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Country Case Study: UK
Primary care in England and Scotland

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1. Summary Information

The primary care system in the UK is characterised by ‘first contact care’ to a general practitioner (GP). Patients register with a GP practice and in return receive comprehensive generalist care including drug prescriptions. GPs also co-ordinate access (gate-keep) to more specialist care through providing referrals and traditionally provide care continuity to an individual over time. Most GPs operate as independents, typically in partnerships of 4 or 5 GPs, and operate to a contract set by the Government.

The UK’s focus on primary care that is universal, comprehensive and free at the point of delivery is a key factor that has enabled the UK National Health Service (NHS) to be ranked as one of the most progressive and high performing health system in international comparisons (for example, in the work of Barbara Starfield) [1], though it remains comparatively weak in terms of access and responsiveness to demands.[2]

Since the early 1990s, the UK has experimented with a range of policies seeking to re-invest and enhance primary care provision. As a result, primary care provision has moved from isolated and small general practices to larger multi-disciplinary teams with ever growing responsibilities for tasks such as tackling service integration, disease management, health improvement, responding to patient choice and commissioning hospital services.

Of the most important recent policies implicating real change to the nature of primary care provision in the UK, the most radical is a new element of performance related pay where approximately 50% of the remuneration to general practices is based on achieving a range of nationally set quality-based targets. These aim to incentivise practices to become more focused on ill-health prevention through the effective management of people with or at risk of developing a range of long-term conditions.

This paper

Since 1999, devolution of political autonomy across the four home nations of the UK (England, Scotland, Wales and Northern Ireland) has led to explicit variations in the nature of health reform and primary care delivery. In this briefing we concentrate on primary care in England and Scotland.

1.1 Governance

Governance mechanisms in primary care are complex in the UK since they consist of a mixture of collaboration and competition, trust and accountability. Professional self-regulation remains a cornerstone of the system, specifically in terms of maintaining clinical standards of the professions through education, training, registration, continued professional development, and revalidation. However, greater emphasis has been placed on influencing clinical behaviour through evidence-based protocols and national guidelines whilst the routine monitoring of clinical quality and patient satisfaction has seen primary care become much more 'managed' than in previous years. All NHS organizations have a statutory duty to ensure the quality of their services as well as to keep their organisation financially solvent.

England

It is the role of 152 Primary Care Trusts (PCTs) in England - organizations responsible for the health and wellbeing of a defined geographic population - to take responsibility for commissioning services, monitoring standards and holding primary care providers to account for their performance. Each PCT has a 'clinical governance' function led by a health professional (normally a GP) tasked with the continuous improvement of standards and to safeguard quality by creating an environment of clinical excellence. The Government provides guidance to support this through national standards and evidence-based guidance. In addition, each year a performance assessment - the *Annual Health Check* - is administered by the Health Care Commission, a semi-autonomous regulator. The systems of performance assessment are essentially self-regulated through self-reported returns on activity (both by primary care providers to their PCT, and by the PCT to the Health Care Commission). A system of both random and targeted spot checks help to verify the data submitted.

Scotland

In Scotland, 14 NHS Boards and the 40 Community Health Partnerships (CHPs) working within a system of 14 NHS Boards manage primary and community health services. In 2003, NHS Quality Improvement Scotland (NHS QIS) was given responsibility for overseeing standard setting, monitoring and supporting implementation. NHS QIS has since carried out an interim review of governance arrangements within NHSScotland focusing specifically on the key issues of single-system working; clinical governance; risk management; and patient focus and public involvement. It is the responsibility of the 14 NHS Boards account for the performance of CHPs which are a sub-committee of the host Board. It is important to recognise that CHPs are part of the NHS Board in Scotland with particular responsibilities for working with local government and the third sector (voluntary and independent organisations) to improve services in local communities.

1.2 Financing/remuneration in primary care

For the main primary care providers - GP practices, pharmacists, dentists and optometrists - payments for services are based on nationally-agreed contracts across the whole of the UK. For example, in 2004, a new contract for general medical services (nGMS) was implemented across the UK intending to give

practices more freedom in designing services to meet local needs whilst encouraging better team-working and skill-mix.

The introduction of performance-related-pay

From an international perspective, one of the most radical changes in UK primary care in the nGMS contract has been the introduction of the world's biggest pay-for-performance experiment - the *Quality and Outcomes Framework* (QOF). Approximately half of a GP practice's income is achieved through payments based on the achievement of performance and quality targets.

The QOF stipulates a number of organizational and clinical standards to be achieved and includes payments based on patient experiences. Each standard in the framework is given a points value. A maximum of 1050 points is available of which just over half relate to clinical quality (Table 1). Providers can 'aspire' to achieve a certain level of points (say 900/1050) and are then paid one-third of the remuneration value in monthly instalments with the remainder awarded at the end of the year following an annual visit and return by the PCT.

The contract has been designed to incentivise practices to become focused on ill-health prevention through the effective management of people with or at risk of developing a range of long-term conditions. GP practices have responded to these financial incentives, significantly over-performing against Government expectations in the first year - 98% of family practices attained all the available points for clinical indicators, compared to an expectation of just 75% [3]. Whether this success was due to gaming or the ease of the targets has been debated, but most studies show that GP behaviour has changed to deliver service improvements - for example, a recent evaluation of QOF in Scotland suggests practices actually delivered higher quality than the minimum required to maximise their financial income [4]. However, the long term effects and risks of pay for performance are unknown and adverse consequences - for example to the 80% of primary care activity not covered in performance-related-pay - have yet to be investigated [5].

Table 1: Clinical standards in the new GMS contract, 2004

Service Area	Points Value
Coronary Heart Disease	121
Hypertension	105
Diabetes	99
Asthma	72
Chronic Obstructive Pulmonary Disease	45
Mental Health	41
Stroke or TIAs	31
Epilepsy	16
Cancer	12
Hypothyroidism	8
Total	**550**

'Bolt-on' contracts

Provision of 'additional' and/or 'enhanced' services may be 'bolted-on' to the national nGMS contract where care is provided to a higher specified standard or extended to certain 'specialist' services (such as minor surgery). However, there is no longer a requirement for GPs to provide 'out-of-hours' services meaning responsibility for such coverage has shifted to PCTs (England) and NHS Boards (Scotland).

England
PCTs, using a weighted capitation allocation from the Department of Health, are responsible for funding the healthcare of all patients registered with GPs in their locality - about 9% is allocated for primary medical services including payments related to those primary care suppliers holding national contracts (above). Since April 2004, PCTs may commission or provide primary medical services for their populations by the following routes:

- General Medical Services (**nGMS and QOF**) - see above;
- Personal Medical Services (**PMS**) – which includes Specialist PMS (**SPMS**),
- Primary Care Trust-Led Medical Services (**PCTMS**), and
- Alternative Provider Medical Services (**APMS**).

About 40% of GPs in England have opted to work to locally-negotiated PMS contracts of one sort or another. PMS contracts pay primary care staff on the basis of meeting set quality standards linked to local health needs. Some staff may be salaried. PMS schemes are usually designed so GPs, nurses and community health services staff work in multi-professional teams. Under APMS, PCTs are able to contract for primary medical services from commercial providers, not-for-profit organisations, voluntary and community sector organisations or existing NHS primary care or hospital providers (APMS has, for example, often been used to purchase out-of-hours care). Collectively, it is argued that these routes provide a framework with which PCTs can plan, commission and develop primary care services to meet key policy targets such as offering greater patient choice, improving capacity and access, and greater responsiveness to the specific needs of local communities.

Scotland
Whilst the provision function in English PCTs has diminished NHS Boards in Scotland have integrated responsibilities for service planning and provision. Community Health Partnerships (CHPs) provide through a co-ordinated set of partners a wide range of community-based health services delivered in homes, health centres, clinics and schools. These include health visiting, district nursing, speech and language therapy, physiotherapy, podiatry (foot care), mental health, addiction and learning disability services. Staff delivering these services may work closely with GPs, dentists, pharmacists and opticians (on UK-based national contracts) to plan and develop services across the CHP area.

1.3 The quality of primary care in the UK

Primary care in the UK has traditionally been rated very highly by patients, though access to care and responsiveness has become a key issue. For example, a patient opinion poll of 2.3 million patients in July 2007 undertaken for the English Department of Health found that 84% of patients were satisfied with their level of access to GP services.[6] However, the *Healthcare Commission* - the independent watchdog for healthcare in England - conducted a 2005 survey that gained the experiences of 117,000 patients that uncovered the following satisfaction rates in key areas: [7]

- 92% were satisfied with the quality of care they received;
- 76% definitely had confidence and trust in their doctor (3% no confidence);
- 76% said that they were seen as soon as they thought necessary;
- 74% of people reported that they were seen within the Government's target waiting times
of 48 hours for a GP. This compares with about two thirds of people (65%) in 2003.
- 57% said that they sometimes or always experienced problems contacting their general practice or local healthcare centre by telephone - up 8% on 2003.
- 21% of respondents said that they were deterred or sometimes deterred from going to their general practice or local healthcare centre because of inconvenient opening hours
- 12% of patients were unable to see a GP within two working days, 30% could not book an appointment more than 3 days in advance, whilst more than half had difficulty contacting their practice by telephone.

The data suggests that whilst patients are generally satisfied with primary care services (at their GP) they are not being treated as 'customers' whose preferences for access are being met (rather, they get what they are offered). This poor rating of 'responsiveness' is reflected in international comparative data compiled by the Commonwealth Fund [2].

Quality improvements over time - a mixed picture

It is generally recognized that improvements in primary care quality in the UK have developed over time. This is to an extent related to the wide application of quality standards, protocols and clinical governance procedures to drive up variable clinical standards linked to greater investment. However, there remains significant variability of primary care provision with the co-existence of some of the best primary care and some of the worst in Europe. Of particular concern is the poor standards of care, and poor levels of accessibility, to the 'hard to reach' population groups (the very poor and ethnic minority groups in, typically, inner-city locations). Tackling health inequalities through primary care has been a recurrent Government policy agenda, but has never been adequately addressed. The most recent ongoing review of the NHS in England has suggested that 100 new primary care practices in the 25 worse-off boroughs ought to be established, a figure underpinning the scale of the problem.

1.4 Human resources

The NHS is the largest employer of people in the UK with 1.3m people in more than 600 organizations. The 'workforce' in UK primary care has traditionally been viewed as those employed in 'general practice' surgeries plus dentists, pharmacists and opticians. In both countries, a strong network of primary care practices exist. In England (2004), for example, there were for its 50 million population just over 300 million consultations in general practice (90% of NHS activity) met by: 34,629 general practitioners (c.61.4/100,000); 22,144 practice nurses; and 90,110 practice staff - including physiotherapists, counsellors, phlebotomists, healthcare assistants, podiatrists as well as administrative support staff such as practice managers, receptionists and IT support workers. In Scotland (2004), for a population of 5 million, the ratios of staff per 100,000 is higher across all categories (for example, 77.5/100,000 GPs).

Increasingly, professional staff working in a range of community health services' sectors have been drawn into partnerships with the 'traditional' primary care providers. Though not directly integrated with other primary care providers, the list would include community nurses; health visitors; specialist nurses (e.g. palliative care); school nurses; podiatry; physiotherapy; occupational therapy; speech and language therapy; clinical psychology; midwives; family planning; and community rehabilitation. In England, Walk-in Centres (about 80 centres) and NHS Direct staffed by nurses also provide fast access to advice and/or treatment for minor ailments and injuries without registration or pre-booked appointment. There were just over 2 million attendances in 2004/2005. In Scotland, the range of primary care providers has increased too with Minor Injuries Units appearing in community hospitals and elsewhere. In the Out-of-Hours period, NHS24 (a telephone triage service) is the major route to emergency primary care services.

1.5 Main drivers for reform in primary care

The NHS in England has been fundamentally redefined since 1997 - moving from a comprehensive system of state funding and public provision to a mixed economy of public, private and third-sector providers (though still state funded). The main drivers for reform in England are:

- patient choice and patient empowerment (self-care)
- access targets - e.g. to see a primary care professional in 24/48 hrs, 18-week targets from diagnosis to treatment)
- diverse providers - engagement with the private sector
- competition - money following the patient
- care out of hospitals
- management of long term conditions
- 'system management' - tighter regulations to guarantee safety, quality, fairness, equity and value for money

In contrast to the direction of travel in England, NHSScotland has established a vision for the creation of 'mutual organizations' to further strengthen the collaborative and integrated approach to service improvement that is the hallmark of Scotland's NHS. The main drivers for reform in Scotland are:

- patients as partners in health - empowerment, ownership, rights and responsibilities
- networks and partnership working in planning, commissioning, delivery and performance management
- access targets
- shifting the balance of care
- prioritising the management of long term conditions
- tackling health inequalities

Uniquely in the UK, 'personal' social care (non-medical) for people over 65 is provided free irrespective of income or capital assets and is based purely on long term care needs. The policy has strong public support, but has recently been criticised by Audit Scotland for over-spending on budget and requiring better planning and management.

1.6 Barriers to primary care reform

England
- Lack of engagement and trust from medical profession to policy agenda
- Shortage of management capacity and expertise (e.g. in commissioning)

Scotland
- Contracts (and associated levers) that are more about inputs rather than on outcomes
- Ensuring that profession education and training keeps pace with emerging new models of care

1.7 Practical management/policy challenges in improving primary care

- Improving responsiveness to patients whilst retaining equity of access
- Providing integrated care whilst enabling choice.
- Moving from a medically-dominated model based on treating ill-health to a more holistic socio-medical model based on prevention of ill-health and promotion and maintenance of good health.
- Better co-ordination of care across sectors
- Involving patients and the public in decision-making
- Creating a single electronic patient record enabling full record access, booking of patient appointments, electronic prescriptions and telemedicine
- Demographic trends (more older people, more long-term conditions)
- Ensuring reforms generate better services for patients
- Tackling wider public health needs and inequalities

2. Macro level

2.1 The Health Systems in England and Scotland

The NHS in England has favoured the development of a purchaser-provider model of care where choice, contestability and a growing role of the private and voluntary sector in delivering services has been emphasised. Structurally, it is the role of 152 Primary Care Trusts (PCTs) in England to take responsibility for the health and wellbeing of people in its local area. Commissioning care services (and sometimes direct provision) using a budget received directly from the Department of Health enables PCTs to contract for all primary care services and to hold them to account for performance. The PCT administers nationally-agreed contracts to many of the core primary care providers (GPs, pharmacists, dentist and optometrists) and/or can employ other local contractual mechanisms to substitute for, enhance or provide additional services. Though primarily concerned with primary *medical* care, PCTs are encouraged to jointly-commission with local authority departments where combinations of social and medical care are sought. PCTs are themselves held to account for their performance by 10 Strategic Health Authorities and a regulator - the Health Care Commission - to a national policy framework monitor performance and standards.

NHSScotland has favoured the development of single-system working where 40 Community Health Partnerships (CHPs) working within a system of 14 NHS Boards manage primary and community health services. CHPs act as a focus for integrating primary, community and specialist care services with an explicit remit in forging partnerships with local authorities and the voluntary sector. They influence how NHS boards deploy their resources and play a central role in redesigning services as well as health improvement. The ‘single-system’ ethos is designed to instil shared aims, common values, and clear lines of accountability while breaking down traditional barriers between primary and acute care. Managed clinical networks for a wide range of long-term conditions have become well established and are seen as important systems to promote integration and cross-boundary working with social care.

2.2 Delivery System Designs in England and Scotland

There is no agreement in England and Scotland as to what constitutes ‘primary care’ since it is a portmanteau concept. However, the main ways primary care services can be accessed in the UK are as follows:

- General practitioners (GPs) work with nurses and other staff to treat patients for a range of health problems. They also give health education and advice, run clinics, give vaccinations and carry out simple surgical operations. Every UK citizen has a right to register with a local doctor's surgery and visits to surgeries are free.
- Dental care is provided by dentists, who provide check-ups, carry out treatments, and play a key role in improving dental health. Dental practices can take private and NHS patients.
- Ophthalmic medical practitioners and optometrists provide eye services to the general public. This includes treating diseases and abnormalities of the eyes, providing eye tests and dispensing prescription glasses.

- Pharmacists are responsible for supplying medicines for patients and members of the public either through a doctor's prescription or through general sale, usually from high street pharmacies.
- NHS walk-in centres offer fast and free access to health advice and treatment at convenient times and locations. Their services include treatment for minor illnesses and injuries, assessment by an experienced NHS nurse, advice on how to stay healthy and information on local health services.
- NHS Direct is a telephone line, staffed by nurses, which provides fast and free 24-hour health care advice. This ranges from advice and support on self-treatment to details about appropriate further services. NHS24 in Scotland offers telephone triage to primary care services.

The traditional focus of primary care remains the general medical practice (supported by other primary and community health professionals working in team) and is characterised as first-contact care, accessible by all (free at the point of use), comprehensiveness, co-ordinated for its population (registered list), and activated by patient choice. The gate-keeping function - whereby a GP makes a diagnosis, prescribes a medicine, or provides the referral to specialist and/or hospital clinic - remains fundamental to both systems.

Service Delivery Reforms in England

Since 1997, English policy has begun to embrace a broader perspective of primary care that is increasingly focused on larger, multi-professional, practices that provide a wider range of care services. The GP surgery remains the focus of most primary care, but there has been a movement away from small single-handed surgeries to the development of larger group practice models of care and increasing political support for 'super-surgeries' or 'polyclinics' in multi-purpose premises where multi-professional teams and more specialist care is available. For example, about 50 new 'one-stop' health centres are in the process of construction to bring the services of GPs, dentists, pharmacists, optometrists, health visitors, diagnostics (e.g. x-ray; endoscopy; cardiology and cancer screening) and some enhanced or specialist services such as ophthalmology, orthopaedics, dermatology, ENT. A further set of incentives in a new GP contract has also encouraged general practice to embrace the management of people with long-term conditions linked to a wider political agenda for supporting self-care; the maintenance of people in the home environment; and the better integration and co-ordination of health and social care professionals. However, tension between primary medical care and a broader model of primary care lies at the heart of debates about continued development in primary care.

Service Delivery Reforms in Scotland

NHSScotland's development of CHPs working within a system of NHS Boards has brought more co-ordinated management to the funding, planning and delivery of primary and community health services. An explicit remit in forging partnerships with local authorities and the voluntary sector is in-built. The 'single-system' ethos is designed to instil shared aims, common values, and clear lines of accountability while breaking down traditional barriers between care sectors.

2.3 Health Services Research

Government funding to enable health services research has been a core feature of the UK system for many years. In 2006 a major review of health research funding in the UK was conducted by Sir David Cooksey. This 'Cooksey Review' concluded that health services research needed to be better co-ordinated and be focused on the rapid translation of research findings to enable change that may bring benefits to patients, health systems and the economy. As a consequence, England launched a new national health research strategy - *Best Research for Best Health* - designed to support leading-edge research focusing on the needs of patients and the public to be more directly and better co-ordinated through the *National Institute for Health Research (NIHR).* In Scotland, the recent creation of the *Office for Strategic Co-ordination of Health Research (OSCHR)* has a similar remit.

3. Meso level

3.1 The community

In both England and Scotland there is a growing trend in the development of more integrated primary and community care together with explicit strategies - often based around certain public health priorities - to work in partnership with non-medical professionals and organizations. Joint strategic planning is now commonplace though the translation of such plans into integrated or co-ordinated funding/ commissioning streams and/or shared delivery of care services occurs less often. Many barriers to integrated care working between primary, community and social care sectors exist including:

- Funding streams - separate contracts by profession create different incentives; separate budget allocations between health and social care.
- Administrative - different legal, governance, regulatory and accountability mechanisms
- Organizational - assessment and referral processes, data systems, alliances
- Professional - cultures, ways of working, training etc.

4. Micro level

4.1 Self-management support

In England and Scotland patient surveys consistently show a very high level of satisfaction with primary care. In England, such surveys point to the need to improve responsiveness to patients (e.g. longer consultation times and/or care options) linked to a lack of patient involvement in decision-making - for example, about medication or treatment options. The UK ranks poorly in comparison to other countries in terms of the patient experience with regard to information about medicines, preventative advice, and self-management of chronic disease. However, both England and Scotland have recently invested in an array of policies and support strategies to enable better self-management support. These include:

- The NHS 'Life Check' - an assessment of lifestyle risks to help people make healthier choices;
- Drive for a Fitter Britain by 2012 - exhortation of healthy lifestyles to support physical and mental wellbeing;
- Expert Patient and Carer Programme - investment to support and empower patients and carers, including 'information prescriptions';
- Assistive technologies to support people at home and enable independent living; and
- Individualised budgets so that people may spend social (and soon health) resources directly on a range of potential care/support options directly;
- The "Keep Well" programme in Scotland aimed at reducing risk factors specifically in helath deprived areas.

4.2 Decision support

Significant improvement has been made across the UK in quality of clinical care in general practice. The use of evidence-based practice is commonplace (via clinical guidelines) enforced through clinical governance and audit. However, wide variations in quality persist, especially in the management of chronic disease.

4.3 Clinical information systems

Primary care in England and Scotland is organized around primary care practices where patients must register to access services. This provides strengths in terms of care continuity and record keeping to individuals and their families. Government policies are supporting the development of disease registers to both improve care, prevent ill-health and target patients at risk. In general practice, registers for coronary heart disease and diabetes have enabled disease management whilst national and regional cancer registers enable surveillance and planning of services strategically. However, the issue of disease registries shows that over 400 exist in England alone characterised by heterogeneity in terms of size, quality, funding source and purpose (i.e. epidemiological research; needs assessment; quality). Some localities are using a range of clinical information related to individual patients to formulate an algorithm that predict those most at risk of re-admission to hospital.

The lack of joined-up electronic information systems has been a major problem in the effective transfer of electronic data in the UK. However, from 2000, the English NHS embarked on a £6.2 billion investment over ten years in developing a national information technology system to replace organisations' separate IT systems that were not communicating with each other. The National Programme for Information Technology (NPfIT) is the most ambitious IT project of its kind in the world. When completed, the infrastructure will include:

- NHS Care Records Service - a national electronic patient records system for recording all patient records, appointments and telemedicine
- Choose and Book - an electronic booking service from point of referral
- Electronic transmission of prescriptions
- IT supported payments to GPs, including quality management and analysis

NHSScotland is revising its National eHealth IM&T strategy in order to deliver a suite of integrates systems designed to support patient journeys and secure sharing of patient data.

5. Key findings from England and Scotland

Barriers to improving primary care

England

- Lack of policy success in improving access in areas with the greatest social needs (hard-to-reach groups) - widening inequalities in access.
- Policy focus on meeting access waiting times (24/48hrs) has impacted negatively on standard of continuity of care.
- Lack of patient involvement in decision-making - for example, about medication or treatment options.
- Patient responsiveness weak
- Shifting resources away from hospitals and into primary/community care lags behind policy intent
- Lack of care co-ordination across sectors (primary-secondary; primary-social)
- Continuity of care becoming strained due to specialisation of care by professionals in larger group practices; more choices in locations for first-contact care; part-time working and move away from 24/7 care responsibilities.
- Medical focus of general practice means a less comprehensiveness service, though range and scope of care increasing

Scotland

- GMS contract (e.g. systematically penalises deprived practices)
- Shifting resources from acute lags behind policy direction
- Some evidence that public are by-passing primary care (especially out of hours)
- Most primary care still delivered in traditional one-to-one consultation
- Only recently have primary care clinicians been given education and experience of improvement methodology.
- Insufficiently strong incentives to maximise care in the primary care setting.

Success factors in improving primary care

England

- Patient registration to nation-wide system of primary care practices that manage referrals to specialists (gate-keep); enables equitable access; and

Scotland

- GMS contract (e.g. Patient registers enable co-ordination)
- CHPs provide bridge to social care
- Information systems enable co-

enables long-term co-ordination of care to people with complex needs.

- No financial barriers to accessing primary care services.
- Capitation funding according to need.
- Use of a wider primary care team - broad access to primary care reduces the demand for more expensive, specialist-led hospital care.
- Continuity of care to individual patients (and their family) develops trust, makes diagnoses easier and more accurate; and improves compliance.

ordination

- Scottish primary care collaborative has improved access, patient experience and outcomes
- Greater use of a wider primary care team
- Long term conditions collaborative and patient experience programme now underway.

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