

Notes from Visit to
National Primary Care Research
and Development Centre,
University of Manchester, England
May 31 - June 1, 2005

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Executive Summary - Brief Synopsis of Visit

**Manchester, England
May 31, 2005-June 1, 2005**

Primary care is a foundation of effective, sustainable health care systems. The small to medium sized office remains the single largest platform of formal medical and health care, and the offices of primary care physicians are being actively re-designed now. This redesign is complicated and filled with opportunities to improve and also to diminish the desired effects of primary care, e.g. access, comprehensiveness, longitudinality, efficiency, and equity. It is not a tweeking that is proceeding apace; it is a re-make.

The variation in health care arrangements and policies across nations is known to present opportunities to assess differential effects that otherwise would go ignored. There are immediate opportunities to learn across national boundaries about what is working and how well in primary care. Such knowledge can find immediate application in the changes being made, and is far from “academic.” The UK’s primary care system, despite being acknowledged as a strong primary care system, is in the midst of dramatic changes orchestrated via the National Health Service. The relatively poor performance of US health care has provoked a willingness to change that in a well performing system would probably not exist. This combination is potent and represents immediate opportunities for decision-makers in the US and the UK to guide the “re-make” of primary care with more real world experience than is available in either nation alone.

The attached report is an unpolished narrative of an exchange in early June of 2005 between representatives of the Robert Graham Center in Washington, D.C. and the National Primary Care Research and Development Centre in Manchester, England. It was not requested by any organization, but rather grew out of both of these Centers’ work and is being shared with a small number of individuals in leading organizations known to be invested in improving primary care. Perhaps one or more such individuals will see in this report opportunity relevant to its current efforts and worthy of action. Its content has been reviewed and edited for accuracy by the leadership of the Manchester unit.

Ten examples of “30,000 foot level” conclusions the exchange visitors reached, on the basis of the specifics they learned during the visit are:

1. The primary care function is out of balance in both the UK or the US. What primary care can do (especially in both acute and chronic disease care, both primary and secondary prevention, and uniting public and mental health with medical care), is much larger and of greater importance (effectiveness) to both the US and UK than previously.

2. Primary care's systems of care delivery and its business plans are not adequate in either the US or UK for the tasks government, the public, and intermediaries expect primary care to achieve. It must be re-designed and is in the midst of redesign in both countries, right now. New operating definitions of continuity and comprehensive service are needed.
3. Experiments in primary care delivery abound in the US and the UK; and decisions are being made quickly, with only preliminary or no evaluation. Imbedding evaluations in new approaches/programs and responding to their findings in nearly real-time is possible in both the US and UK. Sharing findings from real-time evaluations can also occur quickly, to mutual advantage.
4. No one knows how to structure the revenue streams to cover the costs of primary care, but it is clear that further investments in primary care are necessary to garner its powerful, salutary effects for entire populations.
5. Pay for performance is having an effect on primary care practice, sometimes for the better. It may be necessary in the US to agree on a denominator (register of patients for which the practice can be held accountable) for all practices to use in assessing their performance.
6. Teamwork is no longer elective in primary care, and a huge gap exists between the teamwork that is now feasible through asynchronous, information-technology enabled care, and what is happening. Many case studies are in play on both sides of the Atlantic, under differing conditions. Training and educational strategies for teamwork among health professionals are lagging badly in both the US and UK, and this is likely to emerge soon as a rate-limiting step in high-performance primary care.
7. The profession of medicine practiced at the frontlines of health care is at risk in both the US and the UK. It need not be, but some approaches now underway may convert being someone's doctor from work and a calling to a job with a rulebook.
8. Both the US and UK are over-consuming international medical graduates, probably to their advantage but likely to the detriment of other nations.
9. The practice as a unit of analysis is crucial, and measuring practices, difficult as it is, is progressing in both the UK and US.
10. Establishment in the US as already in the UK, of standard practice information systems can be linked to aggregate data to measure performance. Standards for IT systems are great enablers of progress in redesigned primary care, more visible in the UK than US. Because the nature of primary care incorporates an ongoing relationship with patients, these IT systems desperately need to incorporate classification and terminology (new metrics) sufficient to create episodes of care and standardize assessment.

It would be advantageous for key US organizations to sustain for the foreseeable future exchanges with other countries to enable the US to see itself more clearly and import innovations of relevance. The UK presents immediate opportunities with great promise including updates concerning Scotland's situation and a

regular series of exchanges with the National Centre in Manchester and their associates. Much can be shared via the internet, but there is no adequate substitute for face-to-face dialogue.

Other visitors would see other things and draw other conclusions. It is not as if there is little to learn from one another. Rather it is how much can be learned that can find prompt application in the redesign of primary care that is underway. Individuals and organizations in both the US and UK could benefit from a steady diet of exchanges.

Visit Notes

The National Primary Care Research and Development Centre and Others Manchester, England May 31-June 1, 2005

Background

Initiated by Larry Green, the Centre graciously engaged as guest visitors from the US, Dr. Martey Dodoo (economist and demographer at the Graham Center) and Dr. Green (family physician, senior scholar in residence at the Graham Center and director, Prescription for Health at the University of Colorado.) The context, purpose, timing, and specific questions guiding the visit are attached as exhibit 1.

The primary purpose of the visit was to learn about GP compensation and the quality framework being used in general practice in the UK in the context of the new GP contract. Preparatory work for the visit consisted of reviewing multiple reports generated by the Centre via their substantial website, a report of a prior visit by Dr. Robert Phillips, director of the Graham Center, and a manuscript in preparation by Centre staff concerning the financial incentives to improve the quality of primary care in the UK.

Main Questions used as framework for our discussions:

1. What elements of the new contract and its approach to compensation of general practitioners are: (a) welcomed by both the NHS and GP's? (b) in dispute (and why)?
2. What is presently known quantitatively about the impact of the new arrangements on (a) the expenses and (b) the revenues of general practices?
3. What is presently known quantitatively about the impact of the new arrangements on (a) clinical services and (b) any measured clinical outcomes?
4. What are your best guesses about #2 and #3 above for ongoing evaluations not yet completed?
5. So far, what in your judgment have been the best and worst effects of the new contract and its compensation mechanisms? Which elements of the new contract had the best and which had the worst effects?
6. What have been the new contract's net effects on basic service characteristics like: patient panel, size of practice, hours of patient care, collaboration with nurses and other non-physician clinicians?
7. Based on everything you know about general practice and its economics, what do you now think about compensation mechanisms that include a blend of capitation(or physician salary), premium payments for

- robust/extended services, and incentive payments(bonuses) for achieving particular goals of service delivery or clinical outcomes?
8. If you were required to install in general practice a blended compensation scheme as outlined in #7 above, what would be the distribution/range of the amounts of compensation attained through each of the 3 components?
 9. In your opinion, what is the most important source of influence for general practitioners now in the UK?
 10. How are general practitioners feeling now in the UK, in general, and specifically concerning the new contract? Is there a consensus setting up?
 11. When will formal evaluations of the new contract and GP compensation be available and how can we access them?

These notes constitute the report of the visit and are organized into four sections with 18 accompanying exhibits. The first section is brief and basic background information on the UK's national health service (NHS) system, primary care in the UK, and the four primary care organizations visited in Manchester: the national primary care development team (NPDT), a local primary care trust (PCT), a local GP practice, and the Primary Care Research and Development Centre (NPRDC). The second is commentary based on answers to the 11 questions formulated in advance of the visit and used as a framework for our discussions. The third is additional commentary derived from discussions during the visit with, in some instances, conclusions or further questions developed during the visit. The fourth section is comprised of brief summary comments by the two visitors, Dr. Green and Dr. Doodoo.

Section One

The NHS in the UK was set up 56 years ago and is recognized by the World Health Organization (WHO) as one of the best health and social services organizations in the world. The NHS is managed by the Department of Health and currently involved in programs and setting national standards to improve quality of services and transform organization to cope with the demands of the 21st century.

The NHS's Modernization Agency has a National Primary Care Development Team (NPDT) based in Manchester. We talked to:

- Sir John Oldham, who is Head of NPDT. He got his knighthood from his work on the impact of the NPDT.

The Department performs its functions through a series of Strategic Health Authorities. The plan for improving health and social services, increasing capacity when needed and ensuring high quality services in their local areas. Primary Care Trusts (PCTs) are local health organizations managing the provision of all health services in the UK. They now get about 75% of the NHS budget, and are responsible for planning primary care and its interface with

secondary care in the UK. We talked to two key staff of the Central Manchester Primary Care Trust:

- Karen O'Brien and Jodi Kelly, PCT managers with responsibility for implementing different aspects of the new GP contract.

The PCTs closely manage all GP practices in the UK. We talked to a staff member with primary responsibility for new contract activities in the Robert Darbishire Practice, a large local GP practice:

- Ms Anna Thomson, Quality Improvement Facilitator, who has day to day responsibility for producing the data needed to claim payments under the new GP contract.

Also based in at the University of Manchester and collaborating closely with the University of York is the National Primary Care Research and Development Centre (NPCRDC), a multi-disciplinary, academically independent centre, established by the Department of Health in 1995 to undertake policy related research in primary care. Their function and activities closely match those of the Robert Graham Center. They have responsibility for evaluating the new contract. We talked to:

- Professor Martin Roland, Director of NPCRDC, professional host for the visit, advised on who to talk to, set up all the meetings and talked to us at various times throughout the visit.
- Professor Bonnie Sibbald, Deputy Director of NPCRDC, and expert on Physician Workforce studies, talked to us on short notice about workforce and new contract issues.
- Dr Stephen Campbell. Project manager of the "Quality and Incentives in Practice (QuIP)" project, evaluating the impact of the quality and outcomes framework of the new GP contract at NPCRDC
- Professor Hugh Gravelle Professor of Economics at NPCRDC's base at the University of York.
- Dr. Aneez Esmail, Senior Lecturer in General Practice at NPRDC.

Section Two

1. What elements of the new GP contract and its approach to compensation of general practitioners are:

a. welcomed by both the NHS and GP's (why)?

Martin Roland stated that generally the UK's GPs do not like change, however this time, GPs welcomed the notion that the NHS believed they could provide high quality care that was worth paying for. This view promotes effective working relationships between the NHS and GP's. Also received well by both are: (1) reassignment of after-hours

coverage from individual GPs to other organizational arrangements, and (2) evidence based indicators of quality practice.

Note: John Oldham suggested: The move toward revisions that emphasized quality started in 1996 and by 2003 a ground swell of acceptance by about 1/3 of GPs culminated with a shift toward getting paid as a practice responsible for a population, not just because you are a doctor. Actually having a population for which you are accountable= the key idea for quality measurements. "Don't diminish patient choice of their physician, but sustain registration." NHS Direct- "will not destroy listed practice." Getting paid for quality rests on this denominator that makes possible explicit payment for quality and permits establishing the principle that hence forward doctors will be paid for the quality of their work and its effects.

b. in dispute (why)?

Initially (early 2004) GP's were greatly concerned about a negative impact on continuity, an erosion of personalized care, and behavior changed for money with an attendant loss of "professionalism"—but it is still too early to tell what effect is actually achieved. Steve Campbell's guess is that the GPs absorbed the changes but may not have engaged fully the new approach or accepted it. There are mixed feelings about introduction of market forces into the work of GPs. While GPs don't like being told what to do, they "will grab the money anyway."

What belongs in the base pay and what belongs in incentive.

What to do when the evidence for indicators is viewed as weak.

The robotic loss of connection with the patient precipitated by completing the Quality and Outcomes Framework (QOF) data collection procedures.

Too easy for GPs to do well (according to the newspapers) and almost no discussion of the non-clinical indicators nor the importance of infrastructure development for general practice.

How to incorporate measures of listening, completeness of care, and patient safety.

How to use the elements available in the new contract to enable general practice to work further with other disciplines to efficiently establish a full range of services for people.

How much can be achieved how fast—the plan now is apparently to achieve full commissioning (revised fund-holding) by all GPs and robust, valid QOF in full swing by 2008, with some regular revisions anticipated.

The ability of the PC Trusts to simultaneously be the carrot and the stick to improve GP.

The distribution of the NHS money between the hospitals and the primary care sector with hospitals still getting approx 85% of the money.

Will the new contract and QOF destroy or save general practice?

Note: John Oldham could identify no unanticipated consequences, other than higher than anticipated point scores and their associated expense for the NHS.

2. What is presently known quantitatively about the impact of the new arrangements on:

a. the expenses of general practices?

Hugh Gravelle: “No clue.” There is a group of accountants (AISMA) working on this, with their work showing up in the news in late May.

Karen O’Brien and Jodi Kelley (PCT): Some practices rewarded staff with the point money, e.g. as much as 1000 pounds each. No idea what the money was actually spent on.

Karen O’Brien and Jodi Kelley (PCT): Nurse time has been extended.in the practices.

(The PC Trusts are responsible for paying for practice computer systems and are spending much more for broad-band connectivity and software.that supports the new contract and the QOF)

Big pressures on improving the space of GP to absorb new services and escape “rabbit hutch” conditions.

b. the revenues of general practices?

Martin Roland suggested that the period of implementation of the new contract has not been long enough to allow for determining if there have been any meaningful impacts yet. Up to 30% of practice income

is now arriving via the quality points and practices distribute it differently, from bonuses for all staff to GP's pocketing all of it (confirmed by several individuals). Hugh G: "They are getting more money, about 20% more (gross) income, probably looking at 10-15k pounds on an average income of maybe 80k pounds. Probably will get more accurate impact estimates from tax records later." Martin expects that the additional funds at the Robert Darbishire Practice will be used to hire an additional nurse practitioners and a pharmacist.

3. What is presently known, especially quantitatively, about the impact of the new arrangements on (See Exhibit 2):

a. clinical services?

On average practices are getting about 950 points and are showing a ceiling effect.

The practices fall on a u-shaped curve, with some doing very well, more in the middle, and some doing badly—with the PC Trusts most interested in the best and worst.

It is known that the total points earned were higher than predicted, but how this "point performance" affects actual services and outcomes is "anyone's guess now."

Practices indeed have a culture that is probably persistent over time and not readily altered.

The new contract probably has accelerated rate of change of services provided by general practitioners.

Practices are working hard and hiring staff to use common codes, (Read Codes—several individuals asked us what SNOMED was), with noted improvements in reported data accuracy.

There is a belief among many that the QOF is changing GPs from doctors with a vocation to doctors with a job.

b. any measured clinical outcomes?

Clinical audits show improvements from 1998 to 2003 for angina, asthma and diabetes.

Hugh G: "There are no routinely collected clinical outcomes associated with the contract . . . I would doubt it would impact mortality, which is available."

John O: There are data now that show improvements in coronary heart disease and diabetes baseline measures following the introduction of the new contract. Similar data are available now in Scotland, Wales and Northern Ireland using before and after type analyses.

PCT representatives reported a decline in mortality accompanying increased prescribing of statins and also declines in admission rates.

4. What are current best guesses about #2 and #3 above for ongoing evaluations not yet completed?

John O: Unlikely to be adverse consequences from patients' perspectives. The new contract makes it easier for PC Trusts to commission and take charge of practice services—which perhaps should be left with the practices.

Martin R.: identified (1) patient dissatisfaction with GP's letting go of out of hours coverage, (2) increased demand for nursing services by GPs to provide the protocol-driven care, and (3) required large further investments in computer systems to be unintended consequences of the new contract.

5. So far, what in the Centre's judgment have been the best and worst effects of the new contract and its compensation mechanisms?
 - a. Which elements of the new contract had the best effects?
 - b. Which elements had the worst effects?

(Note: These are incorporated as possible in other segments)

6. What have been the new contract's net effects on basic service characteristics? (This question necessarily morphed into what is likely to be the effects)
 - a. patient panel size?

In a system that assures universal inclusion, many expect this will be driven mostly by the number of GPs; and the contract's increase in compensation for GPs is likely to increase the number of GPs and thereby possibly reduce panel size.

- b. size of practice?

Steve Campbell fears it will disincentivize the solo practice, a type and scale of practice that could remain very important. Hugh Gravelle thinks there has been a steady increase in practice size. Practices now average 3.5 to 4 GPs with 5,000 to 6,000 patient panels and this has been trending up for about the last 20 years. The new contract is probably unlikely to reduce the size of practices, but whether it would cause further practice size increases is uncertain. To reduce the additional average overhead costs for collecting data for the QOF and obtaining points for the new contract, some practices may find economies in merging with other practices and thus decreasing the number of practices but increasing practice sizes.

Sir. John suggested that some practices will not be able to respond and will go away, not so much as closures, but as mergers to scale up. He also predicted fewer equity partners, more salaried physicians, and new equity partners such as nurses. Hugh Gravelle speculated that over time there have been relatively more women GPs than men GPs.

c. hours of patient care?

There is skepticism about the adequacy of available data. Hours worked is solicited in the Centre's practice assessments—so will get a feel for this in their survey. Hugh G is working on some estimates of numbers of consultations per patient.

Aneez Esmail suggested that there is a definite impact on after-hours coverage with a reduction in hours on call for GPs. New money showed up from the government for the new organizations to do the call. A GP could accept a 6,000 pounds loss by not taking call, and then agree to work for the new coverage organization for considerably fewer hours and get paid at a higher rate, mitigating the negative financial effect. Some of the other experts we talked to confirmed this. The PC Trust representatives indicated that patients were not necessarily pleased with being redirected to other locations for care.

d. collaboration with medical specialists?

A broader range of services is being provided via GPs, sometimes with medical specialists attending to patients in GP settings, typically in parallel, not together.

e. collaboration with nurses?

GP's are hiring more nurses to do more things necessary to get the new GP contract points and additional compensation. This is creating

market pressures that are raising salaries for nurses. Anna Thompson suggested that the new emphasis on quality has changed most (i.e. had the greatest impact on) the role of the nurses, which has not necessarily been viewed as positive by the nurses.

f. collaboration with other non-physician clinicians?

New types of “assistants” are forming, specifically to help people self-manage their conditions and also to broaden services provided by GP’s. Some are called “physician assistants,” but they do not necessarily or typically reflect the skill set of US PAs. Also new administrative positions are emerging, such as IT support and staff to track and manage strategies to get more points, and these may not be affordable by smaller practices. Currently cannot get hard data on this and very few examples exist.

g. other? The QOF permits “cherry-picking,” “cream-skimming.” The Central Manchester PC Trust has already seen patients changing practices at a higher rate.

7. Based on everything known now by the Centre and others about general practice and its economics, what is the thinking about compensation mechanisms that include a blend of capitation (or physician salary), premium payments for robust/extended services, and incentive payments (bonuses) for achieving particular goals of service delivery or clinical outcomes?

The compensation system is likely to do best with a blend of some sort of capitation with additional targeted payments for service.

John O: “We will never go back to not paying for quality.” The QOF and new contract will be reassessed in 2008 at end of the UK budget cycle, and the priorities of the newly-minted directions will be reconsidered, revised and propelled onward.

8. If the Centre were required to install in general practice a blended compensation scheme as outlined in #7 above, what would be the distribution/range of the amounts of compensation attained through each of the 3 components?

	Salary	Premium	Incentives
John Oldham	60%	10%	30%
Steve Campbell	20%	40%	40%
Hugh Gravelle	75%	-	25%
Karen and Jodi	70%	10%	20%
Anna Thomson	25%	25%	50%

Hugh G: Would roll more things into capitation payment and have 2 components (e.g. higher caps for working in shortage areas, being a senior physician)

9. In the Centre's (and others') opinions, what is the most important source of influence general practitioners have now in the UK?

John O: GPs influence has diminished in part secondary to societal reframing of the role of clinical and other professionals. What is different in the UK is that deliberate alternatives have been developed, and this reduces the perceived role of GPs by the public and the NHS. Now, many nominally in charge of primary care have not been intimately involved in primary care and have a view of it from other perspectives, e.g. secondary care and hospital perspectives. GP is now out of vogue and does not have a good name with the managerial/administrative personnel, but GP scores highly in surveys of public opinion. General practice's greatest strength is in community advocacy, which in part is threatened by the democratization of information, deprofessionalization, and a change in attitudes among entering GP's who see GP more as a job than a profession—a profession that they are not prepared to receive or ready to handle.

10. How are general practitioners feeling now in the UK?

- a. in general?—impossible to know, no data source. The Centre has some data about worklife satisfaction: up in 1989, down in 1991, rising to 1998, dropped in 2002/3. Overall changes in structure of primary care are associated with drops in work satisfaction. Hugh Gravelle thinks some GPs consider the new contract as a way of controlling health expenditure. The NPRDC is redoing the survey in September 2005.
- b. concerning the new contract?

Not necessarily good or bad; just is. But all GP's seem to be trying to get as many points and as much revenue as possible. There is some persistent opinion that the new contract/QOF is a bad idea. (The Centre is planning to resurvey in 2005.

Martin thinks that might probably be significant gaming of the new system through exception reporting, He thinks the data is not available yet, but that there are rumors that in Scotland some indicators may be "exception reported" for 85% of patients.

- c. a consensus? No. Completely opposite views are being expressed.
- d. Scotland may be different, e.g. exemplifying some very successful developments in rural general practice.

11. When will formal evaluations of the new contract and GP compensation be available and how can we access them?

The broad categories of data (the quality points earned for what measures, some prevalence data, for every practice in Eng, Wales, and Scotland, with practices reporting both their denominator and numerator) for April 2004 - April 2005 will be publicly available for England and Scotland very soon, perhaps for Scotland in early June. (Should be accessible by web; Martey has Hugh's information to contact to locate the data set). Formal evaluation report using quality indicator data should be available in mid 2006.

The Centre's QuIP project has a cohort 42 practices that it will continue to assess to determine impact of the new contract.

Knowing the impact is sorely compromised by the near absence of prior measures of practice and few data about the nature of practices themselves. (Mike Pringle et al, e.g. has a large database on about 500 practices that may be useful) Hugh G: "Really big evaluations are not likely—we will have to settle for some before and after work." The things that can be tracked for sure over time to assess the effect of the GMS (General Medical Services) include admission rates for practices and prescribing and medication fills.

Section Three

The new contract is a standard contract, implemented locally quite differently.

The Quality and Incentives in Practice (QuIP) project is the main tool for evaluating the impact of the new contract on quality of care in general practice and teasing out what caused the effects observed (Exhibit # 2). QuIP has indicators additional to those in the new contract's Quality Outcomes Framework (QOF). Prior to the new contract, The NPRDC had 68 to 60 nationally representative general practices that it studied longitudinally. For the new contract evaluation however, NPRDC is studying only 42 - 48 practices because some practices have merged.

The old Personal Medical Services contract (standard for all) has been displaced by a General Medical Services contract that is individualized for each practice

(with 70% of practices now on the GMS with the PMS not applying to them)—but everyone is subject to the quality targets. In QuIP, they don't know when the GP's went PMS.

The QOF has 146 indicators - 56 about practice management with only 184 points, 76 clinical indicators with 550 points, 10 indicators for additional services with 36 points, and 4 indicators for patient experience with 100 points (see exhibit # 3). The patient experience indicators are now all process oriented, i.e. doing a patient survey and discussing it with the practice's PCT. The Centre has additional quality indicators in its studies from 1998.

NPCRDC uses QuIP to audit the practices (specifically on asthma, angina and diabetes (type 2) and patients are assessed separately by postal survey including assessing patient satisfaction. Then to assess what might be causing any detected changes, the NPCRDC questions the QuIP practices via practice questionnaires (e.g. team climate survey, job satisfaction questionnaire—for all staff—use components from at least 3 other surveys including some of Shortell's material) and a one-week diary for nurses (from NP's to proper nurses to medical assistant types) and another for physicians. (with about 69% physician and 78% nurse response.) NPCRDC also randomly select from their study practices 50% (about 20) practices for a telephone survey that is narrative. No narrative diary used. The Centre is the only location in the UK with the longitudinal “run-in” group of practices. Random samples of patients respond at rates in the upper thirties/lower forties. The Centre pays the practices to participate in this set of studies.

Steve Campbell reported work with 9 European countries trying to use common measures of practice and finding the differences in practice very challenging, and suggested efforts are at risk for setting the measurement bars too low.

There is talk of moving from multiple computer systems to ONE single UK office computer system, decided by NHS and paid for by the NHS—no timeline seen. Even though GP's have used the same code for about 5 years now.

Steve Campbell expressed support for solo practice and has concerns about changes that sweep GPs into larger groups to get the infrastructure, organizational competence, and financing of overhead. He also thinks there should be more emphasis on practice and nurses and less on GPs.

First comment from Steve Campbell about question 8 was that few GPs go into medicine for the money—rather to make a difference, and these new contract incentives are entirely monetary, making medicine a job rather than a vocation. The vocation needs to be addressed!

“Practice-based commissioning (fund holding by another name) was reintroduced in April of 2005 which entitles a GP practice to hold and manage the funds for

services (from just one or two aspects of care to virtually all aspects). The gov't anticipates that the practice could spend savings/gains on their practices, agreed to by a committee of the PC Trust. A number of ways are available to divert the funds to the GP, e.g. into premises that they could then sell and keep the proceeds. (Fund-holding was up to almost 50% when abolished)

"Commissioning" has been re-implemented with the objective of controlling cost and shifting money from one heading/bucket to another. There has been relatively little evaluation of fund-holding—Hugh G's work showed 3-5% reduction of admissions and similar sized effects on prescribing and shorter waiting times (about 5% shorter) in fund-holding practices. The reintroduction of practice commissioning is accompanied by other changes in contracting, and can be seen as an independent/additional policy option to the new GP contract. A number of fundholders are being quick to resume, increasing their power vis a vis the hospitals. As a condition of getting a budget, the commissioned practices must agree to offer patients' choices of 4 or 5 providers for various services.

Martin R suggested that the reintroduction of fund holding last April was in part due to frustration with the primary care trusts that are small and not being effective purchasers—"the hospital trusts are much more effective." The key issue is that for commissioning of general practices, PC trusts need to be large enough to be well informed and staffed to deal with the hospitals and also with expensive infrequent events, but small enough to discriminate on quality at the local level. Having ended it primarily on grounds of inequity and then regretted it the NHS has re-introduced fund-holding with a new name. Pay for results with hospitals happens to be being introduced simultaneously, e.g. correcting relatively low numbers and rates of operations esp by UK surgeons.

Another developing change being rumored currently is the possibility of permitting patient registration at multiple sites (?concurrently), a threat to the accountability of the GP-registered list. This is motivated in part by convenience-seeking such as seeing a doctor near work or at school.

Anna Thompson is an example of a new type of staff person in general practice. She is employed by the Rusholme Medical Center's Robert Darbishire Practice, an academic practice long associated with the University of Manchester. She earned a degree in psychology, is a trained teacher and was teaching in a primary school when she took her current job as a full time quality improvement facilitator at Rusholme Health Center. She was our contact there for this visit and provided a wealth of information. She started work at Rusholme "from scratch" in August of 2004 and is the only such person at the Center. A working group focused on the QOF has been set up comprised of the practice manager, GP's and staff to look at where the practice was and what it needed to do to respond to the quality points. Anna judged it to be a good thing that she and the practice were both NEW to the challenges. She explained the "QOF":

1. The practice was doing much of what the contract called for but not documenting it. Documentation required setting up new data software systems.
2. The Center had just brought in a new computer software system in May of 2004, and it permitted her to develop new systems that included templates of the values that were needed to report the points and to automatically produce Read codes.
3. The NHS provides QMAS (software nationally) that automatically takes from the practice's own electronic record once per month an automatic upload of the stipulated measures. Someone at the practice inputs via keyboard the organizational quality points. March 31 is the drop-dead date that determines payment. Feb 14 was called "national prevalence day" in which QMAS database established for each practice the prevalence of all the indicator areas.
4. She confirmed exception reporting (also due March 31) that permits leaving people in the prevalence report but not included in the calculations for quality points, e.g. a patient living abroad, who after 3 contacts could not be brought in.
5. The job of the quality improvement facilitator has evolved and the position has migrated from auditing various aspects of the practice to servicing the quality points effort.
6. Everyone refers to Anna as the QIF (Quality Improvement Facilitator) who does the QOF (quality and outcomes framework). She works 37 hrs per week.
7. Rusholme, by virtue of being a university practice and rather large (17,000 patients with 6 part time and 10 full time GPs and 4-5 practice nurses, 1 practice assistant, 1 NP who prescribes, no mental health staff and already had a practice manager and a non-physician practice director (who started in reception).
8. The GP opens patient record and if the patient's problem is on the quality list, a prompt appears and can be selected to list the measures for that problem. The system offers the patient the opportunity of an "informed dissent" option and can take them out of consideration.
9. The E-record has a drop down box that identifies for each patient what, if any, of the QOF items are pertinent to this patient and brings them up on request.
10. The record is created during the visit by the GP and entered. The system software assembles progress on quality indicators nightly and produces day-by-day status reports of each indicator. It resets to zero annual measures on April 1. (Subsequent discussion with PC Trust raised some questions about "zero," with the Trust suggesting that each patient's measures should role on their own annual time frame, not all benchmarked to April 1) The information system does monthly automatic uploads to a national data center that PC Trusts and NHS administrators can access and monitor.

11. There is an onsite audit of the practice by visitors that includes review of a random sample of patients for the practice to confirm participation/verify etc. The auditors largely follow a principle of trust at this point, just accepting as fact whatever the practice states.
12. Organizational indicators require documentation that is submitted in advance of the site visit.
13. The QIF in this practice with salaried physicians is not incented to get more points; she is just on salary, but she believes in other practices the QIF-equivalents are paid more for more points.
14. Overall, Anna reported positive reactions to the QOF by staff and GPs, based a lot on having succeeded beyond predictions. Patients are getting more contacts from the practice and some patients are getting more service.
15. She volunteered that patients with mental health problems only have 4 indicators, and she believes there will be others, anticipating revisions after 2 years of what the targets are.
16. Patients know via national news and publicity that GPs are being paid differently and occasionally raise it as an issue. But in general the patients are largely “oblivious.”
17. There are some, but very few, reports of patients asking for their practice’s data. There is a new law (public information act) that requires practices to provide a report of their performance on request by anyone visiting the practice as a patient (even someone from outside the country). Rusholme has had no requests. She suspects media requests are happening.
18. She indicated there is a spectrum of views of the staff—not by type of staff, but by person and longevity, with younger staff being generally more able to use the computers and more receptive to the QOF.
19. Anna expects further changes, but doubt paying for quality will go away.
20. She identified “encouragement to work as a team” as the best result of the quality framework. The worst effect is the extra workload that may not lead to benefit.

Karen O’Brien (pharmaceutical advisor/QOF lead/chronic disease management) and Jodi Kelly (4 years of practice management experience in GP before coming to the PCT/understands what it takes to change and do practice, advises on non-clinical quality indicators) at Central Manchester Primary Care Trust.

1. The QOF is the measurement aspect of the new contract.
2. The GPs saw the QOF as a pay increase, not a means to improve practice. Their competitive spirit was triggered, comparing to the practice down the street.
3. Overall, the GPs need to be more than “medics” and many don’t have the capacity to manage the business and measurement issues.

4. Many differences in how GPs use the additional compensation. Some are actually giving their staff one pound sterling per point they get.
5. KO: "I have grave concerns about the validity of the reports this year, that a lot of points were collected just by clicking a box on a computer."
Needed: validate that the data actually reflect what happened in the practice. Example: 90% compliance with an indicator not matched by equal prescribing. JK concurs that this is their greatest concern about QOF/great weakness at this point.
6. Acknowledged differential challenges of practices in poor and more wealthy areas and rewarding for easy work vs the harder work.
7. Data for clinical measures flow from practice to national data warehouse back to the PC Trust. The organizational measures are also transmitted at the late stages of the review to national warehouse, but these were done by hand according to a protocol provided by, reviewed and confirmed by the PC Trust which the Trust concludes sufficiency and reports back to the practice who then enters.
8. Great strength of QOF = getting practices to focus on what is important and starting standardizing care toward optimum.
9. The QOF results will be posted on the web for all the trusts. The prevalence data will also be known. (Unclear if it will be practice specific nationally, but will be at the level of the trust.)
10. The PC Trust is responsible for doing a 5% random sample of practices for an in-depth audit. Just inventing the process and details of how this will be done.
11. "We spend a lot of time with those practices that are lost, trying to bring them along, and they just want to fight with us."
12. Some PC Trusts have a patient group attached to their board.
13. Some QOF complaints include:
 - a. Danger of "Don't want to be too busy seeing patients that don't have quality points".
 - b. Everything had been done in such a rush
 - c. Not enough practice input to PCTs in planning
 - d. If additional compensation is not invested back into the practices it may lead to long term crisis (expected 50% of additional compensation would be ploughed back)
 - e. There are physical space issues in some practices.
14. The relation between the doctor and patient has been changing for the worse, causing a fracture – see the new GP contract as serving to heal the fracture.
15. Next year the compensation per quality indicator point doubles.

Workforce Discussion with Professor Bonnie Sibbald, Deputy Director of NPCRDC

We had an opportunity to also discuss the health care workforce with an expert, Professor Bonnie Sibbald:

From her perspective:

1. The US remains the country of choice for all International Medical Graduates (IMGs). It is seen as the land of opportunity, where you can always get a job and the quality of care can be outstanding. And, there is no national health service fixing the pay level of physicians, appealing to the most ambitious physicians. The US is viewed as “THE superpower,” known by its appearance on TV and the big screen movies. For all these reasons, the US tends to get first pick of the IMG’s, while the UK gets physicians in the “family chain” of the commonwealth trade routes.
2. India is training doctors for exportation, to the specifications of the importing nation. It is a big industry for India, confirming that there can be a return on a nation’s investment in producing doctors for another country.
3. The IMG’s are in fact a flexible mechanism to adjust for excess and deficiency in the worldwide marketplace for physicians.
4. “At least for the next 10 years, the “community-based physician” is a sure thing. But they are not necessarily for dealing with routine acute problems or ongoing, stable chronic problems.”
5. Since 2000, the NHS has been trying to plan the health care discipline workforces together.
6. ADAPTABILITY=the key objective in the training of physicians. Train in core competencies initially and then train “directionally” as desired/needed.
7. The new GP contract presumes that general practices with aggregate into larger groups and is actually “fuel on a burning fire” to expand the health care workforce in the UK—GP’s, information technologists, nursing, practice managers (vs a lead practice nurse or chief receptionist), new types of physician assistants, quality managers.
8. Practice managers used to manage paper records, IT staff and rostering. Now they are younger men, coming from other sectors of the economy (e.g.: the army) and are highly professional with degrees in management.

Section Four: Commentary

LAG Commentary

It is stunning how little is known about practices. This profound ignorance does not interfere in the least with grand schemes to modify them or any other part of the NHS.

The ability to distinguish in the UK the effects of the new GP contract from secular trends and confounding by other (frequent) policy shifts in the UK—is limited.

It is likely that what many see or fear as the demise of general practice is actually its renaissance. It is as if the environment is changing to make the space necessary to install new, high-performance, frontline medical practice.

Specialization is not the same as specification. Specifying general practice does not of necessity break it down into specialties, and fretting over whether or not general practice is a medical specialty could be replaced by full-throated specification of general practice to the considerable benefit of the profession and the public.

Not unlike the citizens of the US, the British people have changed: they don't trust the authority of the doctor, they expect a service that is reasonably convenient, and they make trade-offs between their relationships with their doctor and other objectives/realities of their lives, e.g. personal mobility, presence or absence of a chronic condition such as mental illness.

"We Brits have low expectations." "I feel guilty going to see my GP." "I feel lucky to see the same GP twice."=statements by KO and JK at PC Trust that really surprised me.

There is clearly an international marketplace in play that competes for the affection of physicians and others seeking meaningful, well-paid employment. Adaptability is a key attribute for the workforce being trained now.

Martin and others at the Centre agree that quantitative practice data don't correlate with quality at all and expressed interest in talking with Ben Crabtree et al. about methods of assessing practices.

John Oldham seemed to agree with the notion of an assistance organization to help the small to medium sized practice, providing services that the practice sees as "out-sourced."

In my opinion, the AAFP, ABFM and the Robert Wood Johnson Foundation would benefit greatly from a steady diet of exchanges with the UK and specifically the National Centre in Manchester.

Commentary by Martey Dodoo

Based on the discussions we had with the various experts and key players:

1. A good and fitting evaluation of the proposed national demonstration project of 20 family medicine new model practices would require the collection of suitable data on the 20 practices in at least two data points before and two points after implementation. We may want to describe a historical profile of family practices, define or describe our baseline for the

- evaluations, and create a system to collect data from the practices as soon as possible.
2. We may need to set the performance indicator bar lower initially in order to get “buy-in” after which the bar may be raised.
 3. In the national demonstration we may want to also test:
 - a. various compensation combinations
 - b. various organizational scenarios including team composition, staff qualification, that would promote the new model.
 4. In deciding what is the best measure of quality of care, should we also decide on whether to use the family doctor or the practice as the basic unit in evaluation of the new model.
 5. In developing quality measures or indicators we may also need to consider including rural and poor area incentives.

List of Exhibits

1. Visit Set Up – Background and Questions (3 pages)
2. PowerPoint slides – handout dated Jan 18 2005 – hard copy only (7 pages – 6 slides per page)
3. Quality and Outcomes Framework (QOF) (quality indicators – rationale for indicators, methods of data collection and monitoring – 114 pages)
<http://www.bma.org.uk/ap.nsf/Content/QualityOutcomes>
4. Quality and Incentives in Practice (QuIP) Study materials:
 - a. Workload diary for physicians - hard copy only
 - b. Workload diary for nurses of various types - hard copy only
 - c. Audit/Review forms for asthma, diabetes, and angina - hard copies only
 - d. Audit/Review forms for co-morbid asthma, diabetes and angina.(i.e. one of the other of the three conditions) - hard copies only
 - e. QuIP study - patient satisfaction survey – 8 pages – hardcopy only
 - f. QuIP study – Confidential GP and office staff questionnaire – 8 pages – hardcopy only
 - g. “Frontline 13: QuIP handout – 1 page – hardcopy only.
5. National Primary Care Development Team: NPDT-An Overview. Developing capacity and capability for public service improvement – 8 pages.
6. NPDT - Unique Care – Practice-based Clinic Disease management - 4 pages – hardcopy only.
7. GP Opinion Survey Report 2001 – 73 pages
<http://www.bma.org.uk/ap.nsf/Content/GPC+%2D+National+Survey+of+GP+opinion+2001>
8. GP Contract Framework April 2002 (BMA explaining new contract to GPs) (38 pages)
<http://www.manchesterlmc.co.uk/New%20GP%20Contract.pdf>
9. Minimum Practice Income Guarantee (MPIG) – 2 pages
10. Disease Prevalence factor (2 pages)
http://www.natpact.nhs.uk/uploads/Prevalence_guide.pdf
11. New GMS Contract QOF: Determining Aspiration payments for 2004/2005 Guidance Notes for Practices (8 pages)
<http://www.manchesterlmc.co.uk/aspiration-payments-practice-guide.pdf>
12. Focus on Quality Achievement Payments (2 pages)
13. Annex D: Carr-Hill resource allocation formula (6 pages)
[http://www.bma.org.uk/ap.nsf/Content/NewGMSContract/\\$file/gpcontractannexd.pdf](http://www.bma.org.uk/ap.nsf/Content/NewGMSContract/$file/gpcontractannexd.pdf)