in common with one leading supermarket chain, would suggest that 'every little helps.'

Peter Murchie
Fellow in Primary Care Oncology, Cancer Research UK Research Training.
Email: p.murchie@abdn.ac.uk

REFERENCES

1. Freund T, Schwantes U, Lekutat C. OOH care and locum doctors. *Br J Gen Pract* 2007; **57(541):** 668–669.
2. Campbell M, Fitzpatrick R, Haines A, *et al*. Framework for design and evaluation of complex interventions to improve health. *BMJ* 2000; **321(7262):** 694–696.
3. Murchie P, Hannaford PC, Wyke S, *et al*. Designing an integrated follow-up programme for people treated for cutaneous malignant melanoma: a practical application of the MRC framework for the design and evaluation of complex interventions to improve health. *Fam Pract* 2007; **24(3):** 283–292.
4. The Society of Motor Manufacturers and Traders Limited. http://www.smmtco2.co.uk (accessed 12 Sep 2007).
5. Scottish Health Statistics. The web site of ISD Scotland. http://www.isdscotland.org/isd/info3.jsp?pContentID=1048&p_applic=CCC&p_service=Content.show&. (accessed 12 Sep 2007).
6. National Statistics. http://www.statistics.gov.uk/statbase/xsdataset.asp?More=Y. (accessed 12 Sep 2007).

PBC and out-of-hours work

Make no mistake, practice-based commissioning is here to save money. It should also improve patient services as a crucial component of a corporate efficiency drive by the largest employer in Europe. Of course, in a politically-sensitive organisation, cost and service cutting must be discrete and this is performed with varying success across the breadth of the NHS.

But these are the crude efficiencies and we now have an opportunity for a root and branch reform. As always there are valuable lessons from the past which could make this latest plan a roaring success. Whatever one felt about fundholding it was an immensely valuable exercise which demonstrated that GPs could manage the care of their patients beyond the surgery door and save money. Diagnostics, treatments and interventions were all done more quickly, conveniently, and at less cost. Developing this theme alone could turn around the fortunes of the NHS.

The critical reform must address the subtleties of decision making in primary care. As a GP I spend £120 000 on just the outpatient care of my patients. Multiply this up by my 40 000 GP colleagues and the national outpatient spend exceeds £5 billion. We know there are a wide range of referral thresholds among GPs but the reasons are ill defined. It is widely acknowledged that a GP with a special interest may refer more patients within that specialty so the explanation is not fundamentally knowledge related. One of the crucial factors is working within our 'comfort zone'. As GPs we live and work in a field of clinical doubt and tackle this by evolving strategies in patient treatments that are followed up and amended if necessary. The most common reason for GPs to fall victim to complaints is a lack of follow-up arrangements. If we accept that we need to widen this comfort zone then the service redesign pathways and speedier diagnostics have a clearer meaning. The aim is to put the GP at the centre of the patient care plan and to use him/her to access appropriate investigations which will stay in primary care unless referral is in the patient's best interests. Frequently it is not and, in the case of our work in cardiology and ophthalmology, only half the patients need to see the consultant — according to the consultants! The potential impact across secondary care could be immense and rationalisation is inevitable. It does seem logical however that as primary care does more historical secondary care work they, in turn, should be developing more current tertiary high value procedures to offer to patients in their localities.

Governments have made serial crashing errors in their understanding of primary care, which so often fails to accept just how much illness is kept outside hospital. Understanding and developing the 'comfort zone' is the path to cheaper and yet better care which must be more supportive and yet fulfilling for GPs. Finally, I would like to offer a controversial view about out-of-hours care which is consistent with these thoughts.

We know just how grossly the government undervalued out-of-hours care both directly and indirectly. Paying for the service is one thing but the unscheduled referral costs was a sting in the tail. I feel there is a role for local GPs in out-of-hours care at least in telephone triage. Bearing in mind that maybe 90% of our time is spent with just 10% of our patients we have the capacity to talk down and use our local knowledge to re-route a vast number of 'emergency' patients who are probably already known to us. This is what we do and have done for generations. I urge Alan Johnson to empower and facilitate those who can really make a difference.

John Havard
Saxmundham Health Group, Saxmundham, Suffolk, IP17 1AS.
E-mail: John.Havard@gp-d83053.nhs.uk

Correction

In the article 'Is Primary Care the right place for genetic diagnosis?' *Br J Gen Pract* 2007; **57(542):** 750–751, there is a typing error. The sentence reads 'Primary Care was viewed as the place to undertaken genetic diagnosis, at least for the time being'. It should have read 'Primary Care was *not* viewed as the place to undertake genetic diagnosis, at least for the time being'.