"... this model [QOF] *is not appropriate for the vast majority of patient contacts where the GP knows that the subtle nuances of 'whole person management' are the principle requirement."*

Support for grassroots could rescue general practice

What has happened to the career that I entered 26 years ago? I am sure this is a common thought among my generation of GPs. However, general practice is a hugely complex process and it is difficult to pick out specific areas that need to be changed to mount a rescue effort.

Changes have been successively imposed on a primary care system consisting of GP partnerships that was formulated for a different era, and so it is little wonder that it is no longer fit for purpose. The unsustainability of the current system has become more apparent over the last decade since the New Contract. The principle paradigm is one of data collection. Numerous other management diktats have also been imposed onto the primary care team trying to carry out the already difficult and messy job of frontline medicine. However, the imposed processes do not fit most of the time with the real world of clinical practice. The QOF may have improved evidence-based care standardisation in specific disease areas such as diabetes, but this model is not appropriate for the vast majority of patient contacts where the GP knows that the subtle nuances of 'whole person management' are the principle requirement. In addition, individual practices do not have enough time or a big enough management team to deal with the escalating bureaucratic requirements.

In my opinion the key to a solution is to reinvigorate the confidence and trust of the two main parties involved in primary care, that is, the primary care team and the patients. This means moving away from the current vogue of encouraging GPs to become 'Leader-Managers' and aiming to refocus on establishing a robust local primary care team. By this I mean the 'organic' team developing together and trusting each other on a personal level, which results in an efficient, self-sustaining, and protective way of working. Nothing should be allowed to disrupt this team as has increasingly happened with impositions by political and management 'initiatives' that do not bear any relation to the real work of general practice.

However, the model to facilitate the above will necessitate a change in the overall shape of general practice. For example, this will probably include a shift towards a salaried GP service, especially as (unsurprisingly) the vast majority of younger GPs are shying away from becoming principals. If some GPs want to become 'Leader-Managers' within a new management structure then that would be fine, but the vast majority of GPs probably want to focus primarily on the medicine that they were trained to do while allowing managers to manage.

Once the above structure is established this will enable appropriate management initiatives to correct the problems within the current system, for example:

- introducing new methods of working such as a separation of acute care (aligned with a quality out-of-hours service) from management of patients with long-term conditions or multiple comorbidities where the latter will truly benefit from continuity of care and longer consultations;
- reducing the 'churn' among practice staff who move on due to an unhappy working environment;
- encouraging improved working conditions and further career development options for GPs; and
- thus attracting doctors to work in general practice by witnessing happy GPs working in a pleasant working environment.

I fear that without fundamental change the service will struggle on with an increasingly unhappy workforce and reduction in quality of service with reduced patient satisfaction, whatever gloss may be put onto it by politicians or management.

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