The GP practice

A guide for community pharmacists and pharmacy staff

August 2013

BMA

PSNC

NHS Employers

Contents

Section 1. About this guide

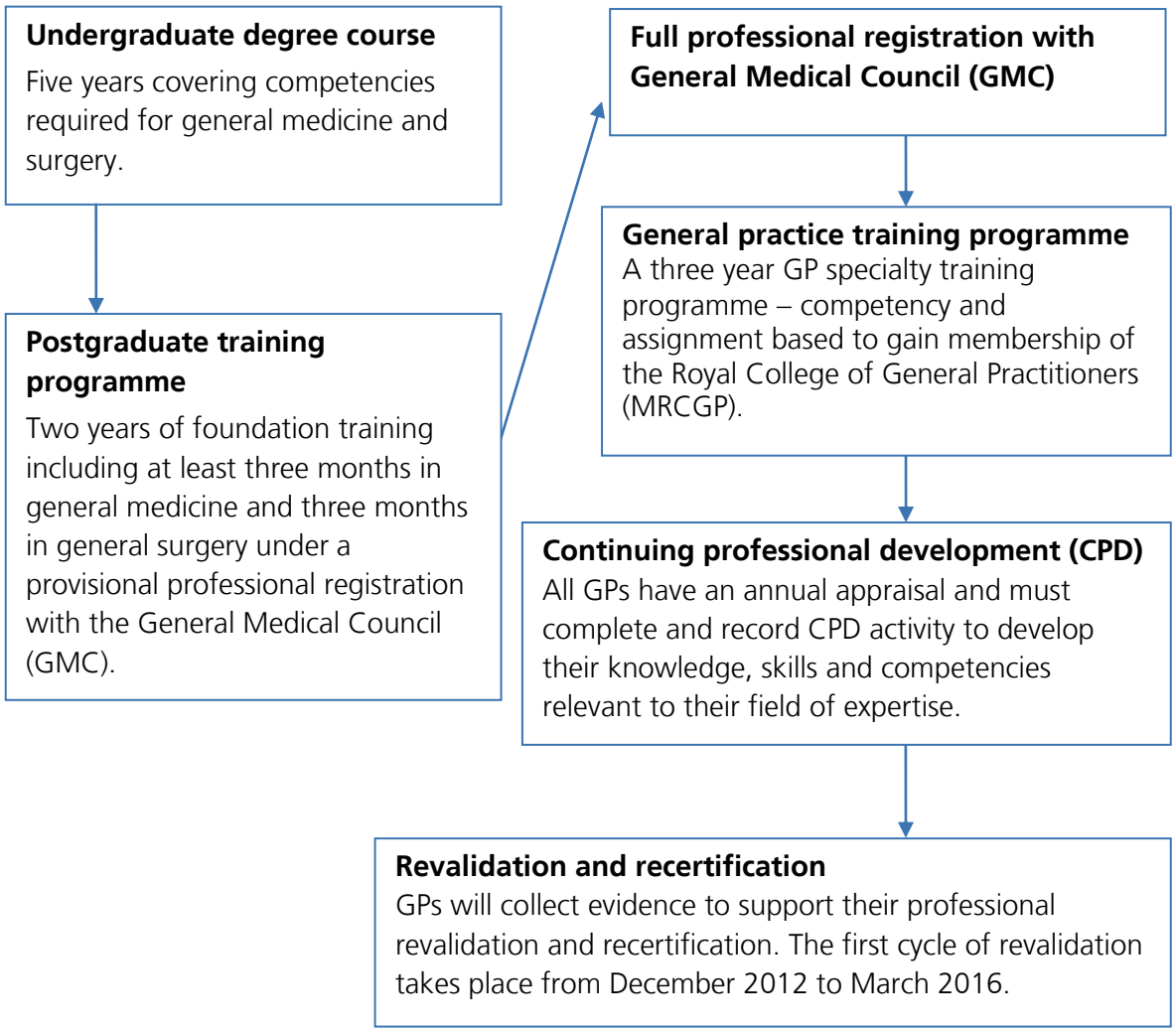
This guide aims to support General Practitioners (GPs) and community pharmacists in developing more effective working relationships and in turn, improve primary care services for patients. It covers key areas such as funding arrangements for practices, the impact of the Quality and Outcomes Framework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

The document 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.

Section 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 Primary Care Commissioning website[1].

[1] Primary Care Commissioning – GPs and pharmacists with special interests: http://www.pcc-cic.org.uk/article/gps-and-pharmacists-special-interests-gpwsi-and-phwsi

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.

Section 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 was updated in 2013 and 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 (GMS) contract, both BMA members and non-members.

Section 4. NHS contracts for primary medical services

4.1 Contractual routes

There are three contractual routes that NHS England can use to commission primary medical services for the population:

Contract	Details
General Medical Services (GMS) contract	This is a nationally directed contract between NHS England and a practice. The 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 a local contract agreed between NHS England 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) contracts	This allows NHS England to contract with 'any person' under local commissioning arrangements.

4.2 The GMS contract

Type of services	What they cover
Essential services – must be provided by all contractors.	This includes 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 opt-out of providing the services.	This includes cervical screening, contraceptive services, childhood vaccinations and immunisations, child health surveillance and maternity services.
Enhanced services – practices can choose whether or not to provide these services.	Enhanced services that are nationally commissioned through the GP contract by NHS England and legally directed by the Secretary of State are known as Directed Enhanced Services (DESs).
Community based services – may be commissioned from practices or other qualified providers.	From 1 April 2013, money previously allocated by PCTs for enhanced services transferred to CCGs (except for public health local enhanced services funding, which has been allocated to Local Authorities).

Type of services	What they cover
	CCGs may choose to use these resources to reflect local needs and priorities, including commissioning additional community based services (which can be provided by GP practices or other qualified providers under NHS standard contracts).
Transitional local enhanced services (for 2013/14)	Before 1 April 2013, some enhanced services were specified and commissioned locally by PCTs – more commonly known as local enhanced services (LESs). Responsibility for such services which did not expire on or before 31 March 2013 transferred to NHS England. NHS England has directed CCGs to manage these services, now known as transitional enhanced services, on its behalf. Mid year review points were included in the transfer arrangements giving CCGs the opportunity to decide how to use the funding beyond this point.
Local improvement schemes	CCGs do not have powers in their own right to pay for improvements in services provided under the GP contract. CCGs can, however, apply to the relevant NHS England area team for delegated powers to use resources from their budget to pay for improvements in services provided under their GP contract or to support activities such as clinical audit or peer review.

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 need (morbidity and mortality), 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. Payments made under MPIG are called correction factor payments. From 2014/15 funding to general practice will move towards equitable funding over a seven year

Funding stream	Details
	period. MPIG payments will be taken into account, gradually phasing them out.
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, public health, quality and productivity and patient experience indicators. Although voluntary, the majority of practices participate. Practices score points according to their levels of achievement and payments are calculated on the points the practices achieve. In 2013/14, practices can achieve a maximum of 900 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 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 GMC or equivalent authority in another European Economic Area member state).
Payments for premises provide resources for premises.	Many 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, for example borrowing costs (formerly known as cost rent) or notional rent reimbursement. Payments to contractors are calculated on the amount of rent the practice would pay if renting the premises and this is agreed with the District Valuer (DV). Other contractors rent their premises, in which case they receive rent reimbursement for actual leasehold rent. The level of reimbursement is calculated by the DV in relation to local current market rents (CMR). NHS England area teams are responsible for rent reimbursement payments to GP contractors.
Dispensing payments only apply to those practices that	As of 18 September 2012 there were 1,086 dispensing practices serving 3.34 million NHS

Funding stream	Details
provide dispensing services.	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 CCGs, on behalf of NHS England 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, for example extended opening hours and annual seasonal influenza vaccinations	Up to 15%
NHS England administered funds, for example premises' reimbursements, locum fees (to reimburse practice costs relating to cover of maternity leave and so forth) and seniority payments	Up to 15%
NHS incentive schemes and private services, for example 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 The Quality and Outcomes Framework (QOF)

The clinical domain in QOF includes conditions such as Chronic Obstructive Pulmonary Disease (COPD), diabetes mellitus and hypertension. 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 comprehensive 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.

Section 5. Running a general practice

5.1 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 ('contractors')	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. Approximately 75 per cent of GPs are partners (this figure does not include locums).
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. Most locums operate on a freelance basis providing cover for a number of practices.
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,

Position	Role
	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 include: • 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: • monitoring of long-term conditions such as asthma, diabetes, and hypertension • cytology services • family planning • smoking cessation • childhood and travel vaccinations.

Position	Role
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 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: • coordinating 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 CCG medicines management pharmacists. 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.

5.2 Structures

The operational aspects of a GP's role are not limited to running traditional practice surgeries. Since 1 April 2013 all practices have been required to be a member of a CCG, responsible for commissioning hospital, community and mental health services. Additionally, many GPs are now actively involved in related activities outside of the practice. These include helping to develop local healthcare policy, clinical leadership roles for external and NHS organisations such as NHS England, CCGs and Local Authorities 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 disease
- 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 among the team of GPs, for example IT lead, QOF lead
- leadership of and participation in CCGs
- 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
- external or non-NHS related work, for example prison care, private medical officer, medico-legal work, employment tribunals and high cost drugs appeals tribunals.

5.3 Clinical Commissioning Groups (CCGs)

Since 1 April 2013, all GP practices in England are legally required to be a member of a CCG. CCGs are GP-led organisations responsible for commissioning services including emergency care, community and mental health and maternity care. There are 211 CCGs, commissioning services for an average of approximately 226,000 people each. CCGs are accountable to NHS England and its area teams, and supported by commissioning support services/units (CSSs/CSUs). In addition to GPs, each CCG governing body must include at least one registered nurse and one secondary care doctor. They are responsible for around 60 per cent of the NHS budget.

As part of the CCG constitutions, all GP practices are required to be a member of their CCG. However, not every GP will have a lead role within their CCG.

Section 6. The GP practice prescribing budget

6.1 Budget setting methodology

Every year, NHS England will set the prescribing budget for each CCG, 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 STAR-PU prescribing unit
- an average spend per patient for the CCG calculated for cardiovascular, respiratory and diabetes prescribing using QOF prevalence data. This figure is then applied to each CCG as appropriate
- consideration of historic spend of the practices in the CCG
- high cost drug spend by the practices in the CCG
- adjustments made for deprivation and care home patients, for each practice in the CCG
- recent NICE guidance and other national clinical treatment guidance
- new medicines.

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

The CCG 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 Prescribing strategies

Many CCGs will develop plans and strategies to address identified local heath priorities. This may include clinical and cost-effective prescribing measures.

The table below shows some of the prescribing-related activities and their benefits for general practice. It also 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, for example 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 (MURs) can add value in ensuring the switched medicines are taken appropriately and safely.
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 contractors previously prescribed high levels of branded products.	
Technological Support for switching programmes.	Introduction of *Scriptswitch*[2] software into general practice prescribing systems.	Implementation and management costs, usually offset by significant savings, if contractors 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.
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.	

[2] *Scriptswitch* is a licensed software product that informs GPs of an alternative product during prescribing. Product suggestions for switching are locally managed according to PBC and/or PCT agreements.

Activity	Features	Potential benefits for the practice	Potential pharmacy involvement
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 and NMS services can be helpful to reinforce self-care messages and ensure medicines are being taken correctly.

Section 7. GPs investing in the future

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 CCG (on behalf of NHS England), although some practices may chose to expand their IT solutions beyond what is provided by the CCG.

Section 8. Frequently asked questions

What is the financial arrangement for practice IT infrastructure management?

The CCG, on behalf of NHS England, will fund all essential 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.

How are premises funded?

Practices run by independent contractors may own their own building and receive either borrowing costs or notional rent reimbursement from NHS England for making their premises available to provide NHS services. Alternatively, GP contractors are able to lease premises from third party landlords or NHS Property Services (formerly PCT-owned premises), NHS England pays actual leasehold rent reimbursements to GP tenants.

If a contractor chooses to or is asked to relocate, the relocation must be approved by NHS England and the rent for the new building approved in advance. Financial support is provided towards the legal and professional costs of relocation under agreed arrangements.

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

Historically, the BMA advised on recommended charges for private services but this has largely been abandoned because it was considered anti-competitive by the Competition Commission. Contractors 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, for example fees for providing Blue Badge certificates; adoption medicals; social services reports; reports for the Department for Work and Pensions (DWP), attendance and disability living allowances. Fees for reports to solicitors tend to be locally agreed. There are agreed fees for providing insurance reports, which can be found on the BMA website.

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.

NHS Employers
www.nhsemployers.org
GMScontract@nhsemployers.org

General Practitioners Committee
www.bma.org.uk
info.gpc@bma.org.uk

PSNC
www.psnc.org.uk
info@psnc.org.uk

Ref: EGUI23701