in general practice for out-of-hours and for accident & emergency services. There are high levels of deprivation in many areas and an economy that depends largely on the public sector. There are also many areas with higher levels of economic inactivity than in the rest of the UK. The legacy of the 'Troubles' is reflected in high levels of stress, anxiety and depression experienced by many patients. Many patients live in rural areas with poor infrastructure in terms of transport and other services. In spite of these difficulties general practice in Northern Ireland is delivering an extremely high quality of service; GPs here achieved the highest averages of points in the Quality and Outcomes Framework.

There are many small acute hospitals – 15 hospitals currently provide acute services for a population of 1.7 million. These are strongly supported by their local communities but struggle to attract staff and to provide an acceptable range of services. The private sector has a smaller capacity than in England and there is a lower level of private health insurance.

Historically, waiting lists have been much longer than in many other regions of the UK. Considerable efforts have been made to address this problem in the past year but waiting periods of several years for orthopaedic or eye surgery, and of up to two years for outpatient appointments, have been common. There are still waits of up to a year for GP referrals to physiotherapy and investigations such as ultrasound.

Some of the initiatives introduced in England have not been transferred to Northern Ireland. NHS Direct, Choose and Book, Walk-in Centres, Foundation Trusts and a centralised electronic patient record are some of the interventions that have so far not been suggested for the province.

Northern Ireland has had integrated health and social services for many years. While this has not always worked as effectively as many would have wished, it offers the possibility of a more holistic approach to patient care. There are some areas in Northern Ireland where close cooperation between social and health care is offering real benefits, especially to elderly patients. There is also a strong network of community hospitals run by GPs that offers a wide range of services such as intermediate care, rehabilitation and acute admissions for nursing care.

Northern Ireland is also the only part of the UK that shares a land border with another country with a different healthcare system. This offers the potential for developing structures that will allow patients from each side of the border to access services in either country depending on which is more accessible. There is also the potential for innovative ways of working, drawing on ideas from the Republic of Ireland.

A major reorganisation of Northern Ireland's Health and Personal Social Services (HPSS) agency as part of the Review of Pubic Administration (RPA) is currently underway. A Health and Social Services Authority (HSSA) will be set up in place of the existing four Health and Social Service Boards. Seven primary care-led Local Commissioning Groups will also be established as local offices of the HSSA. Five new integrated Health and Social Service Trusts will replace the 18 existing trusts. The Department of Health, Social Services and Public Safety will become smaller. As well as this major change there is considerable uncertainty about the political future and concern that a devolved administration may change priorities and reverse decisions already made. As in many other parts of the UK, healthcare professionals are suffering from change fatigue.



## Future plans

As has been detailed above there will be seven Local Commissioning Groups set up in the next year. The management boards will have a high level of GP involvement. There are currently no plans for PBC but instead Community Commissioning Associations will be established. These will be partnerships of practices and other healthcare professionals that commission services for a defined population. This will include social care and offers the potential for strong community participation in decision making. The emphasis in these groups will be on partnerships with local communities; one positive legacy of the 'Troubles' has been a number of strong local community associations. The individual general practice is seen as the building block of the system.

The need for investment in information systems is recognised and investment is planned to ensure a unified and responsive system that will allow the rapid transfer of relevant information. The need for highly qualified and trained staff is seen as a priority, and leadership training is planned for health professionals. A programme for investment in primary care infrastructure is planned with new health and wellbeing centres being constructed to house both individual general practices and the wider primary care teams. There is also the promise of capital investment in GP premises in smaller communities.

## Priorities for general practice

General practice in Northern Ireland has offered a high level of continuity of individual care. This is threatened by a number of pressures including access targets. With increasing co-morbidity and complex medical conditions being managed in primary care there is a need for longer consultation times.

Three issues need early attention: GPs and others involved in commissioning will need support and training to ensure that they achieve the maximum benefits for patients from the new arrangements. The development of robust and imaginative ways is needed to involve patients in setting priorities and in the commissioning process. Improved communication and IT systems are vital if we are to be effective in providing the high level of care expected by our patients.

Northern Ireland has an extremely dedicated and caring primary healthcare workforce; they need to be valued and supported. A strong professional ethic within the healthcare community is the patient's strongest protection.

**Dr Jennifer McAughey** FRCGP
Chair, RCGP Northern Ireland

## Wales

Six years after devolution, the four UK countries have developed increasingly different healthcare policies that have had a profound effect on healthcare structure. Wales is faced with immense challenges in terms of health care – according to the HealthACORN Report;[81] Wales has eight out of the ten poorest and most deprived health areas in the UK and some of the poorest health in Europe.[82] The Welsh Assembly Government has sought to overcome Wales's poor health status by creating a 'twin track' strategy (documented in *Designed for Life*[83]), based on preventing ill health and improving accessibility to acute care. This strategy relates to health and social care – stating a preference for collaboration, not a reliance on market or competitive mechanisms and a positive preference for building capacity within the health service itself. The preference for cooperation is reflected in Wales's Local Health Boards being coterminous with Local Authorities.

Dr Julian Tudor Hart, general practitioner from Glyncorrwg, described the Inverse Care Law.[84] In 2006 he was awarded the College's prestigious Discovery Prize. His research used an epidemiological approach but it was rooted in clinical care and the relationship he had developed with his patients – a collaborative relationship, producing social value. This ideal has influenced Welsh Assembly Government policy.

### Issues of particular relevance to Wales

#### Health inequalities relate as much to the patients living in valley practices, inner cities and rural areas

The Welsh Assembly Government review of acute service provision has highlighted the issues relating to a policy of centralisation and specialisation in rural areas[85] – a policy that proposed changes in acute hospital provision without sufficiently addressing the profound implications on the other providers of health and social care, in particular primary care. Wales is a rural country with the great majority of its land mass rural and 36 per cent of its population living in remote and rural communities. Any future blueprint for general practice must take into consideration the *needs of rural communities*. It is important that a robust academic infrastructure is developed to underpin rural practice and rural health.

As has already been stated, Wales has a high incidence of deprived health areas. The connection between poor physical health and poor mental health has been established, and mental health is therefore a major economic issue in Wales. In addition to *Designed for Life*, Wales also requires a *primary care mental health and wellbeing strategy* if it is to achieve its aim of improving health and social care in 21st-century Wales. RCGP Wales established the Wales Mental Health in Primary Care (WaMH in PC) Network, whose latest initiative is to establish a Gold Standards Framework for Mental Health in Wales. Other initiatives being undertaken in Wales include promoting disability equality and improving end-of-life care (EOLC).

#### Education and training in Wales

The RCGP (UK) position on the requirement to spend at least 18 months of the three-year specialty training programme in a general practice setting is overdue. We will be working collaboratively with the Postgraduate Dean in Wales to implement the PMETB standards for specialty training in general practice and to support the new curriculum and nMRCGP assessments for GP specialty registrars. The Postgraduate Deanery has ensured a continuing input from RCGP Wales into postgraduate GP training issues via a newly constituted Independent Advisory Committee (IAC).

**Post-CCT activities**

In addition to matters relating to training, the IAC has a role accrediting GPwSIs, feeding into standards and quality assurance for appraisal and continuing professional development (CPD) for GPs in Wales, as delivered by the Postgraduate Deanery on behalf of the NHS, and in generally forging strong working relationships with partners.

### Undergraduate education in primary care in Wales

Third-year medical students at Cardiff spend five days in GP surgeries in placements all over Wales. In the final year, students spend six weeks full time in general practice, where they can improve their clinical skills and have a chance to view general practice as a career option. Many students write that, after the six-week placement, they are now considering a career in general practice where previously they had not. Feedback via the GP appraisal process is that GPs find that undergraduate teaching enhances their working lives. Undergraduate teaching in primary care provides improved quality of working life for Wales's current generation of GPs and recruits the GPs of the future. Welsh GPs consistently deliver very high-quality teaching.

### Research

The University of Wales College of Medicine (UWCM) was one of the first UK institutions to establish an academic chair in general practice. Since the 1970s, the original UWCM Department of General Practice, and now its successor, Cardiff University's Department of Primary Care and Public Health, has consistently contributed to the discipline of primary care through research, teaching and service development initiatives to the highest international standards. We will continue to need support for a stronger academic base for general practice in Wales, and to ensure there is equality of opportunity for resources between all parts of the UK.

## Future priorities and a vision for primary care in Wales

RCGP Wales is developing a vision of primary care in values. Working in partnership with others this vision feeds into and informs the policies and current organisational changes within the Welsh Assembly Government. We aim to give a clear picture of how primary care in Wales should look in the future, including structure, workforce, skills mix and the team, training and education, relationships with secondary care and social care, and the role of patients and their carers. There is a perceived threat amongst GPs that certain policies may have a detrimental effect on patient care, in particular the GP–patient relationship. We have begun this piece of work by identifying and stating the core values of our profession – and these values will serve to underpin our vision – values that are emphasised in this *Roadmap*.

Many of the issues raised in this *Roadmap* document are generic to all four countries, whilst appreciating the differences that devolution has brought. As a College with members in all four countries, we must work together to benefit from each other's successes and lessons learnt.

**Dr Helen Herbert** FRCGP
Chair, RCGP Wales

## Scotland

RCGP Scotland is taking forward a large number of initiatives including a focus on *The Essential General Practitioner*. A series of meetings have taken place to explore the core aspects of general practice and to build a framework document on the future of general practice in Scotland. Further details of this can be obtained from RCGP Scotland or from its website, www.rcgp-scotland.org.uk.

# 13 References




1 The College of Family Physicians Canada (CFPC). *SOAR Family Medicine 2006: an international colloquium of six organizations to advance the renewal of family medicine. (Proceedings of the SOAR Colloquium)* Toronto: CFPC, 2006, www.cfpc.ca/local/files/Communications/SOAR%20Meeting%20Proceedings%20Final.pdf [accessed July 2007].

2 General Practitioners Committee, BMA. Position Paper: *General Practice in 2005* (internal report).

3 British Medical Association. *Improving Health: the BMA's challenges to the Government* London: BMA, 2005, www.bma.org.uk/ap.nsf/content/BMAmanifesto [accessed July 2007].

4 NHS Alliance. *Squaring the Circle: the place of personal care and small practices in the new NHS* Nottingham: NHS Alliance, 2005.

5 National Association of Primary Care. *National Association of Primary Care's Summit Meeting: a vision of the future for general practice* London: NAPC, 2006.

6 Lakhani M (ed). *A Celebration of General Practice* Abingdon: Radcliffe Medical Press, 2003.

7 Royal College of General Practitioners, General Practitioners Committee of the British Medical Association, NHS Alliance. *Valuing General Practice* London: RCGP, 2001.

8 Heath I. *The Mystery of General Practice* London: Nuffield Provincial Hospitals Trust (John Fry Trust Fellowship Series), 1995.

9 European Academy of Teachers in General Practice (EURACT). *European Definition of General Practice/ Family Medicine (Leeuwenhorst definition 1974)*, www.euract.org/html/papo4107.shtml [accessed July 2007].

10 World Organization of Family Doctors (WONCA). *The European Definition of General Practice/Family Medicine* London: WONCA, 2002.

11 European Observatory on Health Systems and Policies. *Glossary: primary health care (PHC)*, www.euro.who.int/observatory/Glossary/TopPage?phrase=P [accessed July 2007].

12 Royal College of Physicians, Royal College of General Practitioners (joint statement). *Making the Best Use of Doctors' Skills: a balanced partnership* London: RCP/RCGP, 2006.

13 Plamping D. Looking forward: change and resistance to change in the NHS *British Medical Journal* 1998: **317**: 69–71.

14 Spiers J. *Patients, Power and Responsibility* Abingdon: Radcliffe Medical Press, 2003.

15 Department of Health. *Health Reform* London: DH, www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/HealthReform/fs/en [accessed July 2007].

16 Department of Health. *Our Health, Our Care, Our Say: a new direction for community services* London: DH, 2006, www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf [accessed July 2007].

17 Department of Health. *Choice Matters: increasing choice improves patients' experiences* London: DH, 2006.

18 British Medical Association. *NHS Does Not Provide Choice Says Public* London: BMA, 2006, www.bma.org.uk/pressrel.nsf/wlu/SGOY-6QZF7D?OpenDocument&vw=wfmms (press release) [accessed July 2007].

19 Coulter A, Le Maistre N, Henderson L. *Evaluation of London Patient Choice: patients' experience of choosing where to undergo surgical treatment* Oxford: Picker Institute Europe, 2005, www.pickereurope.org/Filestore/News/LPC_final_report.pdf [accessed July 2007].

20 Mechanic D. The functions and limitations of trust in the provision of medical care *Journal of Health Politics, Policy and Law* 1998; **23**: 661–86.

## References


[21] British Medical Association. *General Medical Services Contract* London: BMA, www.bma.org.uk/ap.nsf/Content/Hubthenewgmscontract [accessed July 2007].

[22] Lipman T, Johnstone C, Roland M, Wilkie P, Jewell D. So how was it for you? A year of the GMS contract *British Journal of General Practice* 2005; **55(514)**: 396–7.

[23] Lester H, Sharp DJ, Hobbs FD, Lakhani M. The Quality and Outcomes Framework of the GMS contract: a quiet evolution for 2006 *British Journal of General Practice* 2006; **56(525)**: 244–6.

[24] Roland M, Campbell S, Bailey N, Whalley D, Sibbald B. Financial incentives to improve the quality of primary care in the UK: predicting the consequences of change *Primary Health Care Research and Development* 2006; **7(1)**: 18–26.

[25] Whalley D, Bojke C, Gravelle H, Sibbald B. GP job satisfaction in view of contract reform: a national survey *British Journal of General Practice* 2006; **56(523)**: 87–92.

[26] Royal College of Physicians. *Doctors in Society*: *medical professionalism in a changing world* London: Royal College of Physicians, 2005.

[27] Picker Institute. *PCP Overview* Oxford: Picker Institute Europe, www.pickereurope.org/page.php?id=9 [accessed July 2007].

[28] British Medical Association. *Professional Values* London: BMA, www.bma.org.uk/ap.nsf/Content/profval [accessed July 2007].

[29] General Medical Council. *Good Medical Practice* London: GMC, 2006.

[30] Modernising Medical Careers (MMC) homepage, www.mmc.nhs.uk/pages/home [accessed July 2007].

[31] Davison IW, Deighan M, Fraser AA, Field SJ, Kelly S, Thomas HR. *Newly qualified GPs: well-equipped or under-prepared? (In AMEE International Medical Education Conference, Amsterdam, Netherlands, September 2005)*. Publication: 30903.

[32] www.bbc.co.uk/radio4/today/reports/politics/nhs_cake_20070118.shtml [accessed July 2007].

[33] Healthcare Commission. *Survey of Patients 2005: primary care trust* London: Healthcare Commission, 2005, www.healthcarecommission.org.uk/_db/_documents/04019373.pdf [accessed July 2007].

[34] YouGov. *GP Services*, www.yougov.com/archives/pdf/OMI050101083_1.pdf [accessed July 2007].

[35] Greco M and Jenner D (CFEP – UK Surveys). *What Do Patients Think of Their Health Professionals and Their Practices?* Exeter: CFEP; 2005, www.cfep.co.uk/pdf/Patient%20Feedback%20Report.pdf [accessed July 2007].

[36] Donaldson, Sir Liam (Chief Medical Officer). *Good Doctors, Safer Patients: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients* London: DH, 2006.

[37] Fugelli P. The general practitioner and the spirits of time. In: M Lakhani (ed). *A Celebration of General Practice* Abingdon: Radcliffe Medical Press, 2003, pp. 173–86.

[38] Pereira Gray D. The creation and achievements of the RCGP. In: M Lakhani (ed). *A Celebration of General Practice* Abingdon: Radcliffe Medical Press, 2003, pp. 131–44.

[39] RCGP Academic Advisory Group. *Registration, Continuity, Comprehensiveness and Co-ordination in Primary Care: a summary of the evidence*. Paper submitted to RCGP Council, 2005.

[40] Stewart M, Brown J, Weston W, *et al. Patient-Centered Medicine: transforming the clinical method* (second edition) Abingdon: Radcliffe Medical Press. 2003.

[41] National Primary Care Research and Development Centre. *What Patients Want from Primary Care* Manchester: NPCRDC, 2005.

[42] Krogstad U, Hofoss D, Hjortdahl P. Continuity of hospital care: beyond the question of personal contact *British Medical Journal* 2002; **324**: 36–8.

[43] Coulter A and Jenkinson C. European patients' views on the responsiveness of health systems and healthcare providers *European Journal of Public Health* 2005; **15(4)**: 355–60.

## References


[44] Coulter A. *Engaging Patients in Their Healthcare: how is the UK doing relative to other countries?* Oxford: Picker Institute Europe, 2006, www.pickereurope.org/Filestore/Downloads/Six-country-study-6-4-06-web-version.pdf [accessed July 2007].

[45] Levenstein JH, McCracken EC, McWhinney IR, Stewart MA, Brown JB. The patient-centred clinical method. 1. A model for the doctor–patient interaction in family medicine *Family Practice* 1986; **3(1)**: 24–30.

[46] Brown J, Stewart M, McCracken E, McWhinney IR, Levenstein J. The patient-centred clinical method. 2. Definition and application *Family Practice* 1986; **3(2)**: 75–9.

[47] Stewart M, Brown J, Levenstein J, McCracken E, McWhinney IR. The patient-centred clinical method. 3. Changes in residents' performance over two months of training *Family Practice* 1986; **3(3)**: 164–7.

[48] Baker R. Placing principle before expediency: the Shipman Inquiry *Lancet* 2005; **365**: 919–21.

[49] Royal College of General Practitioners. *Response to the Report of the Chief Medical Officer for England (Sir Liam Donaldson) – Good Doctors, Safer Patients* London: RCGP; 2006, www.rcgp.org.uk/pdf/corp_good_drs_safer_patients.pdf [accessed July 2007].

[50] British Medical Association. *Survey of Practice Premises Report*, 2006, www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFsurveygp/$FILE/SurveyofGPpracticepremisesREPORT.pdf [accessed July 2007].

[51] Salisbury C, Dale J, Hallam L (eds). *24-Hour Primary Care* Abingdon: Radcliffe Medical Press, 1999.

[52] Gravelle H, Dusheiko M, Sheaff R, Sargent P, Boaden R, Pickard S, Parker S, Roland M. Impact of case management (Evercare) on frail elderly patients: controlled before and after analysis of quantitative outcome data *British Medical Journal* 2007; **334**: 31.

[53] NHS Alliance. *Squaring the Circle: the place of personal care and small practices in the new NHS* Nottingham: NHS Alliance, 2005.

[54] The NHS Institute for Innovation and Improvement/Improvement Foundation. *High Impact Changes for Practice Teams* Manchester: NHS Improvement Foundation, 2006, www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,288.html [accessed July 2007]

[55] Royal College of Radiologists/Royal College of General Practitioners. *The Framework for Primary Care Access to Imaging: right test, right time, right place* London: RCR, 2006.

[56] Chief Science Officer web page. *Physiological Measurement Project: delivering the 18 week patient pathway*, www.18weeks.nhs.uk/public/default.aspx?load=ArticleViewer&ArticleId=557 [accessed July 2007].

[57] Stott R and Godlee F. What should we do about climate change? Health professionals need to act now, collectively and individually *British Medical Journal* 2006; **333**: 983–4.

[58] McWhinney IR. The essence of general practice. In: M Lakhani (ed). *A Celebration of General Practice* Abingdon: Radcliffe Medical Press, 2003, pp. 1–18.

[59] Lester HE, Glasby J, Tylee A. Integrated primary mental health care: threat or opportunity in the new NHS? *British Journal of General Practice* 2004; **54(501)**: 285–91.

[60] Baker R, Freeman G, Boulton M, *et al. Continuity of Care: patients' and carers' views and choices in their use of primary care services* London: National Co-ordinating Centre for NHS Service Delivery and Organisation (SDO), 2006, www.sdo.lshtm.ac.uk/files/project/13b-final-report.pdf [accessed July 2007].

[61] Freeman G. *Continuity of Care: report of a scoping exercise for the SDO programme of NHS R & D 2000* Oxford: Department of Health Research Findings Register, 2004, www.refer.nhs.uk/ViewRecord.asp?id=1285 [accessed July 2007].

[62] Parchman M, Noël PH, Lee S. Primary care attributes, health care system hassles, and chronic illness *Medical Care* 2005; **43(11)**: 1123–9.

[63] Baker R. The clinical observer: on the up or over the hill? (RCGP Annual General Meeting, Mackenzie Lecture 2003) *British Journal of General Practice* 2005; **55(515)**: 468–71, www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=15970072 [accessed July 2007].

## References


[64] Saltman R, Rico A, Boerma W. *Primary Care in the Driver's Seat* Buckingham: Open University Press and Geneva: WHO, 2006, www.euro.who.int/Document/E87932.pdf [accessed July 2007].

[65] Starfield B. The effectiveness of primary healthcare. In: M Lakhani (ed). *A Celebration of General Practice* Abingdon: Radcliffe Medical Press, 2003, pp. 19–36.

[66] Starfield B. *Equity in Primary Care* (John Fry Fellowship Lecture) London: Nuffield Trust; 2004.

[67] Starfield B. New paradigms for quality in primary care *British Journal of General Practice* 2001; **51(465)**: 303–9, www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=11458485 [accessed July 2007].

[68] Starfield B. Primary and specialty care interfaces: the imperative of disease continuity *British Journal of General Practice* 2003; **53(494)**: 723–9, www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=15103882 [accessed July 2007].

[69] Starfield B, Lemke KW, Bernhardt T, Foldes SS, Forrest CB, Weiner JP. Comorbidity: implications for the importance of primary care in 'case' management *Annals of Family Medicine* 2003; **1**: 8–14, www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=15043174 [accessed July 2007].

[70] Royal College of General Practitioners. *The Future of General Practice: a statement by the Royal College of General Practitioners* London: RCGP, 2004, www.rcgp.org.uk/PDF/Corp_future_of_general_practice.pdf [accessed July 2007].

[71] Hart JT and Humpreys C. Be your own coroner: an audit of 500 consecutive deaths in a general practice *British Medical Journal* 1987; **294**: 871–4.

[72] Hart JT, Thomas C, Gibbons B, Edwards C, Hart M, Jones J, Jones M, Walton P. Twenty five years of case finding and audit in a socially deprived community *British Medical Journal* 1991; **302**: 1509–13.

[73] Wilson T and Sheikh A. Enhancing public safety in primary care *British Medical Journal* 2002; **324**: 584–7.

[74] Gannon C. Will the lead clinician please stand up? *British Medical Journal* 2005; **330**: 737.

[75] Preston C, Cheater F, Baker R, Hearnshaw H. Left in limbo: patients' views on care across the primary/secondary interface *Quality in Health Care* 1999; **8(1)**: 16–21.

[76] Lakhani M (ed.). *A Celebration of General Practice* Abingdon: Radcliffe Medical Press, 2003.

[77] RCGP GP Curriculum homepage, www.rcgp-curriculum.org.uk.

[78] Sylvester S. Measuring the learning practice: diagnosing the culture in general practice *Quality in Primary Care* 2003; **11(1)**: 29–40.

[79] The College of Family Physicians of Canada. *Primary Care Toolkit for Family Physicians*, 2006, http://toolkit.cfpc.ca/en/index.php [accessed July 2007].

[80] Society for Academic Primary Care (SAPC). *New Century, New Challenges: A Report from the Heads of Departments of General Practice and Primary Care in the Medical Schools of the United Kingdom*. London: Royal College of General Practitioners, 2002.

[81] CACI and TNS. CACI/TNS *Health of the Nation Report* (HealthACORN Report) London: CACI and TNS Healthcare, 2007.

[82] Welsh Office. *Better Health, Better Wales* Cardiff: Welsh Office, 1998.

[83] Welsh Assembly Government. *Designed for Life: creating world class health and social care for Wales in the 21st century* Cardiff: Welsh Assembly Government, 2005.

[84] Tudor Hart J. The Inverse care law *Lancet* 1971; **1(7696)**: 405–12.

[85] NHS Wales. *Designed to Deliver: shaping our acute hospitals in Mid and West Wales* Cardiff: NHS Wales, 2006.

# Appendix 1: Report on the RCGP open public consultation, 11 October 2005



## The consultation

The Royal College of General Practitioners in conjunction with its Patient Partnership Group ran an open consultation event on 11 October 2005 to gauge current feelings and future aspirations for primary care with particular reference to general practice services. The event ran concurrently with the Government listening exercise 'Your Health, Your Care, Your Say'.

The event was targeted at adult users of primary care through the local media and libraries as well as open invitations to local interest groups and Patient Partnership Involvement fora. The event was attended by 42 members of the public from a diverse range of backgrounds. The event was not intended to be a 'scientific' or statistically representative survey.

## The process

The evening was broken down into two sections with members of the public divided into facilitated small discussion groups. Attendees were asked to discuss in the first session what they found worked particularly well in respect of their GP practice. The emphasis was on what three things they valued the most and what three things they would like to see improved. In the second session the emphasis was on what issues would the attendees like to see in a future healthcare system, with particular reference to GP care and in particular what issues would they like to see addressed by the upcoming Government white paper *Our Health, Our Care, Our Say*.[16] Each table fed back key points to a plenary session that were captured live on a computer.

### Session 1

Things that people liked about general practice:

- continuity of care – 'A GP who knows who I am'
- free at the point of use
- doctors that listen and spend time with patients
- services that are local and convenient.

Things people would like changed:

- GPs to become more customer focused
- more time with their GP
- greater access to appointments with their GP.

**Session 2**

Things people would like to see in primary care and general practice in the future:

Access

- Would like better patient access to their own records (smart card).
- Improved flexible access to GPs' surgeries including improved provisions for out-of-hours services and commuter services.
- Able to get an emergency appointment.
- Would like same-day access to good-quality local surgeries.
- Would like a one-stop shop with more services available at practice level, e.g. scans, outpatient clinics and PHCTs (Primary Health Care Teams).
- Would like regular health checks.
- Would like to see referrals for exercise and leisure.
- To be given a better choice of registering with the GP of their choice and having more access to GPwSIs.
- Would like access to evidence-based complementary therapies.
- Would like to see GP services become more comprehensive (e.g. QOF).
- Would like more choice in the type of treatment received (prescriptions extending choice).
- Would like to see more interlinking between practices. Possible schemes to see local-area practices working together to provide specialist services.

Communication

- Would like to see better links with social care, including secondary care social services and voluntary and self-care organisations, as well as charities.
- Better continuity of care (communication between primary and secondary care).
- Would like to see improved links with education and health, and an improved preventative public health education agenda.
- Would like to see a GP PALS *(patient advice and liaison service)*.
- Better information service to inform patients of options, including those outside the NHS.
- Would like more user involvement at practice level.
- Would like to have improved facilities for electronic communication.
- GP-to-GP referrals.

Awareness

- Would like GPs to better understand the needs of their communities, including awareness of cultural beliefs, as well as providing greater opportunity for public involvement and community empowerment.
- Would like to see an improvement in mental health training for GPs.
- Improved training and support for receptionists.
- Avoidance of age discrimination.
- Improved disability awareness training.

Their thoughts on the white paper

- Would like to protect the special relationship that exists between a patient and a GP who knows him or her.
- Would not like to see a commercialisation and fragmentation of the service, and have concerns that commercial organisations would 'cherry pick' the best parts. This could lead to some areas being excluded due to not being commercially viable.
- Value the role of the GP as a generalist.
- Would like to see any changes piloted first.
- Much uncertainty amongst community healthcare professionals.



## Summary of feedback received from feedback forms from attendees

Attendee feedback forms rated 81 per cent of the sessions as excellent or very good. Many also provided excellent comments and observations:

*Patients commented to me how impressed they were that the College had hosted such an event. Perhaps the RCGP should do it more often which would give a wider patient perspective than just PPG members could provide.*

*We need more groups like this.*

*I am glad that I attended the evening. I feel I learnt a lot from the contributions of the participants. This forum should happen at least quarterly.*

The participants felt that the facilitator-style feedback sessions worked well and were:

*Very inclusive and extremely well facilitated.*

*Compact, relevant and well noted.*

*A very useful interaction and learning tool.*

However, some people felt that not all the stakeholders had been involved and were particularly concerned about geographical and age group biases. However, others mentioned that we:

*managed to get a good cross-section of people.*

There was a request for future events with more time for discussion.

Overall the event was a success, although it must also be recognised that, as with all of these type of events, there is always room for improvement. We will endeavour to use any feedback that we received constructively in the future.

# 2 Appendix 2: RCGP 'call for ideas'



We issued a call for ideas from the GP community on our website. This requested views on a range of issues from how to improve access to primary care development to the relationship between secondary and primary care. We had 47 respondents to the 'call for ideas'. This was an online consultation. Thirty-eight respondents were general practitioners and the rest were from RCGP faculties and special interest groups in general practice.

Ideas put forward included:

- the need to preserve practice-based registration
- to avoid fragmentation of care through better integration and coordination
- to maintain the practice as the basic unit of care
- the need to prevent choice worsening health inequalities
- the importance of maintaining a holistic approach to primary care
- concerted primary care development with more local services and expanded but integrated primary healthcare teams
- support for community facilities that house diagnostics and support services
- a national premises building programme, particularly to house teaching and training functions
- measures to tackle health inequalities
- the importance of being able to book appointments in advance
- concerns about quality and safety of accessing care from multiple providers
- the request for closer ties between generalists and specialists.

## Examples of response to specified issues

### Access

The convenience of forward booking time is essential for routine GP appointments. This is particularly important for certain groups of people, including: those who are working; parents who need to attend with a school-age child; and the elderly and disabled, who may need to organise transportation to the surgery.

Continuity of care is important and there are suggestions that flexibility of the system should be such that advanced booking and continuity of care are rewarded. There was a wish to let practices develop local solutions for appointments.

## Special groups

### Teenagers and commuters

Accessibility is the key for both teenagers and commuters. Attendance can often come down to access and waiting-room issues; sometimes a reception environment can be daunting to vulnerable groups, such as teenagers and people with a mental health problem, so end-of-day appointments or open surgeries may work best for these groups. Training reception staff might be key to making special groups feel more at home.

### Other vulnerable groups

The homeless, drug misusers, asylum seekers and those with mental health problems will all encounter difficulties with making appointments in the normal way. Advance booking may be inappropriate and these groups may have difficulty keeping appointments or with longer consultations. Solutions may include staff training, end-of-day appointments and specialised clinics for the groups in question.



## Patient choice

Choice is primarily about striking a balance pragmatically between access and availability of workforce. There are other issues included in choice, such as financial implications, patient education and primary care team involvement.

Useful choices might include: seeing a doctor of the same sex; involvement in management decisions; and flexibility of booking systems for primary and secondary care appointments.

Patients already get a choice in areas where a choice is practical and they often ask the opinion of the GP. For the most part, it seems that patients are interested in best quality, not necessarily the range of choice; choice can be an extra burden on the most needy patients.

## Access to care without registration

Concerns with this situation include:

- ascertaining who is responsible for long-term arrangements such as illness prevention checks etc.
- the lack of information available – the patient may have already obtained drugs from several other practitioners that day
- no lists means no responsibility
- that it would be 'disastrous' for chronic disease management and continuity of care.

Frequent attendees of walk-in clinics could well have hidden agendas; with continuity of care a doctor will get to know the patient and his or her situation.

There is greater scope for error when records are incomplete and many patients only present selected details verbally; electronic records would help the situation. Alternatively, it would be more workable if patients had a smart card with their medical record useable in all NHS computers.

## Fragmentation of care

Fragmentation of care is not beneficial to patients and it is felt that contracting out disease management would lead to this situation. Patients with several different chronic conditions may have to attend many different clinics/premises; this may not be such an inconvenience for able-bodied patients, but disabled and ill people may find the travelling a great inconvenience. Less accessible care with poor continuity would lead to the likelihood that general practice becomes the backstop that picks up the pieces.

Chronic disease management is more likely to succeed when multiple conditions can be considered simultaneously, in settings such as the GP surgery. There is a need for continuity and people working in teams of health workers that have a professional relationship and can easily consult each other.

Despite these comments, specialist units may play a useful role as a halfway house between primary and secondary care, freeing up busy cardiology/diabetic/respiratory outpatient departments for new and more problematic clinical cases.

The GP is ideally placed to coordinate and orchestrate care for patients.

The practice should be a central hub for information, explanation and clarification. It should provide stability, continuity and support to patients, and should also become more involved in the community so as to become aware of all the local help available for patients. GPs should be advisers/navigators but an increasing range of team members should be available, such as mental health advisers, direct access physiotherapy, gynaecology, etc.

Integrated care is very important for individuals and society, thus GPs and their practices provide a unique service. The GP is the person who will see and be in charge of the big picture; this will become increasingly evident as care becomes more and more fragmented, and GPs will get the chance to shine in respect of interpersonal skills. A good primary care team speak with each other and understand each other's strengths and weaknesses, therefore inter-team referral can mean that patients see the person with the best knowledge/skill on a subject, whilst remaining within a team that can provide interpersonal care. In the face of increasing specialisation in primary care, it is essential that some generalists remain.

There should be a Quality and Outcomes Framework for integration and coordinated care.

## Community hospitals

There was a lot of support for the concept of community hospitals, or a modern variant of a diagnostic centre if it was properly supported. Community hospitals need to change and become largely diagnostic centres. The time has come for diagnostic radiology to sever its secondary care cord and move into primary care. Community hospitals will have MRI, CT and ultrasound. GPs and radiologists will work together to get the right diagnosis. Community hospitals will have nurse-led minor injury units. They will run outpatients for specialists from neighbouring acute trusts. They will have palliative care beds and a rehabilitation ward for step down.

## Practice-Based Commissioning

There was support for the concept of PBC as the key to resolving many current issues and problems, but many respondents reported a lack of knowledge about the scheme.

There was support for the RCGP to get behind PBC and develop tools to help GPs. GPs need to remain responsible for their patients, and the relationship between GP and patient needs to remain a personal one so that standards will rise as PBC might allow the focus of the health service to return to the primary customer, the patient.

It was suggested that collaboration in locality groups was essential to agree cross-referral protocols for enhanced services and commissioning. Not everyone from each practice should be involved – and a representative from each practice could take on a management role.

There was a clear call for the organisational development of practices but the need to avoid inappropriate hierarchical structures.

There should be more support for frail patients in the community, with better access to occupational therapy and physiotherapy. There needs to be better access to social housing. Services need to remain local to be optimal. The services delivered in primary care should be, for example, dermatology, minor surgery, sexual health, physiotherapy, psychology, counselling, etc.



## Health, social care and inequalities

This exercise involved looking at issues affecting disadvantaged and vulnerable groups. Housing is a big issue, as is poverty in the community, which exists for various reasons and which requires an in-depth study. Ethnic diversity and hence language and cultural issues also have a bearing, which is why the social structure and availability of resources come into consideration.

This is a social issue of which unfortunately health is merely the symptom. Investing in the social infrastructure will make most difference.

## Miscellaneous suggestions

- Longer appointments.
- Good access to support services (district nursing, community visitor, home help, physiotherapy) and secondary services. Enough money to employ practice staff and have a decent work environment. Autonomy to create local services.
- Good-neighbour schemes in locality.
- Increased access to consultants for advice – especially in dermatology through e-health.
- Extend pharmacy role in repeat prescriptions, and then refer back to GPs for medication reviews.
- A single electronic patient record is essential.
- Better, locally delivered out-of-hours care.
- Governmental and public health initiatives to reduce poverty especially in homes with children, better education about proper nutrition, etc. A wider application of initiatives like 'Sure Start'. Social services helping with social matters like food hygiene and housing, and not health for example.
- Protected time out for learning is great and should be enforced.
- Willingness by Strategic Health Authorities and Primary Care Trusts to support the shifting of care and resources into primary care. Willingness to transfer community hospital and nursing teams to new locality commissioning groups.
- Public health liaison officers working with GPs. Housing department liaison officers working with GPs, and also provision of special emphasis in care of the homeless, drug addicts/sex workers and other vulnerable groups.

# 3 Appendix 3: *Roadmap* consultation report



Issue 1: Models of care
Is any change needed in how general practice is managed and organised? In what ways does general practice need to develop? What is the impact of PBC on models of care?

## Overall

These were some of the broad points expressed about the management of general practice:

- the best of practices are excellent. They deliver high-quality individualised care whilst achieving excellent levels of chronic disease management and consult patients on how they would like services delivered. These services are based on multi-professional teams. These professionals should have a level of autonomy, but also be interdependent, valuing mutual input. To function effectively the size of the team should be limited to 30–40 individuals who can easily communicate and will usually be co-located
- general practice should develop in ways that are evidence based and not be subject to 'fashion' or political concerns
- general practice needs to steer its own path carefully through the landscape of medico-industrial service providers and alternative holistic approaches to primary care
- the NHS should be run independently of the Government
- general practice needs to evolve in a way that is accountable to patients and that is responsive to their needs.

## Management and organisation of general practice

Many respondents expressed the view that local surgeries should work more collaboratively to facilitate improved service provision whilst maintaining continuity of care and accessibility:

- consideration needs to be given to supporting small and single-practice surgeries. Costs could be saved by sharing administrative loads between groups of small practices as sometimes happened under the GP Fundholding policy. Patients should be able to choose the services of a small practice
- the local control of a self-managed practice is crucial to allowing variation in structure and personnel to suit both the local situation and national requirements. Larger separately managed systems do not do this, often instead concentrating on organisational goals
- practices should pool resources that can enable them to offer a larger skills mix. This could extend the scope of minor surgery in primary care. Diagnostic options, currently only accessible in secondary care, could be brought closer to the patient. This will also mean that GPs can work together collaboratively and ensures that services are not needlessly duplicated
- more investment in premises and equipment for general practice is critically needed in many areas – especially as some services provision is shifted from secondary to primary care settings
- greater cooperative working between primary and secondary care sectors is vital for improving patient care, cutting costs and preventing conflicts of incentive. Practices should be encouraged to provide more secondary care outpatient services
- healthy-living advice should be transferred out of general practice to nurse practitioners who are skilled at prevention, so that GP resources can be better directed at the management of illness

- the presence of good medical professionals in leadership positions is vital to a well-functioning healthcare system; there are often many structural solutions
- to continue to offer a good level of service quality and meet expectations in a free-at-point-of-access model will be difficult. Limits may need to be placed on access to GP time. Triage and better use of nurse practitioners could be part of the solution as could better managing of patient expectations through public education
- sessional doctors now undertake 30 per cent of GP consultations. They will have limited knowledge of localities and few opportunities to input their ideas to improve services. However, they will have good insight into the way that the whole system functions as they will have windows into many different situations, so some effort should be made to capture this. This should be encouraged through the PBC model
- a one-stop shop covering a wide range of services may be particularly beneficial for patients in some localities. This could include counselling, financial, employment and family-related services, as well as GP services
- receptionists are the first point of contact and the public face of a practice, and so need to be well trained and aware of the services available in the surgery, as well as in the wider health and social care community.

## Practice-Based Commissioning

- The structures of PBC and Payment by Results need to be improved to give hospitals an incentive to help GPs better manage referrals to secondary care.
- PBC should be set up to shift the emphasis from cure to patient care and enable a shifting of resources from acute hospital-based care to community-based mental health services and better services for the elderly.
- The funding and specification of PBC should create a mechanism to shift funds from hospital to the community. Practices may need to work together as a consortium to effectively deliver some services that are currently delivered in secondary care.
- The paradigm of GPs being paid small sums for partial episodes of care for each patient, as epitomised in the QOF, has a negative impact on GPs' ability to provide holistic personal care.
- PBC can allow new creative partnerships to develop the delivery of services that are not constrained by splits between primary and secondary care.
- PBC should be seen as a multi-disciplinary task, and incorporate in its design the views of all those involved in the delivery of primary care.

## Private providers

Several respondents thought that there would be many risks associated with private healthcare providers entering the primary care sector. There was also great concern at the perceived increasing power that the pharmaceutical industry has in health care.

- There will be risks to patient care in health care being delivered by service providers whose main concerns are profitability and efficiency. These providers need to be properly regulated to ensure the quality of individual patient care is not compromised.
- The entry of private providers, if not properly managed, could erode the GP–patient relationship.
- Clinical freedoms could be restricted.
- There is concern that private providers will not be on a level playing field with existing providers in the bidding for services. They may operate as 'loss leaders', undercutting rivals in order to gain market dominance.
- Private providers may well be able to provide additional services, such as OOH access, but this may be at the expense of the continuity of care with patients.

Issue 2: Personal care
There is increasing concern about the fragmentation of care and the difficulties of personal care. How can values be preserved and what priority do you place on this? Is the current consultation length sufficient? What are your ideas for the effective and efficient use of time? In what ways does the doctor–patient consultation need to evolve?

## Values of general practice

- There is too great an emphasis on achieving population-wide public health goals. The values of sensible patient-based medical practice, focused on the prevention and management of illness, should be preserved.
- Values can be preserved, as the organisation of general practice evolves, so long as the culture is about quality, comprehensiveness, continuity and accessibility.
- The values and ethical foundation of general practice need to be preserved, and protected from the private healthcare industry, which is motivated by profitability.
- Values can be preserved by contracting GPs to provide holistic care to patients rather than paying GPs for individual episodes or parts of episodes of care.
- Outcomes should be measured rather than specific processes; this will help to ensure that patient choice is central to decision making rather than rigorous process-based protocol.
- The current QOF does not adequately measure the softer side of the GP experience. The interpersonal skills needed by GPs in interacting with their patients are vital to good personal care and there should be more emphasis on these.
- Personal care can be supported by good IT systems that can enable clinicians to work intuitively and support their decision making.

## Doctor–patient relationship

- The patient's responsibilities as a service user should be communicated to him or her.
- Many respondents stressed that the values of the GP–patient relationship needed to be preserved.
- The relationship could be compromised with increasing numbers of private providers in primary care.
- Compassion and continuity of care should be at the heart of building a good relationship with patients.

## Out-of-hours access

- Patients should be encouraged to see their GP within their working hours, as is their legal right.
- What is achievable given the demands of OOH accessibility and patient list sizes within available resources should be carefully assessed.
- There needs to be timely communication in primary care between in-hours and out-of-hours clinicians. GPs should be closely involved with the way OOH care is structured so that an adequate continuity of care is maintained. An understanding of locality and resources available is also crucial.

## Continuity of care

Respondents thought that there were risks that primary care may become fragmented and continuity of care disrupted:

- the continuity of care that patients receive should be preserved
- continuity of care should be acknowledged as a benefit to patients and should not be sacrificed at the expense of increasing productivity
- moving towards a continental-style model of direct access to secondary care may lead to fragmentation and a decline in standards of care
- the ideal should be a single well-trained, well-supported GP coordinating care for each patient. Disparate bodies employed on an *ad hoc* basis to provide service disrupts this continuity and should be opposed
- there is a limit to cost savings that can be achieved by increasing the skills mix in a team. High fixed travel costs and the need for others to travel to check the work of juniors will offset these savings
- it is important that patient lists are maintained to allow a continuity of care; this is especially important for chronic and complex disease management.

Others thought that though services may become fragmented that this could be beneficial if appropriately delivered. They offered ideas as to how continuity of care could be maintained:

- a successful GP–patient relationship need not only be fostered by contacts with a single GP. This can also be done through good joint working between GPs in a practice facilitated by good information-sharing arrangements
- a good skills mix will become ever more important within the healthcare model. For some localities this will still be delivered within the setting of a traditional primary healthcare team. In others it may be delivered best in a more fragmented way with new and imaginative models; in certain urban areas this will be a one-stop shop with diagnostic and treatment provision, combining effectively primary and secondary care
- the use of effective systems for information exchange and team development can support the continuity of care
- continuity of care with patients is important for all members of the team. Elderly patients especially would benefit from continuity of care from all members of the primary healthcare team including the range of community nurses involved in care
- mental health services and other specialist community services should be structured in a way that maintains a continuity of care
- with shorter stays for patients in hospitals, GPs should make contact with the patient soon after discharge; this can be facilitated with good information-sharing procedures between primary and secondary care.

## GP consultation

Several respondents thought that the length of the GP consultation is too short. Opinions varied as to what an ideal duration was:

*I have many patients where a consultation of 30 minutes would be the most appropriate length to deal with the technical demands of their condition.*

*I offer routine appointments of 15 minutes and find that it is the only way to offer a patient-centred service.*

*Surgery appointments should be carefully triaged to manage limited available resources.*

*To improve the use of GP time, home visits should be made an enhanced service, so that GP time can be free for surgery.*

Many respondents thought that the current standard appointment length of 10 minutes could be sufficient, but that flexibility was needed.

- It is unrealistic to set a standard appointment length for all GPs; GPs have different styles and patients different problems.
- Continuity of care with patients requires a number of contacts and for GPs to cover a breadth of services. Ultimately this will limit consultation times. For most, 10–15 minutes is adequate.
- Different models of GP consultation should evolve; consultations could occur via telephone, video web-link and email. These will not be suitable for many patients, but they can increase patient satisfaction by offering ease of access and help manage demands on GP time.

## General practice list sizes

Many respondents expressed the opinion that GP list sizes were too large and needed to be capped. Doctors reported that in some areas appointment time waits could be two weeks or more.



Issue 3: Role of the GP and comprehensiveness
Workforce and services – What should GPs be doing in the future? Should GPs maintain their generalist status or become more specialised? What skills are needed in particular? What should the role of general practice be? How comprehensive a service should general practice aim to provide?

## Role of the GP

These were some of the main opinions expressed about the role of the GP.

- There is a risk that the GP role will become reduced to that of a referral agent and resource manager. In having to manage increasingly complex packages of care for patients GPs are losing their role as patient advocate acting in a holistic capacity. GPs need to safeguard their unique role as holistic gatekeepers.
- GPs should only be conducting triage and not have responsibility for long-term public health. Long-term follow-up should be conducted by nurse practitioners.
- Expansion of the GP role and enhanced local commissioning can be beneficial but it will need to be appropriately managed and resourced, with GPs taking a central role in the process.
- General practice should aim to provide most care for most of the common illnesses as it does now. It should expand into more rehabilitation, elderly care and more mental health services.
- GPs should fully and effectively support non-doctors in playing their part in delivering care.
- In the future GPs should be seen as primary care physicians, working in the community and providing holistic care.
- GPs should have a role in directing patients to non-medical services and should be able to work as part of a multi-disciplinary team, not all of whom will necessarily be medical professionals.

## Comprehensiveness

Most respondents thought the role of the GP as a holistic gatekeeper was vital and needed to be preserved.

- Holistic generalism is a highly demanding specialism in its own right and needs to be preserved. Patients need a generalist advocate who can take responsibility for managing their care pathway.
- GPs are unique in the integrated skills set they bring to the role. With the demise of the general physician, there are no others in the healthcare model that can provide this generalist diagnostic, treatment and triage function.

## Skills and GP specialisation

- GPs should retain their unique skills mix as generalists with an integrated skills set. Specialisation should be encouraged with this in mind.
- GPwSIs are a valuable resource that should be used by surrounding surgeries and help reduce the need for referrals into secondary care.
- With increased specialisation in hospitals it is even more important that GPs retain their generalist skills.
- There is only a need for GP specialisation in those areas where expertise would rationalise referrals into appropriate clinics.
- Undifferentiated, complex and mixed problems are often best and more holistically treated by a generalist, rather than a specialist who may have little knowledge outside his or her own area.
- GPwSIs are extremely valuable in remote areas, where relevant specialists may be at a great travelling distance. It may be important to have certain specialisms in certain areas, for example some inner-city areas may benefit from access to GPs with substance misuse skills.

These are some additional skills that respondents felt GPs should acquire:

- training and awareness in substance misuse should be encouraged and widely available to GP registrars, as this is an increasing nationwide problem that may present itself in many situations. A good level of training should ideally be given in medical school and also included in the GP contract and QOF requirements
- GPs should enhance their skills in general medicine and become able to treat common conditions such as chronic kidney disease and diabetes, and to carry out minor surgery.

## Workforce issues

- The RCGP should strongly lobby against the removal of hard-working overseas medical graduates. This could lead to a shortage of GPs, if predictions of central planning are off target and the safety valve of recruitment from abroad is restricted.
- As the population ages and patients suffer more chronic disease, GPs will be needed in larger numbers to help patients manage their own illnesses, while providing intervention where necessary.
- A higher proportion of generalists in the primary healthcare team need to be maintained, in multiple professions; practice nurses, district nurses, physiotherapists, psychological support, geriatric and rehabilitation services will all need generalists. There has been too strong a shift towards specialisation in these fields.
- There are problems with recruitment and retention in inner-city areas. Appropriate adjustments could be made to the GMS contract payments system to create incentives that will encourage a flow of doctors to areas where there are vacancies.

## GP role in promoting healthier living

- Greater emphasis should be placed on promoting healthy living rather than medication to reduce health-related problems, and this could be done through locality-focused embedded surgeries. Compassion and the individual patient's perspective within his or her societal context should guide the GP–patient relationship. General practitioners should continue to advocate better local conditions, e.g. encouraging shorter/flexible working hours, less reliance on processed foods.

Issue 4: Role of the College
What would you like the College do to support the future development of general practice and of GPs?

## General

- The College should continue its work promoting excellence in standards of patient care.
- The College should conduct or support research into GP referral patterns and how limits on GP referrals could affect patient care.
- The College should foster the development of members and welcome their input. This requires a tolerance of different clinical methods and working practices. An effort should also be made to engage more lay people in College activities.
- The College should celebrate the achievements of general practice as a profession. The College should encourage GPs to move forward in a fair and equal way with other service providers and patients.
- There should be more College activities that are held outside London.



## Influencing

Several respondents thought the College should continue to be involved in influencing Government at the policy-planning and implementation stages.

- The College should work to ensure that strands of policy emerging from different areas of Government are joined up; GP contracts, clinical and management guidelines, research and information systems all need to function in a cohesive way.

## Education and training

- The College should encourage and provide formative development schemes in management and interpersonal patient skills.
- The College should invest more resources in CPD across the country; PCTs have few resources for this. The College could really develop learning by supporting and organising local meetings for GPs and facilitating practice-based learning as needed. This could be done in conjunction with revalidation and through the faculty structure.
- Education and training resources should be made available over the internet and the RCGP should work collaboratively with other organisations to develop innovative educational products, e.g. with other royal colleges, Care Services Improvement Partnership, Government agencies such as the National Offender Management Service and the Social Exclusion Unit.
- The College should continue to promote excellent clinical leadership through schemes such as the leadership programme. GPs also need help in coming to terms with rapid change; many GPs have found the Plan, Do, Study, Act model of improving performance very helpful.
- The College needs to work with its faculties to ensure that GP appraisals that are part of revalidation can be properly carried out, as the responsibility for conducting these moves from PCTs to the royal colleges.
- The College should increase its provision of care pathways and clinical guidelines.
- Consideration needs to be given to providing more elements of training in management and skills to organise holistic packages of care and in team-working. Those entering the GP profession do not always have these skills, which are necessary for modern general practice, or the expectations needed to deal with the uncertainty that arises from changing models of care.

## External communications

Several respondents thought the College and general practice as a profession should be involved in better communicating with patients and those in the healthcare sector.

- Better communication is needed with public, health managers and the Government to promote the role of the GP within health care.
- The public need to be engaged by the profession about how it perceives its duty of care; what we do and why we make the recommendation we make. General practice as a profession, as well as individual GPs, must work positively and responsively on their image, and not take for granted patient loyalty and support.
- The College should positively engage with the press to counteract unbalanced, negative stories.

## Communicating with GPs

- It is vital that the College continues to communicate its role to GPs. Recent developments, such as the 'Seven Days' bulletin, have helped GPs at the grassroots keep up to date with the ever-changing world in general practice.
- The College should engage with GPs through the faculty structure and encourage continuing involvement with the College.

Issue 5: Your special issue
Please put forward any other issue or constructive suggestion that should be included in the *Roadmap*.

## Patient involvement

Several respondents thought that it was important that patients should be better engaged and their opinions on general practice and primary health care sought.

- There should be greater emphasis placed on seeking out patient opinions of primary health care.
- 'We need to engage the public to understand how they want to face developments in primary care rather than simply best-guess what they want.'

## Referral

- Attempts to limit GP referral rates will cause problems. GPs could be caught in ethical and legal dilemmas if they have a need to seek second opinion but a disincentive to do so. Research could also be undertaken to collate an evidence base.

## Private sector

- GPs working in the private sector are medical professionals in the same way that those working for the NHS are.

## Faculties

- RCGP faculties should match NHS boundaries in order to be more effective; they should be coterminous with deaneries.

# Appendix 4: *Roadmap* for General Practice Breakfast Summit, report, 17 May 2006



## 1. Introduction and welcome

Professor Mayur Lakhani welcomed those present to the meeting. He hoped that the presence of representatives from a wide range of organisations would lead to a well-informed and robust debate on the future direction of general practice. He reminded the group that the meeting would be held under the Chatham House Rule.

## 2. List of delegates

Professor Mayur Lakhani (Chairman of RCGP Council) (in the chair)
Dr Kate Adams, GP, RCGP member
Dr Ken Aswani, RCGP Council member
Dr Rifat Atun, Director, Centre for Health Management, Tanaka Business School
Mrs Jane Austin, Director of External Relations, RCGP
Dr Alison Baker, Director of Professional Development and Quality, RCGP
Dr Maureen Baker, Honorary Secretary, RCGP Council
Professor Richard Baker, Leicester University
Professor Dame Carol Black, President RCP and Chairman-Elect, Academy of Medical Royal Colleges
Mr Graham Box, Chief Executive, National Association for Patient Participation
Mr Harry Cayton, National Director for Patients and the Public
Professor Angela Coulter, Chief Executive, Picker Institute
Ms Hilary De Lyon, Chief Executive, RCGP
Mrs Ailsa Donnelly, Chair, Patient Partnership Group, RCGP
Dr Agnelo Fernandes, GP, Parchmore Medical Centre
Professor Steve Field, Chair, Education Network, RCGP
Ms Liz Kendall, Special Adviser to the Secretary of State
Professor Helen Lester, University of Birmingham
Ms Gill McDonald, Director of Membership and Development, RCGP
Dr Helena McKeown, RCGP Council member
Mr Dilip Manek, Director of Operations, RCGP
Dr Hamish Meldrum, Chairman, General Practitioners Committee
Mr Graham Pope, Chair, Allied Health Professions Federation
Professor Deborah Saltman, Royal Australian College of General Practitioners
Dr Andrew Spooner, RCGP Council member
Ms Gillian Watson, PR Manager, RCGP
Dr Patricia Wilkie, Chair, Academy of Medical Royal Colleges Patients Group
Ms Barbara Wood, Co-Chair, British Medical Association Patient Liaison Group
Ms Lynn Young, Community Health Adviser, Royal College of Nursing

## 3. Background

Professor Lakhani set the scene for the discussion using patient and practice examples. Questions had arisen about the optimal purpose of general practice in the context of the modern health service and patient expectations. He mentioned a letter he had received from an RCGP member asking what the College was doing to fight for the preservation of the generalist role. He thought that the 'distress' of the profession could be summed up in a notice that is found in some waiting rooms: 'Remember, one appointment, one patient, one problem'. What was the 'end game', he queried, and what might be the vision for general practice within the NHS?

Professor Lakhani said that he felt that real progress had been made in improving standards, e.g. through the QOF, and that general practitioners currently enjoyed high levels of public trust. However, he remained concerned about the rich–poor divide in health service provision. Complacency was to be avoided, and at different stages in its history the RCGP had been able to generate renewal in general practice. He saw a real need at the present time for a roadmap to provide strategic direction for general practice.

Professor Lakhani suggested three crunch questions:

- How does organisation and management of general practice need to change and develop?
- What should be the degree of specialisation within general practice?
- Values – what is it that we don't want to lose? How does patient choice fit in with the core values of general practice?

He concluded by saying that similar debates are being held in many countries and that the RCGP would be involved in an international summit in September 2006.

He invited a number of guests to deliver brief opening statements.

## 4. Professor Angela Coulter

Professor Coulter spoke of her work on patients' experience of primary care since 1983. She felt that general practice was the 'jewel in the crown' and that generally patient experiences of general practice were very positive. Patients appreciated the coordinating role played by GPs, and were in favour of retaining the registered list and the referral system. However, Professor Coulter also saw a need for change; a recent Picker Institute study had revealed that patient engagement in the UK was lower than in any other country. She saw the UK system as 'paternalistic' and pointed to evidence that patient engagement can improve health outcomes. She also felt that people very much wanted choice and to have a say in their own treatment, and that patient choice was compatible with the registered list.

## 5. Professor Dame Carol Black

Dame Carol said that Professor Lakhani had invited her to look at general practice from a specialist perspective. What does good general practice look like from a specialist perspective? She welcomed the closer relationship that was developing between the two colleges and saw it as reflecting the continuum of the patient's journey. She said that she hoped there would be greater flexibility between the different professions in the development of integrated pathways of care. Dame Carol said that she thought that general practitioners needed to be innovative in concentrating on a generalist, holistic approach to health. Similarly, she felt that hospital doctors need to change and develop.

## 6. Dr Ken Aswani

Dr Aswani said that he felt that general practice should build on its strengths. He pointed to the importance of managing co-morbidity. He felt that primary care should be seen in the widest context embracing other professions and that skills mix was of key importance. Dr Aswani saw the development of Practice-Based Commissioning as a key factor. He emphasised the importance of clinical leadership and felt that there was no need for general practice to feel threatened by GPwSIs. Dr Aswani said that general practice had to look carefully at education and training for the role, and barriers to the provision of care should be examined.

## 7. Dr Maureen Baker

In her opening statement, Dr Baker highlighted the leadership role of the RCGP. To ensure that the recent white paper would recognise the strengths of general practice (e.g. through retaining the registered list) she said that the College had worked hard in the lead-up to its publication, including holding a public consultation event. She said that currently the College was concerned as to how it could work best with its members to deliver the future of primary care and support them effectively. She saw an example of educational support as the new GP curriculum and emphasised the importance the College attached to its ongoing review and development.

## 8. Roundtable discussions (numbered for ease of reference)

8.1 System is not geared for rewarding continuity, good outcomes and innovation. Need for a payment mechanism for managing continuity and the outcomes that really matter. There is a tension between choice and managing continuity.

8.2 International perspective: a member of the RACGP currently working in the UK spoke of the need for renaissance of general practice and the role of the College within this. She detected a tension between standards of care, organisational needs and pressures from professional organisations. She said that she felt that leadership should be separated out from management. Intermediate care was more fully developed in Australia than in the UK and made the distinction between groups and teams, and that there needed to be radical rethink of what 'team-working' meant in primary care.

8.3 Another delegate highlighted three major issues where GPs would play a critical part: the shifting emphasis to prevention of care, the integration of care, particularly between health and social services, and moving more appropriate services from hospital into the community.

8.4 The importance of clinicians working together across interfaces was also mentioned.

8.5 GPs could not deliver the new health service without clinical leadership and better trained doctors. The new GP curriculum focused on self-care and patient safety. The curriculum sought to develop the diagnostic role of the generalist and pointed out that if a GP was an effective diagnostician this saved both money and lives. The vision would be for highly skilled, highly motivated, diagnostic generalists.

8.6 One delegate pointed out that the morning's discussion had revealed a degree of paternalism in participants' views of what they felt patients wanted. He said that he felt that a weak spot in the QOF was patient surveys and reminded the group that only a very small number of GP practices had patient groups. He went on to echo earlier comments about the tension between choice and continuity, and said that he thought the electronic care record, if properly managed, would be a facilitating factor in continuity. He also felt that Practice-Based Commissioning had the potential for a real partnership between patients and clinicians.

8.7 The challenge for general practice was how to deliver what patients need, which are: both generalism and specialism, and choice and continuity of care. It is paternalistic to say that we should deliver only what the profession thinks best.

8.8 The QOF was mentioned as a lever for improved standards, and reference was made to the role of generalists in managing co-morbidity.

8.9 GPs are popular with their patients and enjoy a high degree of trust. What patients looked for were competent doctors who were good diagnosticians. The importance of the medical care record, particularly patient-held record, was mentioned.

8.10 Patients were concerned about access to the health service – these concerns were common.

8.11 We must argue against the concept of polyclinics – referring the group to the example of other countries that had tried polyclinics and were now seeking to remove them.

8.12 General practice was a victim of its own success. Current problems in general practice represent a capacity issue. Compared with other Western countries the UK was under-doctored. Problems such as concerns about access to care could not be resolved until the capacity issue had been tackled. In a wants-led system it was felt that the risk was losing universality. One delegate said that he believed in a health system funded by taxation but felt that it was becoming increasingly difficult to provide a comprehensive system based on taxation. It was perceived that the strength of general practice lay in the one-to-one relationship between doctor and patient.

8.13 The core part of the GP role was the one-to-one relationship with patients but the profession needed also to think about community health.

8.14 Effective and supportive forms of patient engagement were needed. One delegate suggested that clinicians should work with patients and the wider public.

8.15 The debate was broadened to include citizens as well as patients. What was needed was a strategic understanding of the situation as a whole. The three key elements for patients and citizens are: access when required; familiarity with the system; and continuity of care provided through readily accessible records.

8.16 Problems can be created in general practice by the bureaucracy of 'tick-boxing' imposed on doctors and the tensions this could create in consultations.

8.17 What are royal colleges for? Traditionally they have been standard setters but should they do more to uphold the standards?

## 9. Tour de table

The Chairman conducted a tour de table to identify new issues and to ensure that all the key issues have been captured.

9.1 Doctors needed to take account of relationships with other disciplines and that there was a need to exploit creative skills mix, with community-based care leading the way.

9.2 Pursuing the theme of citizenship, the College should help doctors develop structures for the profession to be accountable to the public.

9.3 The RCGP should move forward in an inclusive way with other professions as primary care was not just about general practice.

9.4 Focus on strategic leadership and functional teams. Certain practices already exemplify best practice. Only 20–30 people could work effectively together in a practice team. For a GP was the PCT or the patient the boss? He felt that there was a need for managerial training for GPs' post-vocational training.

9.5 The profession had to face unpleasant truths and take account of market forces. Involving citizens in health service provision planning would be good. The College should support GPs wishing to specialise.

9.6 The tension between the doctors' and patients' agenda in the consultation.

9.7 Emphasis on continuous quality improvement.

9.8 Favouring more citizen involvement.

9.9 Choice and continuity of care are not irreconcilable. There is a need for public debate about rationing and the implications for patients, mentioning as an example recent high-profile discussions in the media about herceptin. The group's attention was drawn to the amount of money that people were prepared to spend on cosmetic surgery and vitamin pills.

9.10 The need to look at the self-care agenda from an educational background – patients needed to be educated from a very early stage about health issues. Discussions needed to take account of an ageing population.

9.11 The need for effective communications between primary and secondary care.

9.12 Patient empowerment and involvement in health service planning.

9.13 All practices should aim to have patient groups.

9.14 That there was a need for political leadership.

9.15 General practice is at a crossroads – GPs could be both the champions and drivers of change, but that they needed to take into account the wider community. It was an exciting time to think about primary care and that the message coming across was positive.

## Conclusion and close

Professor Lakhani summed up by echoing the view that general practice was at a crossroads and there was real need for direction at a time of enormous organisational change in the health service. He was confident that renewal can be achieved and this was evidenced by the history of general practice – however, this required a concerted effort. Professor Lakhani said that the thoughts of the group would be reflected in a paper. He felt that it would be essential to work with the RCGP faculties, with patients and other stakeholders.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