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BRIEFING PAPER

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General Practice in England

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Summary

This briefing paper provides general background for Members and their staff on NHS primary medical services provided by general practitioners (GPs) in England. It gives an overview of commissioning arrangements as well as information on changes to GP contracts and funding arrangements.

As well as providing an account of the different contracting routes for core and enhanced services this briefing provides information on the financial pressures and increases in demand facing GP practices as well as data on GP numbers, expenditure and earnings.

It includes sections on specific elements of the 2014/15 GP contract including the introduction of named GPs for over 75s and increased choice of GP practice, and changes to the 2015/16 GP contract which included extending the requirement for a named GP to all patients. The note also includes information on extended opening hours, out-of-hours services, waiting times for appointments and the 2015 Conservative Government commitment to provide 7 day access to GPs. It also provides information on general practice performance data and links to further information.

1. Commissioning and funding of GP services

Primary medical services in England are provided by GPs under contracts with NHS England (before April 2013 the contracts were with primary care trusts (PCTs), which have now been abolished). The mechanism by which funding is allocated to GP practices is complicated, and there are a number of different contracting methods. In addition about a quarter of GPs in England (around 9,000 of the nearly 36,000 GPs in England) are salaried direct employees of NHS organisations.

The majority of GP services are contracted using the nationally negotiated core GP contract: the General Medical Services (GMS) contract.[1] There are also locally negotiated contracts, including the Personal Medical Services (PMS) and Alternative Provider Medical Service (APMS) contracts. PMS is designed to allow GPs to offer a wider range of services responding to local need. APMS contracts allow the commissioning of additional primary care services from the independent sector.

Additional services can also be commissioned through locally negotiated contracts either by NHS England or local Clinical Commissioning Groups (CCGs). NHS England can commission enhanced services, including out-of-hours care and CCGs can commission other services—such as minor surgery—from general practices in their area, directly or on behalf of other local providers. The Quality Outcomes Framework (QOF) provides additional funding based on the quality of patient care. The current contracting arrangements are set out below, and include details of changes to the GMS contract.

1.1 General Medical Services contract

Under the General Medical Services (GMS) contract, introduced in 2004, practices get an amount, known as the global sum, allocated according to a needs-based formula adjusted for geographic differences in cost. Practices also receive a Minimum Practice Income Guarantee (MPIG) that ensures this global sum is no lower than it would have been under the previous contract. Practices are also paid for providing additional care, such as out-of-hours and enhanced services.

The global sum is calculated using a nationally set formula, an allocation methodology, known as the "the Carr-Hill formula" (it was developed in 2003 by a team led by Professor Roy Carr-Hill). The GMS global sum formula distributes global sum payments to practices according to the weighted needs of patients to reflect practice workload and the relative costs of service delivery.[2] Currently, the Carr-Hill formula includes a weighting for deprivation factors. It includes adjustments for levels of

1 The GMS contract is negotiated between the British Medical Association (BMA) General Practitioners Committee and NHS Employers, on behalf of the Government.

2 This formula was reviewed and slightly modified in 2007. See: Review of the General Medical Services global sum formula

chronic disease and premature mortality, both of which are highly correlated with social deprivation.

It is reported that NHS England Chief Executive, Simon Stevens, made a commitment to revise the Carr-Hill formula to account for deprivation in time for the 2016/17 contract.[3]

The NHS Employers website provides information on the main GMS contract funding streams, including the global sum and MPIG. It also provides information on the changes to the contract from 2013/14 onwards:

> The global sum
>
> The GMS global sum formula (the Carr-Hill formula) distributes the core funding - called the global sum - to general practices for essential and some additional services. Payments are made according to the needs of a practice's patients and the cost of providing primary care services. The formula takes into account issues such as age and deprivation.
>
> Minimum Practice Income Guarantee
>
> From 2004, when the new General Medical Services (nGMS) contract was introduced, the Minimum Practice Income Guarantee (MPIG) has been used to top up the global sum payments for some practices, to match their basic income levels before the new contract. Payments made under MPIG are called correction factor payments.
>
> However, as part of the GP contract settlement in 2013, the Department of Health decided to phase out MPIG top-up payments over a seven year period, starting in the financial year 2014/15.
>
> Seniority factor payments
>
> Seniority factor payments were also introduced as part of nGMS in 2004, to reward GPs' experience. Payments are calculated based on a GP's years' of reckonable service in the NHS and 'qualifying income fraction'. The qualifying fraction determines the proportion of the seniority payment a GP receives, depending on whether they earn between 1/3rd and 2/3rds, or more than 2/3rds, of the national superannuable income, but excluding seniority payments.
>
> It has been agreed that seniority payments will cease on 31 March 2020. In the meantime, those in receipt of payments on 31 March 2014 will continue to receive payments and progress as currently set out in the SFE. There will be no new entrants to the scheme from 1 April 2014. The current qualifying arrangements will continue for those currently in receipt of payments.
> It is expected that the agreed changes to seniority payments will result in the quantum of seniority payments from the seniority pool falling by 15% each year from 2014/15 to 2019/20.
>
> Dispensing doctors
>
> As well as providing essential GMS services, some practices - usually in rural areas - provide dispensing services to patients who find it more difficult to access a pharmacy.

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[3] Exclusive: Carr-Hill formula to weight GP pay for deprivation from 2016/17, GP Online, 9 January 2015

> Dispensing doctors receive a fee for each item that they dispense. The dispensing doctors' feescale is calculated by dividing dispensing doctors' remuneration, by the number of items expected to be dispensed in the relevant year.[4]

Guidance from NHS Employers about the GMS contract explains that the General Practitioners Committee of the BMA and NHS Employers will be testing ways of updating existing measures of deprivation ('weightings') in the current allocation formula in order to "ensure that the formula reflects the most up to date information on deprivation". This is being done in an effort to make sure that all communities are allocated sufficient resources to meet their primary care needs. It was also suggested that a 'bespoke' deprivation index could be introduced into the formula by April 2015,[5] although this does not yet appear to have been brought in.

Changes were made to the GMS contract for 2015/16 as a result of negotiations between NHS Employers (on behalf of NHS England) and the BMA's General Practitioners Committee (GPC). Key changes in the 2015/16 contract include:

> The **named GP requirement** is extended to all patients. This is a contractual requirement and builds on the 2014-2015 agreement to provide a named and accountable GP for over 75s.
>
> GMS practices must publish on their website by 31 March 2016 the mean **net earnings** of the partners, salaried GPs and locum staff.
>
> Practices must expand and improve the provision of **online services,** including access to medical records online and online booking of appointments.
>
> Changes to the **Quality and Outcomes Framework (QOF)** for 2015-2016.

The British Medical Association (BMA) has a page on the GP contract 2015-2016 England which summarises the GMS contract changes.

1.2 Personal Medical Services contract

Personal Medical Services (PMS) contracts are a locally-agreed alternative to the General Medical Service (GMS) contract. Introduced under the *National Health Service (Primary Care) Act 1997,* it is only in recent years that the number of practices choosing PMS has grown rapidly and over 40 per cent of all GP practices now have PMS contracts.

Unlike GMS contracts, they are negotiated between NHS England (PCTs before April 2013) and the practice, and are not subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the BMA.

NHS England initiated a national review of PMS contracts in June 2013 in response to concerns some practices were paid significantly more

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4 http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/gms-finance

5 NHS Employers, General Medical Services Contract 2014/15: Guidance and Audit Requirements, March 2014, p20

than others for similar work. NHS England has asked NHS Employers to manage a project to collect data from NHS England Area Teams on all PMS contracts in England. This information will enable NHS England to work with Area Teams to consider how far PMS expenditure (in so far as it exceeds the equivalent expenditure on GMS services) is effectively paying for 'core' primary care services. It will also identify how far it is paying for innovation and quality improvement in primary care and how far it is paying for 'enhanced' primary care services.[6]

NHS England introduced funding changes for PMS and APMS contracts for 2015/16, with effect from 1 April 2015. The changes aim to introduce consistency across GP practices.

The Department of Health published a document on Implementing the 2015/16 GP contract: Changes to Personal Medical Services and Alternative Provider Medical Services contracts which sets out the changes. These include an increase in core funding for GP practices per weighted patient to "deliver a common increase to core funding" – GMS funding was uprated in the 2015/16 contract changes and this change ensures that PMS practices receive similar increases in funding to GMS.[7] There are also changes to seniority payments and out of hours deductions.

However, there are concerns that some PMS practices may also experience funding reductions due to a reduction in the "premium" funding paid to some PMS practices. The BMA explains:

> NHS England's guidance on the application of equitable funding to PMS practices refers to £325 million of 'premium' expenditure, which has been identified as the amount by which PMS expenditure exceeds the equivalent items of GMS expenditure.
>
> The premium has been reduced to £235m in recognition of the fact that GMS correction factor funding is being reinvested in GMS global sum funding over the seven years to 2021-2022. The Government's intention is that GMS and PMS practices should receive equivalent core funding.[8]

The BMA General Practitioners Committee opposed a reduction in premium funding for PMS practices:

> After a long delay, in which there was a moratorium on new PMS reviews, the government recently announced how it intends to apply equitable funding to PMS practices through carrying out PMS reviews and redistributing the 'premium' funding paid to some PMS practices.
>
> While we agree with the need to reduce the variation in core funding between practices, we believe that funding levels should have been equalised upwards rather than downwards, to provide

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6 Further information on this, including general background on PMS contracts can be found on the NHS Employers website here and here. The BMA provides advice on PMS contracts here.

7 NHS England, Implementing the 2015/16 GP contract: Changes to Personal Medical Services and Alternative Provider Medical Services contracts, March 2015, page 6

8 BMA, PMS reviews and equitable funding [last accessed 16 June 2015]

> practices with much needed extra resources to deliver core services to patients.[9]

1.3 Enhanced Services

Enhanced services are provided optionally by practices to cover services not regarded as 'essential' under the contract. The two main kinds of enhanced or extended contracts are 'Enhanced Services' contracts (formerly Directed Enhanced Service (DES)) and 'Community Based Services' contracts (formerly Local Enhanced Services (LES)). The commissioning of these enhanced services is the responsibility of NHS England. Out-of-hours provision is included in these contracts (see below for more information). NHS England has delegated negotiations with GP practices over Community Based Services contracts to CCGs. CCGs can use these contracts to commission the services they see as necessary to meet local needs.[10]

1.4 The Quality Outcomes Framework (QOF)

The Quality Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries, which was introduced as part of the 2004 GP contract. Put simply, it provides additional funding to GP practices which meet a set of criteria for good practice and, in particular, is intended to improve the diagnosis and management of some of the most prevalent chronic diseases.[11]

Changes were made to QOF in the 2015/16 GMS contract, to retire and amend a number of indicators. The BMS, NHS Employers and NHS England have published Guidance for GMS contract 2015/16 on the changes to QOF. This states that:

> These changes [to QOF] are intended to reduce bureaucracy, recognise an increase in workload to specific disease areas and to allow GPs and practice staff more time to focus on the needs of individual patients.[12]

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9 BMA, Background on PMS reviews and equitable funding [last accessed 16 June 2015]

10 Further information about Extended Services can be found on the NHS England website.

11 Further details about the QOF can be found on the HSCIC website.

12 BMA, NHS Employers, NHS England, 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF), March 2015, page 7

2. Recent changes – funding, commissioning and named GPs

2.1 Recent funding commitments

The NHS England *Five Year Forward View*, published on 23 October 2014 stated that NHS England will be investing 'a much higher proportion' of its budget on GP services. It said that 'given the pressures they are under, we need a "new deal" for GPs, and promised to 'stabilise core funding' for GPs for the next two years. The plans also reveal that it will increase funding for primary care infrastructure and design incentives to encourage GPs to work and set up new practices in under-doctored areas.

Information on the "new deal" for general practice, including funding commitments, was provided in June 2015. See section 2.2. below.

In the 2014 Autumn statement the Government announced the creation of a £200 million transformation fund in 2015-16 to deliver the first year of the 'Five Year Forward View'. The fund will begin the work to develop new ways of caring for patients to improve the integration of GPs, community services and hospitals. Building on this investment, the Autumn Statement also announced that the fines collected from the banks that broke the foreign exchange market rules will be used to create a £1 billion fund for advanced care in GP practices in England:

> Bringing together GPs, nurses and specialists, the fund will pay for the modern premises and technology that will give patients access to advanced care, such as chemotherapy and dialysis, in their local communities. These new primary care facilities will also be encouraged to join up closely with local job centres, social services and other community services, in order to ensure that the NHS is also supporting people back into the labour market.[13]

On 15 January 2015 NHS England announced further detail of the 2015/16 tranche of funding to accelerate improvements in GP premises and infrastructure, the first of a four year £1bn Primary Care Infrastructure Fund (as announced in the Autumn statement 2014). NHS England said it would be inviting GPs to submit bids to improve their premises, either through making improvements to existing buildings or the creation of new ones. In the first year it is anticipated that the money will predominantly accelerate schemes which are in the pipeline, bringing benefits to patients more quickly.[14]

In March 2015, the Government announced £550 million of funding for the NHS to improve access to GPs, modernise GP surgeries and improve out-of-hospital care. This includes some of the funding previously announced as part of the Prime Minister's Challenge Fund, the Infrastructure Fund and the Transformation Fund. The Department of Health provided the following breakdown for the funding:

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13 HM Treasury, Autumn Statement 2014, December 2014 paragraphs 1.83-1.84
14 NHS England, NHS England announces £1bn investment in primary care over the next four years, 15 January 2015

> The funding will come from:
>
> £100 million addition to the existing £50 million Prime Minister's Challenge fund
>
> £250 million infrastructure fund for new buildings, treatment rooms and IT
>
> £200 million transformation fund for 29 pilots to integrate services offered by hospitals, GPs, and care homes[15]

The Department of Health have outlined the intended benefits of this funding:

> For patients, this will mean:
>
> - 18 million people will, by March next year, be offered more evening and weekend, video, email and telephone consultations, the equivalent of 8,000 more appointments a day
> - over 8.5 million people will see redevelopment of their existing practices, to increase clinical space and offer additional services
> - greater access to pharmacists, nurses and speech therapists from local GP surgeries
> - more personalised advice from pharmacists who will be able to access medical records
> - more tests, treatments and services offered closer to people's homes, including minor operations and blood tests

In March 2015, NHS England published information on which GP practices have successfully applied for additional funding: Recipients of £350 million of investment in primary care announced.

2.2 A new deal for general practice

In June 2015, the Secretary of State set out the first steps in a new deal for GPs. This contained six main strands:

A new deal on workforce

In order to address concerns about the workforce, the Government commit to increasing the primary and community care workforce by at least 10,000, including an estimated 5,000 more doctors working in general practice, as well as more practice nurses, district nurses, physicians' associates and pharmacists. Jeremy Hunt outlined initiatives to promote the attractiveness of general practice, including transforming the experience that medical students have of general practice, and increasing and filling GP training places.

A new deal on infrastructure

The Government will continue to allocate the £1 billion Primary Care Infrastructure Fund over the next 3 years, to improve primary care facilities across England. The Government will also help practices improve access to electronic health records across the NHS, and help practices to link their patient records to NHS secondary and community care providers and the social care sector.

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15 Gov.uk, GP evening and weekend appointments to increase, 28 March 2015

A new deal on access with a 7 day NHS

In order to improve access to healthcare and improved linked working between pharmacists and GPs, £7.5 million of the primary care infrastructure fund will be used in 2015 to support community pharmacists with training and tools. This is alongside the Prime Minister's Challenge Fund, which will be used to enable 18 million people to benefit from improved access to GPs, including at evenings and weekends, by March 2016.

A new deal on assessing the quality of care provided

In order to develop better data and metrics to assess quality in general practice, the Secretary of State has asked the Health Foundation to work with NHS England to do a stocktake of all current metrics, to review how they can collect and publish better outcomes-driven assessments of the quality of care. An initial assessment is expected in autumn 2015, with the first new datasets around key patient groups published in spring 2016.

In order to improve the support for practices identified as in difficulty, NHS England will work with NHS Clinical Commissioners to develop a £10 million programme of support for struggling practices.

Bureaucracy and burnout

In order to reduce bureaucracy, paperwork and "inappropriate workload", the Secretary of State has asked NHS England to examine how they can reduce bureaucratic burdens on general practice to release more clinical time for patients. Findings are expected in autumn 2015.

Responsibilities for doctors

In return for the commitments promised in the "new deal", the Secretary of State asked for GPs' help to deliver a profound change in the quality of care offered to patients.

This includes empowering general practice to break down the barriers with other sectors, including social care, community care and mental health providers, so that social prescribing becomes as normal a part of a GPs' job as medical prescribing.

GPs were also asked to play an even bigger role in public health, and help to improve lifestyle choices for better health outcomes. The Secretary of State also said general practice needs to be empowered to take real clinical responsibility for their patients, and guidance will be produced by the Academy of Medical Royal Colleges in 2015 to help GPs understand what this really entails.[16]

[16] Department for Health and The Rt Hon Jeremy Hunt MP, New deal for general practice, 19 June 2015

2.3 Consultation on commissioning of GP services

NHS England launched a consultation in August 2013,[17] Improving General Practice – A Call to Action, asking for views on how best to develop general practice services, and how NHS England can best support locally driven changes (e.g. through the development of national contractual frameworks).

An independent review of responses received and an emerging findings report were published by NHS England in March 2014 on its website.

In a response to the consultation a recent King's Fund report, Commissioning and Funding General Practice (2014), evaluates options for future commissioning models. The report also provides a useful summary of current GP commissioning and a brief history of GP contracts.

In May 2014, the Chief Executive of NHS England, Simon Stevens, invited CCGs to come forward to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally. On 10 November the joint CCG and NHS England primary care co-commissioning programme oversight group published Next steps towards primary care co-commissioning. The purpose of the document is to give CCGs the opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements.

2.4 Named GPs for all patients

The 2014/15 contract specified that all patients over-75 (around 8% of the UK population) must have a named GP by 30 June 2014 (and new patients must have one within 21 days of registration with a new GP). NHS England area teams will monitor progress and failure to meet these targets could put GPs in breach of contract."[18]

This requirement was intended to reduce pressure on A&E services from unplanned admissions by over-75s (the Department of Health states that out of five million emergency admissions in 2012 one third were people over 75 and estimates that more than one million could have been avoided[19]). The responsibilities of the named GP, as set out in the 2014/15 contract, are to:

- Ensure that all appropriate GMS services are delivered to the patient.
- Where required, work with health and social care professionals to deliver multidisciplinary care that meets the needs of the patient.

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17 NHS England consultation, Improving General Practice – A Call to Action
18 Further information can be found on the Department of Health website.
19 *Ibid.*

- Ensure that the patient's needs are recognised and responded to by the relevant clinicians in the practice.
- Ensure that the patient has access to a health check, if requested.

While the intention of the named GP policy is to reassure those patients that they have one doctor in the practice who is responsible for ensuring that their needs are met, the individual "named GP" does not have to be personally available for daily contact. It is largely down to practices to decide how to allocate GPs and inform patients but reasonable efforts should be made to accommodate patient preferences.[20]

On 14 April 2014 the Department of Health and NHS England jointly published Transforming Primary Care, which sets out plans for more "proactive, personalised and joined up care", including the Proactive Care Programme, providing 800,000 patients with the most complex health and care needs with:

- a personal care and support plan
- a named accountable GP
- a professional to coordinate their care
- same-day telephone consultations

As described in section 1, the 2015/16 GMS contract for GP practices extends the requirement to provide a named GP to *all* patients. By 31 March 2016 all practices will need to include on their website reference to the fact that all patients, including children have been allocated a named, accountable GP.[21] The BMA has further information on this requirement on its page on GP contract 2015-2016 Named GP.

[20] The BMA provides some practical guidance for GPs on this new duty.
[21] BMA, GP contract 2015-2016 England [last accessed 19 May 2015]

3. Demand, workforce and funding pressures

There have been concerns about the sustainability of a significant number of practices in the context of growing demand for services and changes to funding.

Information on the "new deal" for general practice, including planned increases to the primary care workforce, was provided in June 2015. See section 2.2 above.

Workload pressure

The Royal College of GPs (RCGP) and the BMA have conducted surveys of GPs and highlighted results that show increasing workload pressures, and related increases in stress, and growing numbers of GPs planning to leave the profession.

There have been a number of calls from the RCGP for an urgent increase in the number of GPs and the proportion of NHS funding spent on general practice. In June 2013 the Guardian quoted the then Chair of the Royal College of GPs, Dr Clare Gerada, calling for an urgent increase in general practice's share of the NHS budget so that 10,000 more GPs could be hired, in order to make GPs' workloads sustainable. A report by the consultancy Deloitte Centre for Health Solutions, Primary Care: Today and Tomorrow published in May 2012 noted a number of challenges to maintaining an adequate number of GPs.[22]

In May 2014 the BMA launched a campaign: "Your GP cares", calling for long term, sustainable investment in general practice, as well as highlighting what it says are the "unique strengths that general practice brings to the NHS and how it can be a key solution to managing the increasing pressure on the health service."[23]

In 2013 the RCGP launched "Put patients first: Back general practice" campaign is demanding that the governments of the UK increase funding for general practice from around 8.4% to 11% of the UK NHS budget by 2017 (see data on expenditure in section 4 below).[24]

A BMA briefing highlighting the various workload challenges facing GP services was published in January 2014 (updated July 2014):

> **Workload**
>
> There have been significant increases in NHS activity over the past 14 years, including a 24% increase in GP consultations since 1998[25]
>
> It is estimated that 340 million consultations are undertaken every year, this is up 40 million since 2008[26].

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22 The report was quoted in the press, see the Telegraph, for example.
23 BMA press release, "GP leaders call for urgent solutions to tackle the impending threat to patient services as 'Your GP cares' campaign launches", 13 May 2014
24 RCGP website
25 "Two years of productivity growth", *Health Service Journal*, 17 January 2014
26 Information from NHS England's Call for Action (General Practice) 2013

Over 90% of all contacts with the NHS occur in general practice[27].

The average member of the public sees a GP six times a year; double the number of visits from a decade ago[28].

97% of GPs have seen bureaucracy and box ticking increase since 2012 while nine out of ten GPs felt this took them away from spending time attending to patients needs. Eight out of ten reported target chasing had reduced routine available appointments to patients[29].

Challenges

GPs are facing rising patient demand, particularly from an ageing population with complex health conditions. By 2011 the number of people aged over 65 had reached 10,494,000 and by 2031 it is predicted to reach 15,778,000[30]

By 2021, more than one million people are predicted to be living with dementia and by 2030 three million people will be living with or beyond cancer. By 2035 there are expected to be an additional 550,000 cases of diabetes and 400,000 additional cases of heart disease in England. The number of people with multiple long-term conditions is set to grow from 1.9 to 2.9 million from 2008 to 2018[31].

18 million patients in the UK are estimated to suffer from a chronic condition, with the majority being managed in the community by GPs. Around 53% of all patients in England report having long standing health conditions, many of which will be treated at some stage by GPs[32].

General practice is currently facing a tough financial climate. Since 2008, GP income has declined by 11% drop while there has in the same period been a 2.3 percentage point rise in the cost of running a practice (including the amount spent on keeping GP practice buildings in good shape, energy bills for GP practices and the amount spent on GP staff, including practice nurses and receptionists). The cost of running a practice now accounts for 61.6 per cent of total GP income[33].

In November 2014 the Nuffield Trust published, Is general practice in crisis?, which provides an overview of the current state of general practice in England, and offers some potential solutions to the problems facing general practice – and the wider NHS.

Workforce planning

The Government has acknowledged that there is a need to train more GPs to meet growing demand and a number of Department of Health and NHS commissioned reports have supported this view. A national general practitioner taskforce commissioned by the Department of Health reported in March 2014. It found that:

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27 Information from Transforming Primary Care in London, NHS England.
28 Health and Social Care Information Centre, Trends in consultation rates in general practice.
29 BMA GP workload survey (2013)
30 Figures from the NHS Confederation.
31 Figures included in the BMA's Vision document for the future of general practice.
32 Both preceding bullet points from NHS England's Call for Action (General Practice) 2013: http://www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf
33 NHS England DDRB evidence for 2014: http://www.england.nhs.uk/wp-content/uploads/2013/09/ddrb-evid.pdf

> Despite the longstanding Department of Health policy to increase GP training numbers in England to 3,250 per annum, GP recruitment has remained stubbornly below this target, at around 2,700 per annum, for the last four years. This cumulative recruitment shortfall is being compounded by increasing numbers of trained GPs leaving the workforce, most significantly GPs approaching retirement, but perhaps more worryingly women in their 30s. GP recruitment and retention is a much bigger problem in some parts of the country and often in those areas which have the worst health outcomes.[34]

The Centre for Workforce Intelligence (CfWI) has forecast that a significant, sustained and immediate boost to GP training numbers is necessary to mitigate the risk of a major demand-supply imbalance emerging by 2020.[35] The Health Education England (HEE) workforce plan for 2015/16 also states that the number of GPs has failed to keep pace with the growing needs and expectations of the public, and the demands on GPs to undertake new roles, such as commissioning.[36]

The Department of Health has mandated Health Education England (HEE) to ensure that 50% of trainees completing foundation level training enter GP training programmes by 2016 (increasing commissions for this group to 3,250 places of the 6,500 places per year, an increase of around 20%, when compared with the average of approximately 2,700 per annum in the five years to 2013).[37] As noted above, there have been problems in filling training places, and of 3049 training posts available in 2014 only 2688 were taken up.[38] HEE has said it will undertake additional work on GP recruitment and retention, return to practice and reducing attrition rates.

Transforming Primary Care, which was published in April 2014 by the Department and NHS England also made the following commitment "To ensure that we have a workforce ready to meet the challenges of the future, we are planning to make available around 10,000 primary and community health and care professionals by 2020, in support of the shift in how care will be provided."

Withdrawal of the Minimum Practice Income Guarantee (MPIG)

As part of the GP contract settlement in 2013, the Department of Health decided to phase out MPIG top-up payments over a seven year period, starting in the financial year 2014/15. MPIG was introduced as part of the 2004 GMS contract to smooth the transition to new funding arrangements. These changes have been cited as an additional pressure on practices and was referred to in a number of press articles last year; see for example: "GPs braced for shutdown after 'toxic mix' of loss of funds and high demand", The Guardian, 16 April 2014

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34 GP Taskforce Final Report, March 2014

35 CfWI, In-depth review of the general practitioner workforce: Final report, July 2014. The report builds on preliminary findings published in March 2013; it assesses current work force numbers to forecast supply and considers key drivers affecting work force demand; and regional variations in demand.

36 HEE, Workforce plan for 2015/16, December 2014

37 The initial target was to ensure 50% of training posts go to GP trainees by 2015 but this was extended to 2016 in a refreshed mandate to HEE in May 2014.

38 HEE, Workforce plan for 2015/16, December 2014

NHS England have published anonymised details of the 98 GP practices most affected by the phasing out of the MPIG and have stated that area teams are working with the practices most significantly affected to identify if there are special circumstances that would justify making other payments to them (for example, to reflect any factors that are not adequately captured by the normal funding formula, or if any services that the practice provides would more appropriately be commissioned by clinical commissioning groups (CCGs)).

4. GP workforce, expenditure and earnings data

The table below shows that headcount and full time equivalent GP numbers (excluding Registrars and Retainers) increased year on year between September 1995 and 2009. A fall in numbers in September 2010 has been followed by annual increases and figures for 2013 are almost back to the 2009 peak.

However, in recent years annual increases have been lower than the rate of growth in the population, hence the rate of GPs per 100,000 population has fallen since 2009.

Data on the number of GPs employed in the NHS in England

GP Numbers per 100,000 population, England

	Headcount		Full time equivalent	
As at Sept:	Number	Rate per 100,000 population	Number	Rate per 100,000 population
1995	27,465	56.8	26,114	54.0
1996	27,811	57.3	26,272	54.1
1997	28,046	57.6	26,359	54.2
1998	28,251	57.9	26,455	54.2
1999	28,467	58.1	26,558	54.2
2000	28,593	58.1	26,557	53.9
2001	28,802	58.2	26,628	53.8
2002	29,202	58.8	26,833	54.0
2003	30,358	60.9	27,624	55.4
2004	31,523	62.9	28,308	56.5
2005	32,738	64.9	29,248	58.0
2006	33,091	65.3	30,931	61.0
2007	33,364	65.7	30,936	60.9
2008	34,010	66.6	30,675	60.0
2009	35,917	69.8	32,111	62.4
2010	35,120	67.8	31,356	60.5
2011	35,415	67.8	31,391	60.1
2012	35,527	66.9	31,578	59.5
2013	35,561	66.5	32,075	60.0

Sources:

NHS Health and Social Care Information Centre, Workforce Survey data

ONS Mid year population estimates

Health Education England forecasts that if its planned training levels are achieved, then the number of GPs available for employment would be 36,830fte by 2020, an increase of 14.8% from the 32,075fte recorded as being employed in September 2013. This is based on achieving 3,100 new trainees in 2015 and an average of 3,250 new training GP commissions each year from 2016.[39]

[39] HEE, Workforce plan for 2015/16, December 2014

Real terms spending on general practice in England

The following table shows a time series of investment in general practice and total Government spending on health.[40] The table shows a shift on the share of funding for general practice from 10.6% in 2005/06 to 8.2% in 2013/14. However, there was a real terms increase in spending in 2013/14, the first increase observed since 2009/10.

Expenditure on General Practice, England

	Cash terms £millions	Real terms 2012/13 prices £millions	Real terms % change	Total health expenditure £millions	% of total spent on general practice
2003/04	5,811	7,436			
2004/05	6,914	8,577	15.3%		
2005/06	7,747	9,349	9.0%	72,750	10.6%
2006/07	7,757	9,114		76,877	10.1%
2007/08	7,867	8,980	-1.46%	82,558	9.5%
2008/09	7,957	8,861	-1.33%	88,986	8.9%
2009/10	8,321	9,033	1.94%	94,422	8.8%
2010/11	8,350	8,820	-2.35%	97,649	8.6%
2011/12	8,397	8,714	-1.21%	100,266	8.4%
2012/13	8,459	8,639	-0.86%	102,571	8.2%
2013/14	8,753	8,753	1.32%	106,476	8.2%

Figures for 2005/06 are Gross Investment Guarantee (GIG) The GIG ceased to exist in 2006 and recorded levels of investment from 2006/07 are measured against total spend. While the measures used in 2005/06 and the measures used for 2006/07 – 2012/13 are very similar, it is not possible to draw exact comparisons between the two sets of figures.

Sources:

HSCIC Investment in General Practice, England, Wales, Northern Ireland and Scotland
HM Treasury, Public Expenditure Statistics Analyses, Table 1.3
HM treasury GDP deflators consistent with December 2014 autumn statement

GP earnings

The latest publication on GPs expenses and earnings shows that in 2012/13 General Practitioner Medical Services (GMS) GPs in England had an average income before tax of £105,100; whereas in 2004/05 (the time of the introduction of the GMS contract) their average income before tax was £103,564 in cash terms. Although in cash prices this represents a 1% increase between 2004/05 and 2012/13, in real terms there has been a decrease of 16% from £128,472 to £107,331. This is equivalent to an annual percentage decrease of 2.2% per year throughout the period in real terms

[40] Please note that a comparable series for current Government spending figures for 2010/11 onwards has been creating by using figures from PESA 2013 on outturn and planned resource DEL. Added to these are figures for the Food Standards Agency (FSA) and Personal Social Services (PSS) which were removed from the DH settlement as announced in the 2010 CSR. The CSR gave details of the amount of annual RDEL to be passed to CLG for PSS funding and the amount representing FSA funding.

The full publication is available online: GP Earnings and Expenses 2012/13 but the following tables show GPMS earnings and expenses from 2004/05 to 2012/13 in both cash and real terms:

GPMS Earnings and expenses, England 2004/05 to 2012/13 (cash prices)

	Gross Earnings	Expenses	Income before tax	Annual % change in income
2004/05	£241,795	£138,231	£103,564	
2005/06	£257,563	£143,950	£113,614	9.7%
2006/07	£260,764	£149,198	£111,566	-1.8%
2007/08	£266,110	£155,971	£110,139	-1.3%
2008/09	£274,100	£164,500	£109,600	-0.5%
2009/10	£278,100	£168,700	£109,400	-0.2%
2010/11	£283,000	£175,300	£107,700	-1.6%
2011/12	£284,300	£178,200	£106,100	-1.5%
2012/13	£289,300	£184,200	£105,100	-0.9%

Source: GP Earnings and Expenses Time Series - 2002/03 to 2012/13

GPMS Earnings and expenses, England 2004/05 to 2012/13 (real terms 2013/14 prices)

	Gross Earnings	Expenses	Income before tax	Annual % change in income
2004/05	£299,950	£171,477	£128,472	
2005/06	£310,827	£173,718	£137,108	6.7%
2006/07	£306,381	£175,298	£131,083	-4.4%
2007/08	£303,775	£178,047	£125,728	-4.1%
2008/09	£305,234	£183,185	£122,049	-2.9%
2009/10	£301,882	£183,127	£118,756	-2.7%
2010/11	£298,930	£185,168	£113,762	-4.2%
2011/12	£295,021	£184,920	£110,101	-3.2%
2012/13	£295,442	£188,111	£107,331	-2.5%

Source: GP Earnings and Expenses Time Series - 2002/03 to 2012/13

5. Access to GP services: extended hours, out-of-hours, waiting times and 7 day working

5.1 Extended hours incentives

From 2007 the then Labour Government began encouraging GP Practices to open "extended hours". "Direct enhanced service" (DES) payments[41] were made available to practices offering additional services from April 2007. The DES payment scheme was originally intended to provide £150 million from pre-existing bonus payments to practices offering additional services. This offer was rejected by the British Medical Association (BMA).

Following negotiations with the BMA, £100 million was made available from 2008 for extended hours payments through the DES scheme: equating to £12,000 per year for each practice opening for three additional hours per week.[42]

The *Primary Medical Services (Directed Enhanced Services) (England) Directions 2010* (known as the DES Directions),[43] which came into effect from 1st April 2010, set out the arrangements that Primary Care Trusts (PCTs) were required to make to ensure that all GP practices had the option to provide extended hours. Alternatively PCTs were able to contract out the extended hours access.[44]

The Coalition Government introduced an Extended Hours Access Scheme. This scheme replaced the previous Government's DES scheme. On 4 April 2011 the Department of Health published guidance for PCTs on implementing the scheme: Guidance: GP Extended Hours Access Scheme Directed Enhanced Service - 1 April 2011 - March 2013.

The new DES scheme rewards GP practices for providing around three hours extra appointment time a week per average practice, at times that suit the needs of patients.

As part of the General Medical Services contract changes for 2013/14, the Department of Health announced that the Extended Hours Access DES would be re-commissioned for a year effective from 1 April 2013.

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41 DES payments were already in use to reward GPs for other improvements such as providing quicker appointments.

42 *The Guardian*, 'GPs offered £150m for longer opening times', 20 December 2007

43 The Statement of Financial Entitlements (Amendment) Directions 2010 sets out the payment arrangements that apply to these directed enhanced services. Archived Department of Health website, http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Directionsfromthesecretaryofstate/DH_113692

44 The Primary Medical Service (Directed Enhanced Services) (England) Directions 2010, http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_113691.pdf p4-5

The scheme would not be monitored centrally and responding to a Parliamentary Question on extended GP hours [159339], Anna Soubry said that:

> The Government's view is that general practitioners (GPs) must respond to their patients about the care they deliver, and it believes that GP opening hours should be determined locally, in line with the wishes and preferences of their patients.[45]

NHS England now holds responsibility for commissioning of primary care in England. The BMA guidance on the extended hours access directed enhanced service (DES) 2013-14 states that:

> NHS England must ensure that all practices have the opportunity to enter into an extended hours access scheme under this DES (or a scheme under local arrangements offering at least the minimum requirements of this DES). However, NHS England will not remunerate Personal Medical Services (PMS) (or APMS) practices under this 2013 DES for any period of extended access hours which is currently covered by the core hours set out in their contract.

The Prime Minister's Challenge Fund and extended opening

In October 2013, the Prime Minister announced a new £50 million Challenge Fund to help improve access to general practice and stimulate innovative ways of providing primary care services, including extended opening hours (8am to 8pm) and weekend opening for GP practices.[46]

In September 2014, the government announced a new second wave of access pilots, with further funding of £100m for 2015/16. The Government has asked NHS England to lead the process of inviting practices to submit innovative bids and overseeing the new pilots.

The Challenge Fund is not limited to extending opening hours and will fund a number of ways to improve access including:

- longer opening hours, such as 8am-8pm weekdays and opening on Saturdays and Sundays;
- joining-up of urgent care and out-of-hours care;
- greater flexibility about how people access general practice;
- greater use of technology to provide alternatives to face-to-face consultations eg via phone, email, webcam and instant messaging;
- greater use of patient online services; and
- greater use of telecare and healthy living apps to help people manage their health without having to visit their GP surgery as often.[47]

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[45] Deb 12 June 2013, Col 360W http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130612/text/130612w0002.htm#13061290000619

[46] https://www.gov.uk/government/news/seven-day-8am-8pm-gp-access-for-hard-working-people

[47] Further information is available on the NHS England website: http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/ http://www.england.nhs.uk/wp-content/uploads/2014/10/pmcf-invitation-wave2.pdf

Following these announcements practice groups have been able to apply on a competitive basis for funding from the Challenge Fund.

Information on the "new deal" for general practice, including the Prime Minister's Challenge fund, was provided in June 2015. See section 2.2 above.

5.2 Out of hours services

Outside normal surgery hours, unless there are extended opening hours, patients will usually be directed to an out-of-hours telephone number (or NHS 111) where they can be directed to out-of-hours (OoH) services. The OoH period is from 6.30pm to 8.00am on weekdays and all day at weekends and on bank holidays. Services may include some or all of the following:

- GPs working in A&E departments or minor injuries units (MIUs)
- teams of healthcare professionals working in primary care centres, A&E departments, MIUs or NHS walk-in centres
- healthcare professionals (other than doctors) making home visits, following a detailed clinical assessment
- ambulance services moving patients to places where they can be seen by a doctor or nurse, to reduce the need for home visits

In some areas there are also NHS walk-in centres, which like Minor injuries units (MIUs), can provide treatment for minor injuries or illnesses such as cuts, bruises and rashes.

GP practices can choose whether to provide 24-hour care for their patients or to transfer responsibility for out-of-hours services to the relevant NHS England Area Team. Prior to April 2004 GPs were responsible for the provision of out-of-hours services, but most provided the service either by pooling their responsibility through a GP co-operative or by employing a commercial deputising service. Responsibility for this service had become increasingly unpopular with GPs and had been blamed for causing low morale amongst GPs and problems attracting doctors to become GPs.[48]

5.3 Access targets for GP appointments

In June 2010 the coalition Government ended the central performance management of the target for access to primary medical care – seeing a professional within 24 hours and a GP within 48 hours – as part of its agenda to stop central performance management of process targets that it believed had limited justification.[49]

On 12 May 2015 Ed Miliband announced that a Labour Government would introduce a patient right to receive an appointment at a GP surgery within 48 hours of seeking a consultation and within 24 hours if the patient is in serious need.[50]

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48 Further background can be found in the Public Accounts Committee report The provision of Out of Hours Care, (16th Report of 2006-7, HC360)

49 Some further information on GP access is provided on the NHS Choices website.

50 "Ed Miliband vows to guarantee patients a GP appointment within 48 hours", the Guardian, 12 May 2014

The Conservative Party Manifesto contained a commitment to guarantee same-day GP appointments for all over 75s who need them.[51]

5.4 A 7-day NHS

The Conservative Party Manifesto 2015 contained a commitment to provide 7-day a week access to GPs and hospital care by 2020.[52]

On 18 May 2015 Prime Minister David Cameron gave a speech setting out plans for a 7-day NHS. This included improving access to GP services:

> By the end of this financial year 18 million patients will have access to a GP at mornings, evenings and weekends.
>
> By the end of this Parliament I want that for everyone.[53]

The Prime Minister explained that doctors would not be expected to work a seven day week, but the change would be achieved by implementing different shift patterns.

The Prime Minister also set out plans for providing patients with integrated services to support physical and mental health care needs within GP practices, and improving practices' use of IT so that all patients can book appointments and request prescriptions online, and obtain advice by Skype, Facetime or email.

[51] Conservative Party Manifesto 2015, page 38
[52] Conservative Party Manifesto 2015, page 38
[53] Gov.uk, PM on plans for a seven-day NHS, 18 May 2015

6. Choice of practice and boundary changes

The current position is that GP practices are able to register patients from outside their practice boundaries. This change was agreed in November 2013, when NHS Employers and the BMA General Practitioners Committee (GPC) announced changes to the General Medical Services (GMS) contract in England for 2014/15. The intention is to provide patients with greater choice and to improve the quality of access to GP services.[54]

Further information is provided in the NHS Employers summary of the 2014/15 GMS contract:

> Choice of GP practice – from October 2014, all GP practices will be able to register patients from outside their traditional practice boundary areas without any obligation to provide home visits for such patients. NHS England will be responsible for arranging in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.

The implementation of this policy was delayed from October 2014 and came into force on 5 January 2015.[55] However, these new arrangements are voluntary for GP practices. If the practice has no capacity at the time or feels it is not clinically appropriate for an individual to be registered so far away from home, they can then refuse registration.

These changes are in line with the 2010 Coalition's Programme for Government published on 20 May 2010, which stated that "We will give every patient the right to choose to register with the GP they want, without being restricted by where they live".[56]

The NHS constitution states that: "You have the right to choose your GP practice and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons". The Handbook to the NHS Constitution explains what this right means for patients:

> You can choose with which GP practice you would like to register. That GP practice should accept you onto its list of NHS patients unless there are good grounds for not doing so, for instance because you live outside the boundaries that it has agreed with the NHS Commissioning Board or because they have approval to close their list to new patients. In rare circumstances, the GP practice may not accept you if there has been a breakdown in the doctor-patient relationship or because you have behaved violently at the practice. Whatever the reason, they must tell you why.
>
> If you cannot register with your preferred GP practice, the NHS Commissioning Board will help you find another.
>
> **Source of the right**

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54 NHS Choices, Patient choice of GP practices
55 NHS Choices, Patient choice of GP practices
56 HM Government, The Coalition: our programme for government, May 2010, page 25

The right is derived from the duties imposed on the provider of GP services by virtue of regulations made under the NHS Act 2006, in particular paragraphs 15 to 17 of Schedule 6 to the National Health Service (General Medical Services Contracts) Regulations 2004 and paragraphs 14 to 16 of Schedule 5 to the National Health Service (Personal Medical Services Agreements) Regulations 2004.

7. General practice performance data

General practice performance data can be found on the Health and Social Care Information Centre (HSCIC) website: https://indicators.ic.nhs.uk/webview/.

If you look down the list on the left hand side of this webpage you will see the heading "GP practice data" and within that you can select "patient experience". This section provides data on the patient's experience of general practice through responses to the GP Patient Survey. The data within patient experience is divided into 11 parts, under 4 headings:

Access to GP Services:

Appointments at your GP surgery or health centre

- Getting through on the phone
- Seeing a doctor
- Arriving for your appointment
- Opening hours

Experience of Care

- Seeing the doctor you prefer
- Doctor consultation ratings
- Nurse consultation ratings
- Your overall satisfaction

Management of Long Term Conditions

- Planning your care

Questionnaire respondent demographics

Ipsos MORI on behalf of the Department of Health is responsible for the GP Patient Survey, which gives over 5 million randomly selected, registered patients an opportunity to comment on their experience of their GP practice and local NHS services. For more information on the GP Patient Survey or for the raw response data and information on response weighting used in producing the final results, please go to: http://www.gp-patient.co.uk/.

8. Further information

The NHS Employers website is the best source of detailed information on GP contracts, in particular see the webpages on the General Medical Services contract and contract changes.

Further information about GP contracts can be found on the NHS England website and the BMA website.

Professional bodies:

- Royal College of General Practitioners
- National Association of Primary Care
- BMA General Practitioners Committee

The BMA website also provides useful general guidance for GP practices, including information on premises and staffing and particular areas of service provision

The following Library standard notes may be of interest:

- NHS complaints procedures in England (SN05401), January 2014
- NHS charges for overseas visitors (SN03051), October 2014
- Care.data (SN06781), October 2014

BRIEFING PAPER
Number CBP 07194, 15 May 2015