The GP practice – a guide for community pharmacists and pharmacy staff

April 2010

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1. About this guide

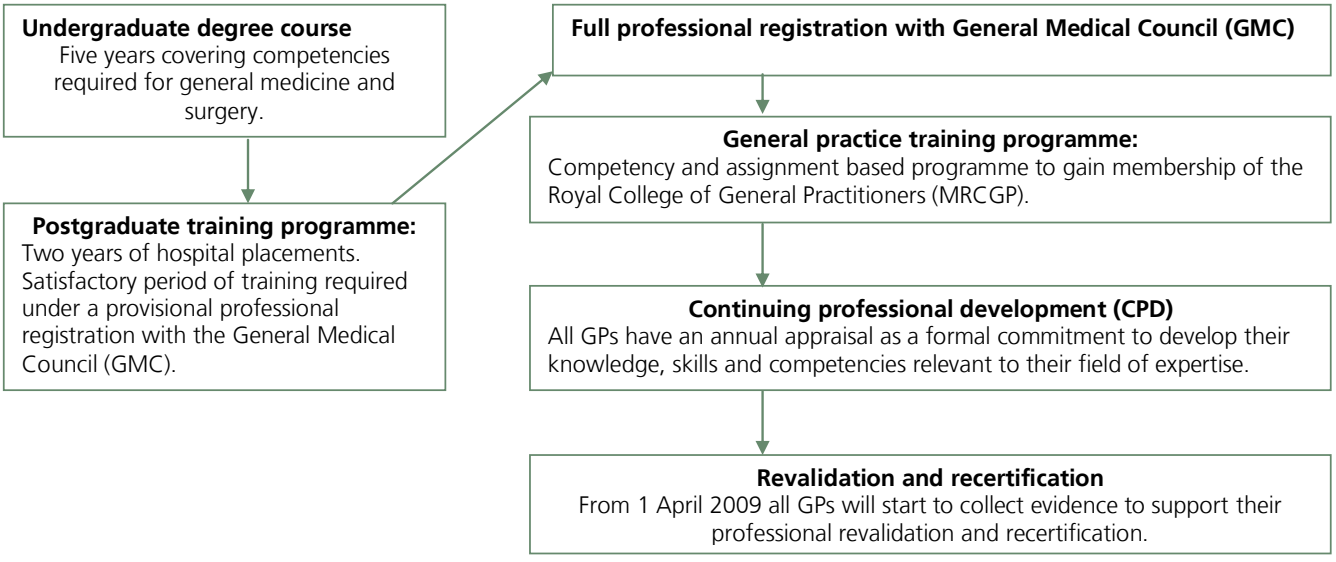
This guide aims to support General Practitioners (GPs) and community pharmacists in developing more effective working relationships and in turn, improve primary care services for patients. It covers key areas such as funding arrangements for practices, the impact of the Quality and Outcomes Framework (QOF), prescribing budgets and policies, and the range of clinical and administrative functions that practices currently provide.

This guide has been developed jointly by NHS Employers, the British Medical Association's General Practitioners Committee (GPC) and the Pharmaceutical Services Negotiating Committee (PSNC). A similar guide has been produced for GPs to give them an insight into the working life of a community pharmacist, pharmacy services and an overview of the community pharmacy contractual framework.

Together, these guides will support the two professional groups as well as provide an insight for NHS commissioners, as new ways of integrated working in primary care start to take shape.

2. Qualifying for general practice

2.1 Education and training



2.2 Extending skills

A small number of GPs have taken additional qualifications to become GPs with Special Interests (GPwSI). This initiative is part of a wider drive to redesign NHS care around the treatment of long term conditions in the community. Further details on the special interest frameworks can be found on the NHS Primary Care Commissioning website.

2.3 The work of a GP

The modern GP looks after a range of chronic conditions that were previously cared for in hospital clinics such as hypertension, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and asthma. GPs must have a broad knowledge covering all medical and surgical specialties, dealing with undifferentiated illness, often at an early stage. To cope with this increasing complexity, larger practices will have a lead GP for certain conditions although all the GPs continue to deal with the full range of illnesses.

Preventative medicine is much more prominent and GPs are now resourced to case-find and treat many chronic conditions at an early stage, before complications have arisen.

3. Key national bodies

There are several national organisations that have key roles in general practice:

- The General Medical Council (GMC) registers doctors to practice medicine in the UK. Its core guidance Good Medical Practice (2006) sets out the principles and values of good practice.
- The Royal College of General Practitioners (RCGP) has many leadership functions. In particular it devises and updates the GP training programme and develops new qualifications and methods of assessment.
- The British Medical Association (BMA) is both a professional body and the main doctors' trade union.
- The General Practitioners Committee (GPC) of the BMA negotiates terms and conditions of service for all GPs contracted to deliver services under the General Medical Services contract, both BMA members and non-members.

4. NHS contracts for primary medical services

4.1 Contractual routes

There are four contractual routes that a primary care trust (PCT) in England can use to provide primary medical services for its population:

Contract	Details
General Medical Services (GMS) contract	This is a nationally agreed contract between a PCT and a practice. A new GMS contract (see 4.2) was introduced in April 2004. Currently, about 60 per cent of practices are on GMS contracts.
Personal Medical Services (PMS) contract	This is locally agreed between the PCT and the practice, together with its funding arrangements. In England, approximately 40 per cent of practices are on PMS contracts. The GMS contract has a strong influence on the content and scope of this contract.
Alternative Provider Medical Services (APMS) contract	This allows the PCT to contract with 'any person' under local commissioning arrangements.
PCT managed practices	These are directly managed by the provider arm of the PCT and all staff (including GPs) are employees of the PCT.

For more details on the contractual routes, see NHS Primary Care Commissioning.

4.2 The GMS contract

There are three different types of services in the GMS contract.

Type of services	What they cover
Essential services – must be provided by all contractors.	They include the management of patients who are ill or who believe themselves to be ill with acute, chronic or terminal conditions.
Additional services – normally provided by all contractors but practices can surrender a percentage of income to opt out of providing these.	They include cervical screening, contraceptive services, childhood vaccinations and immunisations, child health surveillance, maternity services and minor surgery.
Enhanced services - commissioned by the PCT.	They include: • Directed Enhanced Services (DESs) which must be commissioned by the PCT • Local Enhanced Services (LESs) which are locally developed services designed to meet local health needs.

4.3. Funding for GMS practices

Major funding streams

There are several major funding streams for GMS practices:

Funding stream	Details
The global sum funds a practice for delivering essential and additional services to its registered list of patients.	The bulk of these payments are determined by an allocation formula which funds practices based on practice workload and circumstances (including patient demographics such as age and gender).
Minimum Practice Income Guarantee (MPIG) is a financial protection scheme which many practices currently receive additional income from.	This was introduced when the contract payment structure changed in 2004. The future of the MPIG scheme is currently under review.
The Quality and Outcomes Framework (QOF) is a voluntary scheme that provides funding to support aspiration to, and achievement of, a range of quality standards, by rewarding practices for the volume and quality of care delivered to their patients.	The QOF measures practice achievement against evidence based clinical indicators and organisational and patient experience indicators. Each indicator has a minimum level for achievement and although voluntary, most practices participate. Practices score points according to their levels of achievement and payments are calculated on the points the practices achieve. Currently, practices can achieve a maximum of 1,000 QOF points, although payments will vary with the size of the practice and the prevalence of medical conditions for that practice's population, to reflect the workload involved. For the year 2009/10 practices with an average number of patients (6,000 in England) were awarded £127.66 per QOF point. For more details see the section on QOF below.
Enhanced services payments resource practices to provide special services.	These services are not covered within the essential services of the contract. Many current enhanced services were previously provided by the secondary care sector.

Seniority payments reward a GP's experience.	A GP's seniority payment is based on their years of 'reckonable service' to the NHS (this is calculated from the date that a doctor first becomes registered with the General Medical Council or equivalent authority in another European Economic Area member state).
Payments for premises provide resources for premises.	Most GP practices own their premises and make these available to the NHS for patient care. GPs borrow the capital to build the premises and there are schemes that compensate the practice for this. Payments to practices are reckoned on the amount of rent the practice would pay if renting the premises and this is agreed with the District Valuer.
Dispensing payments only apply to those practices that provide dispensing services.	There are currently over 1,300 dispensing practices which serve around four million NHS patients.
Private services	Practices may provide private services for the administration of medications, for example travel vaccinations, life insurance medical reports and certificates, and letters outside normal NHS services.

Practices are not directly funded for Information Technology (IT) because PCTs are responsible for the procurement and operational costs of practices' IT systems. The following table gives the approximate percentage of practice income that is attributable to the different income streams.

Income streams	**Approximate percentage of practice income**
Global sum (including MPIG)	Up to 60%
QOF	Up to 15%
Enhanced services eg extended opening hours and annual flu vaccinations.	Up to 15%
PCT–administered funds, for example premises' reimbursements, locum fees (to reimburse practice costs relating to cover of maternity leave etc) and seniority payments.	Up to 15%
NHS incentive schemes and private services eg GPwSI services, preparing insurance certificates, external tribunals.	Up to 5%
Dispensing – this only applies to dispensing practices and relies on the size of the dispensing list.	Up to 50%

4.4 QOF in more detail

Current clinical areas

The following clinical areas are currently included in QOF:

- secondary prevention of Coronary Heart Disease (CHD)
- cardiovascular disease – primary prevention
- heart failure
- stroke and Transient Ischaemic Attack (TIA)
- hypertension
- diabetes mellitus
- Chronic Obstructive Pulmonary Disease (COPD)
- epilepsy
- hypothyroid
- cancer
- palliative care
- mental health
- asthma
- dementia
- depression
- Chronic Kidney Disease (CKD)
- atrial fibrillation
- obesity
- learning disabilities
- smoking.

QOF has seen evidence based indicators achieved by almost every GP practice in the UK to a very high level. The QOF has delivered benefits to patients through the improved monitoring and treatment of acute and chronic health problems. The coordinated and comprehensive care patterns supported by the QOF have also helped to reduce inequalities across the UK.

Use of READ and Snomed-CT codes in QOF

There are two clinical coding systems; READ and Snomed–CT. READ codes are the most well known in primary care and are used in general practice. Snomed-CT coding is an international coding standard and is expected to replace or subsume the READ coding system in general practice in the future.

The codes cover a wide range of topics in different categories such as signs and symptoms, treatments and therapies, investigations, occupations, diagnoses and drugs and appliances. This enables the recording of episodes of care as part of a full electronic patient record.

Coding extended services: pharmacists and QOF

Community pharmacists who deliver extended services in the pharmacy may find it helpful to speak to local practices so they can include appropriate codes relevant to the practice QOF targets, on any correspondence with the practice.

Comprehensive guidance about the QOF, including a list of all of the indicators and details of the latest QOF changes, is available on the NHS Employers website.

5. Running a general practice

5.1 Structures

The operational aspects of a GP's role are varied. Alongside traditional practice surgeries, many GPs are now actively involved in additional related activities outside of the practice. These include helping to develop local healthcare policy, clinical leadership roles for external and NHS organisations, commissioning activities within the PCT, or as members of the Local Medical Committee (LMC).

Some GPs pursue extended clinical opportunities and become involved in hospital work, for example as a clinical assistant, or become involved in educational activities and developments.

The following list outlines some of the functions that GPs are involved in:

- patient consultations in the surgery/home visits/telephone
- managing repeat prescriptions
- specialist clinics, for example respiratory, diabetes, cardiovascular
- managing incoming and out-going correspondence and related actions, for example patient referrals and following up pathology test results
- practice administrative functions - these are usually split amongst the team of GPs, for example IT lead, QOF lead
- clinical sessions in primary or secondary care settings as GPwSI (see 2.2 above) or clinical assistant roles

- training GP trainees – many practices are training practices
- practice development work or wider PCT/practice based commissioning (PBC) meetings eg prescribing guidance development
- external or non-NHS related work, for example prison care, private medical officer, medico-legal work, employment tribunals, high cost drugs appeals tribunals.

5.2 Roles within general practice

Most GPs are independent contractors, either running the business on their own or in partnership with others. As with all other independent NHS contractors, GPs are responsible for running the business affairs of the practice, providing adequate premises and infrastructure to provide safe patient services, and employ and train practice staff.

Over recent years there has been a steady increase in the number of large partnerships resulting in the consolidation and growth of a number of GP patient lists. In turn, the traditional staff roles have expanded and developed to meet the needs of the practice.

The following table shows the staffing arrangements for a typical GP practice. The roles and the number of staff involved can vary according to the size of the practice.

Position	Role
GP partners	Self employed independent contractors. The partners are essentially shareholders or owners of the practice and take an active role in the strategic development of the practice as an independent business.
Salaried GPs	Salaried by the practice (not by the NHS). This arrangement benefits both the practice and the employed doctor by allowing flexible working patterns where appropriate. This can be especially useful for managing extended opening hours and supporting other activities within the practice.
Locum GPs	The arrangements for contracting with locums vary from practice to practice.
Practice manager	In some larger practices this role may be split across the two roles of a business manager and an administrative manager: • The business manager is often responsible for providing financial and business advice to the partners for the development and implementation of the practice corporate strategy. • The practice manager's role can include a wide variety of functions depending on the staffing structure of the practice. This role will be responsible for the management of practice staff, patient liaison and daily operations within the practice. They are usually the first point of contact on anything relating to the management of the GP contract and QOF, prescription management and IT functionality for the practice.

IT manager	Many practices now employ a separate IT manager to oversee the daily management of the IT infrastructure and functionality within practices. Some of the IT development programmes within the practice will be part of the wider NHS National Programme for IT (NPfIT) which includes: • Choose and Book (C&B) • GP to GP transfer of patients' records (GP2GP) • Electronic Prescription Service (EPS) • Summary Care Record (SCR). The GP IT systems offer a range of functions in addition to traditional appointment scheduling, clinical records and prescribing. GPs can use their systems to review QOF data, provide patient recall functions, run audits and reports, manage referrals and test requests, incorporate pathology test reports and in some cases, analyse referral and prescribing costs and trends within the practice.
Practice nurse	Practice nurses have become significantly more skilled over recent years and are now providing services to patients that were previously delivered by GPs. This is as a result of the training and development initiatives within the nursing profession, leading to the creation of roles such as nurse practitioners and independent nurse prescribers. Much of their work involves managing the care of patients with long-term conditions and running a wide range of extended service clinics in the practice including: • long-term conditions – asthma, diabetes, blood pressure monitoring • cytology services • family planning • stop smoking • childhood and travel vaccinations.
Healthcare assistants (HCA)	The role of the HCA can vary depending on the number of services provided by practice nurses. They often provide assistance to nurses, as well as undertaking routine tasks such as phlebotomy, chaperoning and taking patient blood pressure and weight measurements for long-term conditions' clinics.

Administration staff	The administration staff provide a range of services in the practice including one or all of the following: • co-ordinating the flow of patients • managing patient appointments and telephone calls • managing incoming and outgoing correspondence • preparing prescriptions for review and signing • managing the clinical review recall system of patients with chronic diseases for annual clinical review.
Practice pharmacist	A number of practices have employed a practice pharmacist, although the majority of practices will rely on the expertise of PCT medicines management pharmacists or those employed by practice based commissioning (PBC) groups. The practice pharmacist may also have a prescribing qualification which adds significant scope and flexibility to their role. The practice pharmacist will undertake many duties including: • preparing practice formulary • NICE guidance interpretation and implementation within the practice • repeat prescription review • clinical audits and associated recommendations • clinical switching programmes • patient medication review • clinics for long-term conditions.

6. The GP practice prescribing budget

6.1 Budget setting methodology

Every year, the PCT sets a prescribing budget for each practice, using a formula that contains a number of factors including:

- population profile and list size of the practice using a weighted capitation unit known as the ASTRO PU prescribing unit
- an average spend per patient for the PCT, calculated for cardiovascular, respiratory and diabetes drugs, using QOF prevalence data. This figure is then applied to each practice appropriately
- consideration of historic spend of the practice

- high cost drug spend by the practice
- adjustments made for deprivation and care home patients, for each practice
- recent NICE guidance and other national clinical treatment guidance
- new medicines.

Each practice is reviewed regularly by the PCT's medicines management team using the database of prescription information provided by the NHS Business Services Authority, known as ePACT. The medicines management pharmacists will also provide support and expertise to the practice to help manage their budgets.

The practice will usually set a review programme for key target areas within current prescribing. Some practices have created their own practice formularies to ensure clinical and cost effective prescribing policies are maintained.

6.2 Practice based commissioning and prescribing strategies

PCTs provide their PBC groups with indicative budgets for various clinical activities including hospital services, prescribing, mental health services and community/locality services. PBC groups are then able to focus on developing appropriate plans and strategies to re-design services to address identified local heath priorities. PBC groups will generally prepare an action plan for each practice which will include clinical and cost effective prescribing measures.

Strategies for each practice can be developed that allow savings to be made against the practice prescribing budget. However, financial savings are not the only aim and some practices will invest savings in the increased use of certain medicines, for example for heart failure, chronic obstructive pulmonary disease (COPD) and osteoporosis, to implement local and NICE guidelines.

The table below shows some of the prescribing-related activities and their benefits for GP practices. It suggests how pharmacists could potentially be involved in these activities.

Activity	**Features**	**Potential benefits for the practice**	**Potential pharmacy involvement**
Drug specific prescribing protocols	Rationalising the use of some medicines based on robust evidence base eg Bisphosphonates, active isomers of established medicines, Angiotensin Receptor Blockers (ARBs).	Significant financial savings can be achieved by following agreed protocols.	Pharmacists can support these programmes with effective patient advice and partnership working with the practice. Medicines Use Reviews (MUR) can add value in ensuring the switched medicines are taken appropriately and safely.

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Activity	Features	Potential benefits for the practice	Potential pharmacy involvement
Drug switches of groups of patients to cost effective generic alternatives	Switching programmes to achieve maximum generic prescribing where clinically appropriate.	Potential generic savings can be significant where GPs previously prescribed high levels of branded products.	Pharmacists can support these programmes with effective patient advice and partnership working with the practice. MUR can add value in ensuring the switched medicines are taken appropriately and safely.
PBC use of branded generics in all practices	All practices within the PBC group switch large groups of patients to a defined set of generic medicines produced by one manufacturer. The items will be prescribed by a specific 'branded generic' name, ensuring the pharmacy can only supply this product. The reimbursement price of the medicines is initially set lower than the drug tariff price.	Although the savings derived from this type of switch may initially be significant, the prices set by the manufacturer have been known to change therefore reducing any further savings.	This programme may impact on the pharmacy medicines purchase and distribution arrangements, and create delays in sourcing the product for the patient.
Technological support for switching programmes	Introduction of *Scriptswitch* software into GP practice clinical prescribing systems.	Implementation and management costs, usually offset by significant savings, if GPs accept the recommended switch. Formularies should be managed regularly for maximum acceptance rates.	Formularies should be communicated to the pharmacies regularly to ensure maximum availability of the medicines.
Use of alternative therapies	For example, acupuncture, in-house physiotherapy and TENS machines for pain management.	Reduced prescribing of analgesic and anti-inflammatory medicines.	Pharmacists can support the practices with patient education and advice.

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Activity	**Features**	**Potential benefits for the practice**	**Potential pharmacy involvement**
Involvement of specialist nurses and counsellors	For example, community psychiatric nurses, graduate mental health workers, cognitive behavioural therapists, counsellors and the primary mental health team.	Reduced prescribing of anti-depressants.	Pharmacists can support the practices with patient education and advice.
Introduction of repeat dispensing programmes	The management of regular medication regimes for appropriate patients by the community pharmacist, dispensing from a set of 'batch' prescriptions for a defined period of time. Before a 'batch' prescription is dispensed, the pharmacy will check the patient's need for the medicine and whether there has been a change in circumstances since the medicine was first prescribed, which may mean it is not appropriate to supply the item.	Potential reduction of medicines not taken correctly or regularly according to clinical requirements.	Collaboration with practices for patient selection. Adherence issues communicated to the practice.
Pharmacist-led disease specific clinics	Rationalise the prescribing for patients on multiple medicines. Effective management of treatments for some long-term conditions and providing patients with self-care advice and support.	Potential savings from medicines no longer appropriate for the patient's circumstances. Some cost avoidances of additional medicines or hospital admission, if risk of potential exacerbations reduced.	MUR service can be helpful to reinforce self-care messages and ensure medicines are being taken correctly.

7. GPs investing in the future

Many GP practices and PCTs have made commitments to invest in premises' upgrades to ensure GP buildings and facilities are fit for their purpose.

The majority of GP practices will now have strategic development plans that will include continual development and staff training programmes. Where a particular clinical area requires greater consideration for the practice's patients, the GPs, nurses and pharmacists will ensure specialist skills and competencies are acquired to meet the need.

The practice will also ensure the IT infrastructure is suitable for the practice's requirements, taking into consideration any service redesign programmes being developed in their locality, such as integrating care with other providers or introducing remote monitoring technologies. The financial investment for IT developments may be funded by the PCT, although some practices may chose to expand their IT solutions beyond what is provided by the PCT.

8. Frequently asked questions

8.1 What is the financial arrangement for practice IT infrastructure management?

The PCT will fund all aspects of the IT hardware requirements and approved software, and support the maintenance of the hardware and most of the approved software. All consumables are funded by the practice, as well as all training and development costs for the system.

8.2 Are GP premises funded by the PCT?

Practices that are run by independent contractors may own their own building and get a premises' allowance from the PCT for making their premises available to provide NHS services, although many practices may not own their own premises but will still be independent contractors. In these circumstances the PCT funds the rent to the landlords.

If a practice chooses to relocate, the relocation must be approved by the PCT and the rent for the new building approved in advance. The removal costs are funded privately, although financial support is provided towards the legal and professional costs of a relocation under agreed arrangements.

Practices may choose to rent some of the areas in their building to the provider services division of the PCT.

8.3 Are there any guidelines for the charges that GPs make for private services?

The BMA used to advise on recommended charges for private services but this has largely been abandoned because it was considered anti-competitive by the Competition Commission. Practices are now free to set their own charges.

There are recommended national fees for some services which are outside the NHS but within the public sector eg fees for providing Blue Badge certificates; adoption medicals; social services

reports; reports for the Department for Work and Pensions (DWP), and attendance and disability allowances. Fees for reports to solicitors or insurance companies tend to be locally agreed.

8.4 Could a pharmacy provide some of the same private services as the local GP practice?

If the pharmacy can provide the service to the clinical safety standard required for those services, then the pharmacy can compete with the GP practice. However, to maintain good working relationships with local practices, such matters are best discussed openly.

Further information

- NHS Primary Care Commissioning for details on special interest frameworks and the contractual routes – **www.pcc.nhs.uk**
- The General Medical Council (GMC) for the Good Medical Practice Guidance (2006) – **www.gmc-uk.org**
- NHS Employers website for details on QOF changes – **www.nhsemployers.org**
- Scriptswitch website for details on the prescribing decision support for NHS organisations – **www.scriptswitch.com**

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