Implications of the new GP contract

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ABSTRACT – A new contract for general practitioners (GPs) was introduced in the UK on 1 April 2004 which has implications for secondary care. In particular, the contract means that GPs can opt out of out-of-hours care, and accident & emergency services have voiced their concern that their workload may increase as a result. The new contract provides the potential for a rise in GPs' salaries by two means: through the provision of the Quality and Outcomes Framework which includes the management of 10 common chronic diseases; and through 'Enhanced Services', which are a series of optional 'extra' more specialised services with national specified standards that can be commissioned by primary care organisations (PCOs).

KEY WORDS: chronic disease, continuity, gatekeeper, out-of-hours care, primary care, quality

In June 2003, general practitioners (GPs) in the UK overwhelmingly (80%) supported a new contract to be introduced on 1 April 2004. It has been hailed by some as the biggest change in their employment terms since the NHS was founded in 1948. As well as being paid for 'essential' services which are the core activity of a GP's daily work, GP practices would receive additional income for 'quality' in relation to defined chronic diseases and the organisation of primary healthcare services. Furthermore, this new contract could enable GPs to provide and be paid for 'enhanced services' traditionally confined to hospitals, and so formalise the recent concept of GPs with Special Interests (GPswSIs). There are obvious implications here for the delivery of services in secondary care.

Continuity of care

The Government and negotiators hope that patient care will improve as a result of the new contract. However, this is unknown, as a pivotal change of this new contract is that patients will no longer be registered with an individual GP, but with a GP practice. Patients are likely to see a greater range of primary care practitioners, rather than simply a GP. This could be a healthcare assistant, a practice nurse, one of many other healthcare practitioners from the primary healthcare team (PHCT), or a GP. Some have argued that this could be the end of the traditional doctor–patient relationship, continuity of care and the personal doctor. Furthermore, as many GPs opt out of out-of-hours care, this will further fragment continuity of care, and accident & emergency (A&E) services have voiced their concern that their workload may increase as a result.

If GPs are no longer responsible for individually registered patients, but the practice is, what will happen to the concept of a GP principal? Will GPs become 'consultants in primary care'? The terms 'principal' and 'non-principal' no longer apply and all are GPs whether as partners, salaried doctors or locums, and these doctors have been transferred from the supplementary lists of primary care organisations (PCOs) to lists of 'medical performers'. (Any doctor with certificated vocational training in general practice who wishes to perform general medical services or personal medical services in primary care will have to be included on a PCO medical performers list from 1 April 2004.)

Components of the new contract

The components of the new contract are organised into three categories of payment:

(1) the 'Global Sum' (GS), which is based on payments under the 1990 GP contract
(2) Quality and Outcomes Framework (QOF)
(3) Enhanced Services.

The QOF and Enhanced Services are new and additional means of payment to practices.

Quality and Outcomes Framework

Under the new contract, GP practices may choose to provide only essential care for patients who are acutely or chronically sick and gain reimbursement through the Global Sum, or to offer a wider additional range of defined services through the QOF and Enhanced Services. It is anticipated that quality of care as stipulated by the national framework of standards (quality indicators) of the QOF will be an important focus for GP practices. To many, the QOF is the salient feature of the new contract, as it is an area which has been given new monies and therefore has the potential to generate additional income. The

QOF and the associated quality standards have been developed from many sources and negotiated by the General Practitioners Committee (GPC) of the British Medical Association. Sources include the NHS Confederation, the quality improvement models such as the Quality Team Development Programme of the Royal College of General Practitioners (RCGP), the RCGP Practice Accreditation Scheme and the PRImary Care Clinical Effectiveness (PRICCE) scheme. The latter was piloted in East Kent from April 1998 using practice incentives to implement many of the organisational standards developed by the RCGP.

There are a total of 1,050 quality indicator points annually that can be attained and claimed for financial reimbursement. The QOF has been organised into four domains:

(1) clinical (comprising 10 chronic disease areas)

(2) organisational (five areas)

(3) additional services (four areas)

(4) linked payments (two areas relating to patient experience).

Each area is subdivided into individual quality indicators which are described in two publications[1,2] and are therefore not detailed in this article. Standards have been set for varying levels of achievability where the number of points gained for an indicator varies according to the threshold that is achieved. For example, a minimum threshold may be 25%, and the maximum threshold may be 90% which will gain the full possible allocation of points for a quality clinical indicator.

There are 10 clinical areas in the first domain of the QOF which relate to chronic disease management and this will be of particular interest to those working in secondary care. These are listed in Table 1, together with the number of available points. There are 550 clinical quality indicator points, and so just over half the available total points (1,050) reside in this first domain, with a considerable potential impact on secondary care.

Disease registers will be created for all of the chronic diseases shown in Table 1 and if targets are met, eg in relation to annual reviews, achieving optimum blood pressure control, achieving smoking cessation, ensuring patients are taking appropriate medications and receiving influenza vaccinations where indicated, then hospital referrals and admissions may be reduced as a result.

The remaining 500 points are divided between the three other organisational and service domains, as shown in Table 2.

Quality assurance in relation to prescribing, continuing professional development, child and women's health and patient satisfaction will therefore be rewarded financially. However, this and all other data must be appropriately coded on GP practice computers in order to receive this reimbursement. Therefore all practices will need to be computerised or they will not survive.

Everything that is in the QOF has an evidence base and was not simply felt to be 'a 'good idea'. The quality indicators are specific and measurable elements of practice outcomes that can be used to assess the quality of care. The focus is very much on quality rather than quantity, so practices are paid for the percentage of defined targets that are achieved and not just the number of patients seen. There is 'extra' income, but there is also 'extra' work required to facilitate a long-awaited pay rise for GPs. Some doctors may argue that the targets set are unrealistic and in some situations may not be achievable.

There is debate about whether this voluntary form of clinical governance contains the most important indicators and standards. They may not always match existing targets set in the National Standards Frameworks (NSFs) and by the National Institute for Clinical Excellence (NICE). For example, in relation to the third chronic obstructive pulmonary disease quality indictor (COPD 3), five points are available for where the

Table 1. The clinical domain of the QOF.

Clinical domain	Available points
Coronary heart disease	121
Stroke and transient ischaemic attacks	31
Hypertension	105
Diabetes mellitus	99
Chronic obstructive pulmonary disease	45
Epilepsy	16
Hypothyroidism	8
Cancer	12
Mental health	41
Asthma	72
Total	**550**

Table 2. Organisational and service domains of the QOF.

Organisational domain	Available points
Records and information	85
Information for patients (communication)	8
Education and training	29
Medicines management	42
Clinical and practice management	20
Total	**184**
Additional services domain	
Cervical screening	22
Child health surveillance	6
Maternity services	6
Contraceptive services	2
Total	**36**
Patient experience and linked payments domain	
Consultation length	30
Patient survey	70
Holistic care	100
Quality practice	30
Access bonus	50
Total	**280**
Grand total	**500**

diagnosis has been confirmed by spirometry including reversibility testing. However, NICE guidelines published in 2004 suggested that reversibility testing was of no benefit.[3] The NICE guideline for the management of type 2 diabetes published in 2002 recommends a target for treatment of 140/80 or below,[4] whereas the twelfth diabetes quality indicator (DM 12) of the new GP contract recommends 145/85 or below. Similarly, the sixth quality indicator for coronary heart disease (CHD 6) recommends a blood pressure target of less than 150/90 whereas the CHD NSF published in March 2000 sets the standard to 140/85 or less.[5] Despite this debate, the intention is that the QOF should:

- reduce morbidity
- reduce mortality
- improve the patient experience.

Perhaps one of the great advances that will be achieved from these quality indicators will be the electronic summary of patient records. Funding is now being allocated to universal electronic patient records that can be used in both primary and secondary care, but debate continues as to what they should contain. The electronic summaries generated by quality indicators have the potential to form the basis of the proposed universal records.

Enhanced Services

Common chronic diseases such as hypertension, epilepsy and diabetes are covered in the QOF. Enhanced Services, however, are a series of optional 'extra' more specialised, innovative services to be financed by the new contract which GP practices, through GPs, nurses and other allied healthcare professionals, may choose to provide. Enhanced Services are over and above those defined as part of the Global Sum, but provided to a higher national specified standard that can be commissioned by PCOs. Enhanced Services are a further aspect of the new GP contract 'language' and fall into three categories:

- Directed Enhanced Services (DES)
- National Enhanced Services (NES)
- Local Enhanced Services (LES).

Directed Enhanced Services are viewed as 'essential' services and include:

- improved access, where patients can see any primary care practitioner in 24 hours and a GP within 48 hours
- quality information preparation through note summaries
- childhood vaccinations and immunisations
- influenza immunisations
- extended minor surgery (more than curettage, cautery and cryotherapy)
- care of violent patients.

The aim of NESs and LESs is that some areas of secondary care should be undertaken by GPswSIs who may be able to run a community clinic for a local cluster of practices. This has the potential to reduce the number of referrals and therefore cost of referrals to secondary care, and to relieve secondary care of a heavy workload in particular specialties.

In the absence of a national accrediting body, the accreditation routes to becoming a GPwSI vary between different PCOs. The RCGP has recommended that each person seeking such accreditation should maintain a portfolio of appropriate experience and training where they can demonstrate core competencies in their proposed area of specialist interest. Each PCO should check the Department of Health website (www.dh.gov.uk) to see if relevant guidelines exist before using these GPs to run a LES where the need for a clinical service has been identified. The Department of Health, in conjunction with the RCGP (www.rcgp.org.uk), have produced guidelines for appointment of GPswSIs to the areas of clinical care shown in Table 3.

NESs are recommended additional services under the new GP contract and these are detailed in Table 4.

LESs are local additional innovative services which should be piloted and evaluated. The QOF tends to cover important chronic diseases associated with high morbidity and mortality. However, it could be argued that many other important conditions have been omitted from the framework; these will vary

Table 3. Areas of clinical care where guidelines for the appointment of GPswSIs have been produced.

Care for older people	ENT
Child protection	Epilepsy
Coronary heart disease	Headaches
Dermatology	Mental health
Diabetes	Musculoskeletal conditions
Drug misuse	Palliative care
Echocardiography	Respiratory care
Emergency care	Sexual health

Further details are available on a dedicated website: http://www.gpwsi.org/subindex.shtml

Table 4. National Enhanced Services (NESs).

- Intrapartum obstetric care
- Near-patient testing – monitoring of anticoagulation
- Near-patient testing – monitoring of patients being treated with penicillamine, sulphasalazine, Gold injections, auranofin or Methotrexate for rheumatoid arthritis or Methotrexate for psoriasis.
- Intra-uterine device (IUD) insertions
- Specialised sexual health services
- Specialised alcohol misuse services
- Specialised drug misuse services
- Specialised depression services
- Specialised services for patients with multiple sclerosis
- Care of the homeless
- Immediate care and first response
- Minor injury care

between localities and could form the basis for LESs. The following may be considered for LESs:

- health of asylum seekers
- health of non-English-speaking patients
- patients with learning disabilities.

Other areas likely to be commissioned include:

- neonatal examinations within 24 hours of birth
- care of patients in nursing homes
- area-wide in-hours home-visiting schemes.

Further areas where GPswSIs could be involved include:

- endoscopy
- dermatology.

Franchising of services

Doctors in both primary and secondary care are concerned about services that could be franchised out by PCOs in an attempt to achieve more financially competitive enhanced specialised services. LMCs are pressing PCOs locally and the DH nationally to define exactly what are 'core' or 'essential' services and that practices are rewarded for additional services such as the NES for Minor Injuries. If practices argue under the new contract that for example, a service such as Minor Injuries is not a core service and the PCO will not commission this service as a NES or LES, then this has implications for an increasing secondary care workload.

PCOs will be free and able to commission whatever Enhanced Services they consider appropriate to meet local health needs above a guaranteed minimum level of investment. In essence, PCOs can be viewed as providers. However, these services will be performance managed by the strategic health authorities (SHAs).

The GP as the gatekeeper to secondary care

The new contract provides increased scope for collaborative working between practices working in the desired 'clusters' of the new contract, across primary care, as well as with secondary care and social services. (Already terminology is changing as clusters have now been renamed 'primary care development groups'.) But what if GPs decide to opt out of providing 24-hour care, immunisations, IUD contraception or chronic disease management? PCOs will have to take on the responsibility and commissioning costs for providing alternative providers and instead of much of a patient's care being available in a single practice in one location, they may have to travel to different practices for different services. Ultimately this has the potential to further fragment primary care and its coordination under the original gatekeeper – the GP.

In an attempt to increase patient choice, patients may be able to register with more than one practice. This may be required, for example, as the place they live may be very far away from where they work. Quality of care may be compromised as the necessary patient records may not be available in the absence of a universal shared patient-held NHS electronic record. However, concurrent IT changes predicted in the NHS may overcome this difficulty. Nevertheless, this poses a dilemma for secondary care. To whom in primary care should they direct their correspondence?

Key Points

GP practices will receive additional income for 'quality' in relation to defined chronic diseases and the organisation of primary healthcare services

Funding is now being assigned to universal electronic patient records that can be used in both primary and secondary care, but debate continues as to what they should contain

The aim of national and local Enhanced Services is for some areas of secondary care to fall into the province of GPs with Special Interests who may be able to run a community clinic for a local cluster of practices

A concern that doctors in both primary and secondary care share will be about those services that could be franchised out by primary care organisations in an attempt to achieve more financially competitive specialised services

The new contract has the potential to further fragment primary care and its coordination under the original gatekeeper – the GP

The future

In the BMA, 'Contract News' (April 2004), the then Chairman of the GPC wrote, 'The contract is not perfect and we are by no means complacent'. He went on to say, 'The contract is an evolving contract and its development is an ongoing process.' He emphasises how the GPC will continue to work on the problems and concerns that arise as a result of the implementation of the new contract. The new contract will succeed or fail depending on the future partnerships between GPs and PCOs and has potential impacts on secondary care relating to workload and the commissioning of health services.

GPs should not to lose sight of their two key 'specialist' areas which are traditional general practice but difficult to measure objectively through the new contract and are widely believed to be valued by patients. First, the continuity of care provided by a trusted personal 'family' doctor and second, working as generalists knowing their limitations, where to refer for specialist input and when.

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