Editor's Briefing

TOMORROW'S WORLD

The independent contractor status of general practice dates from the foundation of the NHS over 60 years ago, when consultants were persuaded to become salaried employees of the state, but GPs were allowed to retain their independence. The phrase 'herding cats' possibly came up in policy discussions. The consequences of this decision included a remarkable variety of structure and function in general practice, which has persisted up to the present day, often accompanied by less surprising variations in quality of care. The 'cottage industry' model of general practice, with poorly trained and ill-equipped clinicians operating from sub-standard premises with no proper administrative or professional backup has, rightly, been criticised over the years, although because of the independent contractor status it has been difficult to do anything about it. Defenders of the status quo highlight advantages such as personal care, continuity, community integration and flexibility, but there is nothing advantageous to patients about personal and continuous, but poor, care.

For much of my professional lifetime many GPs simply refused to contemplate conformity with clinical practice guidelines and meaningful audit, and it was not a complete surprise that the blunt instrument of the Quality and Outcomes Framework became part of performance management in general practice. Ironically, as the profession wrestles with a crisis not simply of recruitment and retention, but of morale, professionalism and commitment, new strategies, which should have been considered and introduced decades ago, are beginning to find traction. These include establishing proper, multidisciplinary primary care teams on an appropriate scale, abandoning the notion that small, under-resourced practices are really capable of delivering services fit for the 21st-century, and beginning to work at an administrative and professional scale to provide the care our patients deserve. In the face of the potential impact of these major changes, the long-running discussion about the viability of the partnership model of general practice begins to look less critical.

The first three research papers in this issue of the *BJGP* touch, nicely, on these themes, and also on the important emerging field of the formalisation of social prescribing and care navigation. Tellingly the Introductions to two of these papers begin: *'Significant challenges are facing the long-term sustainability of NHS general practice'* and *'Increasingly unmanageable workloads in primary care makes the recruitment and retention of GPs challenging'*. But there is good news. Over half of all GPs are now working in more or less formal groupings providing services to populations greater than 30 000 people, according to a large observational study by Lindsay Forbes and colleagues, while a cross-sectional study of CCGs in England by Stephanie Tierney and colleagues has found that over 90% of the CCGs responding to their enquiries have some form of care navigation running in their area.

It is also good to see how the integration of pharmacists into primary care teams can have positive benefits on health system indicators, including, according to Benedict Hayhoe and colleagues, reduced use of GP appointments and reduced emergency department attendance, probably accompanied by savings in overall health system and medication costs. The wider primary care team theme is taken up by other articles, including one by Paul Silverston in the *Life & Times* section, who comments on the increasing polarisation of views about advanced practitioners among GPs but concludes that: *'With the promised army of additional GPs still somewhere over the horizon, a cavalry troop of well-trained Advanced Practitioners might just save the day'*. They may be joined by a range of other primary care professionals, including extended role nurses, physician associates, physiotherapists and paramedics.

In a helpful editorial, Matthew Booker and Sarah Voss describe the potential roles for paramedics in primary care, which could include dealing with same-day and urgent problems, undertaking chronic disease clinics, completing home visits, and performing telephone triage, although how best to integrate these new professionals with their undoubtedly valuable skills, into current general practice remains uncertain.

What is certain is that there is no time to lose in harnessing new skills in primary care since the funding and training implications of getting a new wave of doctors into general practice, as promised by the government, are formidable and will take time.

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