

our response is appropriate and effective. Barriers to asking still need to be tackled through education of clinicians using the methods that have been tested in controlled studies,¹⁶ including Lo Fo Wong's trial. Good quality research on effective responses is sparse, although referral to a domestic violence advocate seems to improve outcomes for women experiencing current abuse.¹⁷ Validation of a patient's experience, recording their story (both in a medicolegal and witnessing sense), and non-judgmental support are already central to good general practice. Coupled with an offer of referral to a local advocacy service, such as Women's Aid or Victim Support, our response should be part of a coordinated community response¹⁸ to a major cause of distress and ill health that ends twice a week, in the UK, in a violent death.¹⁹

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The Quality and Outcomes Framework of the GMS contract: a quiet evolution for 2006

A new contract for general medical services delivered by general practices was introduced in the UK in April 2004. A Quality and Outcomes Framework (QOF) was an integral part of the new contract and rewarded practices for delivering more evidence-based care. This marked a fundamental shift in the way general practice was resourced with a mixture of capitation, fee for service and performance-related pay.

The QOF has been described both as 'an initiative to improve the quality of primary care that is the boldest such proposal on this scale ever attempted in the world'¹ and also as a threat to the 'professional basis of general practice, indeed its very existence as a speciality'.² The division of opinion is

reflected in uncertainty whether it has made any difference to patient care.

Theoretically, the introduction of 146 largely evidence-based indicators, 76 in 10 clinical areas, should lead to more consistent care and positive changes in patient-related health outcomes. QOF may have ended personal professional autonomy in some aspects of primary care, with disincentives to offer substandard care or be out of date with clinical opinion. It would, however, be wrong to claim that current improvements in health care are all QOF-related. Substantial improvements occurred in the clinical quality of care for coronary heart disease, diabetes and asthma before its introduction.³ However, there are some early indications

from the Quality Management and Analysis System (QMAS) data and from modelling work⁴ that QOF has continued to encourage improvements to clinical care. QOF may also have created a 'comet's tail' effect between practices, initially demonstrating the existence of health inequalities, but also creating a force that pulls all in its wake. In the 1990s, data on performance-related pay for cervical screening showed that coverage was consistently higher in affluent areas between 1991 and 1999, but that it also led to a narrowing of the ratio rates of inequality between affluent and deprived areas.⁵ It is possible that QOF may have a similar positive effect on the inverse care law, with practices in more deprived areas starting

from a lower baseline in terms of QOF achievement, but improving more over time.

The average QOF achievement at practice level of 959 points (91%) has polarised views of the process, with newspaper headlines suggesting 'Doctors get 20% pay rise just for doing their jobs' while others argued that primary care had 'stepped up' and worked hard to improve patient care.⁶ The disparity reflects, in part, the tension between seeing QOF as a reward for past and ongoing achievements or a performance-related pay incentive, when it has, in reality, acted as both.

An expert panel to formally review the QOF was appointed in 2005 by the NHS Confederation on behalf of the Department of Health. The expert panel was a collaboration between the University of Birmingham, the Society for Academic Primary Care and the Royal College of General Practitioners. The role of the expert panel was to consider existing evidence, some of it submitted by stakeholders during an open 'call for evidence' in Spring 2005, and to produce a series of reports to advise the negotiating teams about the meaning and quality of the evidence as they considered revisions to existing and introducing new areas into the QOF.

This has resulted in a number of small but significant changes in 2006. Fewer points are now allocated to organisational areas, recognising that improvements have been achieved and should now be part of standard not quality care. The 15 indicators in seven new clinical areas are largely evidence-based and all represent good professional practice. They move QOF beyond a focus on chronic disease management towards, for example, recognising and rewarding excellence in patient-centred palliative care and suggest areas for future further development, such as learning disabilities and depression. The evidence in established areas has been revisited and updated and small but important changes made. Where possible, points have moved to recognise outcome over process, payment thresholds have been informed by QMAS data and inconsistencies in wording and guidance have been clarified. Issues of primary prevention in cardiovascular disease and the need to review patient experience within the wider context of access, continuity and

choice have also been highlighted for future development. It has been a quiet evolution rather than a wholesale revolution, recognising a central need for consistency and consolidation within a primary care policy context of almost unremitting change and resource constraints.

Concerns have been expressed about the effect of the QOF on generalist patient-centred practice. We need to better understand the influence of professionals' motivation on performance in a primary care setting, including the possibility that financial incentives in some areas may 'crowd out' internal motivation if professionalism is felt to be less valued.⁷ The existence and extent of the proposed 'halo effect' from QOF indicators to areas not in the Framework, and, crucially, the consequences for patient care when indicators are no longer included are also important issues that need to be addressed as QOF evolves.⁸ The Department of Health also needs to find the right balance between the light touch of 2004/5 based on an assumption of high trust that GPs would behave like altruistic 'knights' in claiming QOF points,⁹ and the current more proactive stance that suggests they may believe the profession to be a mixture of knights and knaves. This is important because it is possible that prescriptive surveillance will act as a disincentive for many members of the profession, and may again 'crowd out' their intrinsic moral motivation to provide good quality care.⁷

Patients have, to date, had a limited input into QOF. Few patient groups submitted suggestions to the review process, and patient involvement has been confined to commenting on rather than contributing to the Framework. This may, in part, reflect the complex process of reviewing and developing indicators. It is, however, an issue that needs addressing in subsequent evolutions. Patients' voices and choices about the elements of quality primary care can, however, be heard in other contexts and can help us to develop QOF in a meaningful way. A systematic review of the literature on patients' priorities for general practice care, conducted as part of a project by the European Task Force on Patient Evaluation of General Practice,¹⁰ found that, above all, patients rate humanity, closely followed by competence and accuracy from primary care. They would like to be treated by

patient-centred health professionals practising in an evidence-based manner. There is also growing evidence to suggest that quality patient care indeed depends on their co-existence. A recent study in the Netherlands found that neither evidence-based depression-specific interventions nor good GP communication skills alone lead to effective treatment for patients with depression.¹¹ Quality care required the combination of evidence-based treatments and good communication skills.

As we enter the third year of the QOF, we need to develop trust on a number of different levels; between QOF zealots and sceptics, QOF bureaucrats and practitioners on the front line, the patient without a diagnostic label seeking reassurance and advice and the over worked multitasking practitioner. Within the evolving QOF, we have an opportunity to provide up to date and more evidence-based interventions that require skilful communication between patients and primary healthcare practitioners. The two sets of skills are not mutually exclusive and both help to maintain our claims for professional status. Such an approach to the consultation can be taught¹² and, if practised appropriately, can lead to better patient health outcomes.

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Guiding principals – general practice and career choices

Like all specialties general practice waxes and wanes in popularity. In the 1980s, soon after mandatory vocational training for general practice was introduced, it was a very popular specialty only to decline in the 1990s. The advent of the 1990 contract for general practice was not well received by the profession and medical students learning in general practice frequently encountered GPs reluctantly striving to meet immunisation and cervical cytology targets.

At about the same time the 'Calman reforms' for specialist training were introduced, promising shortened training together with an expansion of the specialist workforce. The result was increased recruitment into most hospital specialties and a decline in the popularity of general practice training, so that by 1995 only 18% of a graduate cohort study group had decided on a career in general practice.¹

During the last decade considerable effort has been made to improve the quality of community-based learning for undergraduates and this, together with the realisation that general practice offered better career prospects compared to many hospital specialties, resulted in an increase to 33% from the same group of graduates deciding on a career in general practice by 2004.¹

The importance of strong general practice is recognised in the new White Paper: *Our health, our care, our say: a new direction for community services*,² in which it is envisioned that more patients will receive care outside the traditional hospital settings

and that GPs with a special interest (GPwSI) will be accredited for their specific skills. Whether this aspiration becomes a reality or remains a 'fairytale'³ will depend very much on general practice attracting able young doctors who are motivated to deliver high quality patient care.

Modernising Medical Careers⁴ is an ambitious plan to deliver more effective postgraduate medical education, moving from a system of accreditation on the basis of time served to one of structured programmes and assessed competencies. All doctors graduating in the UK will spend the first 2 years after graduation in structured foundation training programmes and from there enter a period of specialist or general practice training. General practice has developed a new curriculum for the modernised training programme, together with an assessment strategy to determine a series of competencies prior to accreditation as a fully-fledged GP.

The first cohort of doctors (other than those already involved in widespread pilot studies) began their foundation programme in August 2005. New funding has been identified to create opportunities for 55% of the 2005 cohort and 80% of the 2006 cohort to spend 4 months training in general practice during their second year. We are therefore on the brink of realising a long-standing ambition for all doctors to experience a period of postgraduate training in general practice. However, already suggestions are being made that the

training opportunities should be transferred to meet the increased pressure in emergency departments.⁵

One of the essential planks of Modernising Medical Careers is a more structured approach to training programmes with less time spent in posts that are unlikely to contribute towards the certificate of completion of training (CCT) and clear entry points to all programmes. This will need expert careers information and advice so that young doctors enter a programme that will equip them to work in a specialty which will suit their aspirations and ability. Young doctors will have new opportunities to understand their preferred working environments, enabling them to make more informed career choices.

Modernising Medical Careers has opened new opportunities for GPs to take a more active role in the development of all doctors; general practice educators are beginning to work more closely with their hospital colleagues to deliver the foundation curriculum. We can therefore open new vistas on the potential opportunities that the White Paper and changing patterns of healthcare delivery will offer and the role that high quality general practice will play. As the role of the GPwSI increases, hospital-based specialists are likely to become more specialised, managing acutely ill patients or providing expertise for patients with chronic disease that fall outside the capabilities of the GPwSI.

The study from Yorkshire⁶ has identified a