



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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**Department of Health and NHS England**

# Improving patient access to general practice

## Key facts

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**7,600**

number of general practices in England in 2016

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**£426m**

increase in funding in 2015-16

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**93%**

percentage of 3,250 GP training places in 2016/17 filled

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<b>£9.5 billion</b>	funding for general practice in 2015-16, including out-of-hours services and the cost of dispensing drugs
<b>£230</b>	cost per appointment hour per 1,000 registered patients of the minimum requirements for the proposed extended access scheme, although funding is intended to cover wider costs and improvements in access
<b>£154</b>	estimated cost per appointment hour per 1,000 registered patients in core contract hours
<b>18%</b>	percentage of practices closed at or before 3 pm on at least one weekday, as at October 2015
<b>76%</b>	percentage of practices closing on a weekday afternoon that were paid to provide access outside of core hours in 2015-16
<b>£63</b>	difference in funding per person between local areas with the lowest and highest allocations after adjusting for need
<b>88%</b>	percentage of clinical commissioning groups with either fully delegated or joint (with NHS England) responsibility for commissioning general practice, as at November 2016

# Summary

**1** Most of the contact that people have with the NHS is with general practice, and this is the first step for most patients in diagnosing and treating health conditions. On 31 March 2016, there were around 42,000 doctors employed in some 7,600 general practices in England. General practitioners (GPs) work with nurses and other staff to treat and advise on a range of illnesses, manage patients' conditions in the community and refer patients for hospital treatment or social care where appropriate. GPs are independent contractors. Practices are typically owned and managed by an individual GP or group of GPs. In 2015-16, £9.5 billion was spent on general practice, once the costs of out-of-hours services and dispensing drugs are included, an increase of £426 million from 2014-15.<sup>1</sup>

**2** General practice plays a vital role in healthcare. We therefore decided to carry out a programme of work on access to these services. Our first report pulled together data from a number of sources to provide a stocktake of the current position on access, demand and capacity. It concluded that, while people's experience of accessing general practice remained positive, patient satisfaction with access had declined gradually but consistently.<sup>2</sup> This report examines how the Department of Health (the Department) and the NHS are implementing their objectives and tackling concerns about access. We set out our audit approach and evidence base in Appendices One and Two. The main body of the report starts with an overview of how access to general practice is currently managed (Part One) before covering the support given to general practice to improve access (Part Two) and availability of funding and staffing (Part Three).

## Key findings

### Setting objectives

**3 The Department has recognised the importance of improving access and set some high-level objectives for this, although it has limited understanding of the pressures in general practice.** The Department is ultimately accountable for securing value for money from spending on health services, including general practice. The Department has set objectives for NHS England around access to general practice. These currently include providing evening and weekend access for all patients and 5,000 extra doctors in general practice, both by 2020. However, as highlighted in our previous report, there are still limitations in data on the demand for, and capacity in, general practice. There are risks to both the levels of access and cost of services if there is insufficient assurance that funding and staff are being supplied in line with demand (paragraphs 1.3, 1.6, 2.3, 3.6, 3.12 to 3.14 and 3.18 and Figure 2).

<sup>1</sup> Our first report (see footnote 2) calculated spending on general practice differently, excluding the costs of out-of-hours services, dispensing drugs and local authority investment in public health services in general practice. Calculated in this way, spending has increased £411 million to £8.2 billion in 2015-16.

<sup>2</sup> Comptroller and Auditor General, *Stocktake of access to general practice in England*, Session 2015-16, HC 605, National Audit Office, November 2015.

**4 The Department and NHS England have not fully considered the consequences and cost-effectiveness of their commitment to extend access.**

They have used pilots to understand the demand for, and provision of, extended hours, and have used these to refine their expectations. However, they have not yet fully assessed the cost-effectiveness of the approach and overall resources that will be required. If the additional funding is only used to meet the minimum additional capacity required by the new commitment, this would equate to £230 per appointment hour per 1,000 registered patients. In core contract hours the cost is an estimated £154. NHS England intends that the additional funding will be used to also cover transformation costs and wider improvements in access. However, it has not yet set out how it will assess whether local plans for spending the additional funding provide good value for money. We have not seen evidence that the Department and NHS England fully understand the effect of this commitment to extend hours on continuity of care or other arrangements for providing general medical services outside of core hours. In addition, there is a risk that commissioners may pay for access that is already provided by another service (paragraphs 2.5 to 2.9 and Figure 5).

#### Contractual arrangements

**5 The main contract does not set absolute requirements on access to services including practice opening hours, but shorter opening hours are associated with poorer outcomes.**

Commissioners manage core general practice services through contracts; the most common is the national General Medical Services (GMS) contract. The GMS contract stipulates that 'core hours' are 8 am to 6.30 pm, Monday to Friday (equivalent to 52.5 hours per week). Practices do not necessarily have to be open throughout these core hours, but they must provide essential services at times to meet the reasonable needs of their patients. When they do close during core hours, the vast majority of practices report that services are covered by a local out-of-hours provider or neighbouring practice. We found variations in practices' opening hours during this period. As at October 2015, some 46% of practices closed at some point during core hours. In particular, 18% closed at or before 3 pm on at least one weekday, despite three-quarters (76%) of these practices that closed receiving additional funding in 2015-16 to provide access outside of core hours. Our evidence suggests that the variation between practices cannot readily be explained by differences in their patients' needs and shorter opening hours are associated with poorer outcomes. We found that patients registered to practices that are open for fewer than 45 hours per week attend accident and emergency (A&E) departments more often. Some commissioners are giving practices additional funding to be open throughout the core-hours period (paragraphs 1.2, 1.5, 2.2, 2.4 and 3.9).

**6 Recognising that the traditional model of general practice is unlikely to be sufficient to deliver its objectives, NHS England is supporting the development of new ways of providing and commissioning services.** NHS England's objectives for general practice include extending access for patients at evenings and weekends; practices increasingly operating at a larger scale and collaboratively; and using a broader skill mix. The GMS contract sets few requirements on practices, such as sharing patient records between practices, that would help NHS England to achieve these intentions. Changes in the contract are negotiated annually between NHS Employers, on behalf of NHS England, and the British Medical Association. Practices hold their core contract 'in perpetuity', meaning there is no end date, which further limits the power of commissioners and strengthens practices' contractual position. In April 2016, NHS England, alongside Health Education England and the Royal College of General Practitioners, published its *General Practice Forward View* which set out a range of intentions, including funding for pilots to test new ways of working.<sup>3</sup> NHS England has also developed a 'multispecialty community provider' contract, which is designed to facilitate better collaboration across practices and services (paragraphs 1.5, 2.2, 2.7, 2.10, 2.17, 3.10 and 3.22 and Figure 2).

**7 The new commissioning arrangements offer the opportunity of greater local understanding in the management of services.** Until April 2015, NHS England commissioned all general practice services. However, 88% of clinical commissioning groups (184 of 209) have now taken on joint or full responsibility for commissioning these services. Due to their local presence, clinical commissioning groups should be better placed than NHS England to identify emerging problems with access. However, our evidence suggests some commissioners currently have a limited understanding of whether services are meeting people's needs and have limited capacity to manage any significant service changes, such as a practice handing in notice on its contract. Commissioners also face a tension in managing performance, as using tools such as breach notices may risk damaging the relationship with the practice. We heard many examples of practices improving access or commissioners effectively supporting practices, but some commissioners struggle to find relevant examples that they can apply to their own circumstances. NHS England has limited assurance about the effectiveness of local commissioning, although it has given guidance and started collecting data on performance management (paragraphs 1.4, 2.3 and 2.11 to 2.15 and Figure 3).

<sup>3</sup> NHS England, Health Education England and Royal College of General Practitioners, *General Practice Forward View*, April 2016.

## Supplying staff

**8 NHS England and Health Education England's efforts to increase the GP workforce are at particular risk from falling retention and increases in part-time working.** To provide good access practices need the right numbers of GPs, with inflows of GPs matching changes in demand and outflows. The time taken to train clinical staff, and increasing demand, mean supplying sufficient numbers is challenging. There are very limited data on these individual flows but the trend in the total number of GPs shows that since 2010 nearly as many GPs have left as have joined. NHS England and Health Education England, alongside the Royal College of General Practitioners and the British Medical Association, published a plan in January 2015 which set out new initiatives to improve GP recruitment, retention and return to practice. In April 2016, the *General Practice Forward View* included, for example, intentions for an international recruitment campaign. Against a target of 3,250 GP training places in 2016/17, Health Education England only filled 3,019 (93%) places, although this was an increase from 2,769 in 2015/16. In addition to this continued shortfall in training places, increased levels of part-time working and falling retention, which are not directly the responsibility of either organisation, suggest there may be difficulties in achieving the goal of 5,000 additional full-time equivalent doctors:

- As we previously reported, between 2005 and 2014 (the latest for which comparable data are available), the proportion of GPs aged between 55 and 64 that left approximately doubled. New pension arrangements may be encouraging GPs to retire early if they have maximised their pension fund before the age of 60.
- There are no reliable data on levels of part-time working over time, but female and salaried doctors – who are less likely to work full-time – are increasing as a proportion of the workforce. The latest available data on part-time working in new GPs suggest that there may be 1,900 fewer full-time equivalent GPs by 2020 than Health Education England had estimated there would be (paragraphs 3.12, 3.14 to 3.15 and 3.17 to 3.20 and Figure 12).

**9 NHS England is supporting general practice to employ a wider staff mix to help improve access but the incentives for practices to employ staff cost-effectively are not yet aligned.** In addition to 5,000 more doctors in general practice, it has committed to add at least 5,000 other staff to work in general practice by 2020-21. This includes 3,000 new practice-based mental health therapists, 1,500 clinical pharmacists and 1,000 physician associates, as set out in the *General Practice Forward View*. It is funding pilots to test new ways of working using these staff groups, and is also supporting the development of practice nurses, practice managers and receptionists. The central funding provided to practices for training and employing staff differs considerably by group. For example, while Health Education England pays the salaries of doctors training to become GPs, practice nurses are typically funded solely through practice income. As a result, practices are not incentivised to use the most cost-effective mix of skill. Managing the supply of different staff groups and providing practices with the evidence and incentives to change would help general practice to be efficient and to meet patient needs in the future (paragraphs 3.22 to 3.24 and Figure 2 and Figure 13).

## Allocating funding

### **10 NHS England is reducing some inequalities in the funding of local areas.**

Funding should be allocated equitably according to need so that local areas and individual practices have an equal opportunity to provide good access. NHS England has sought to make allocations to local areas fairer by introducing a more up-to-date calculation of local needs in 2016-17. However, the allocations to local areas balance historical funding – and so financial stability – with relative patient need. As a result, at the extremes, if Islington was to have the same level of funding in 2016-17 as Knowsley, it would have an extra 47% (£63 per person) after adjusting for need. NHS England has committed to reduce this variation, with planned allocations for 2020-21 having almost half the variation (26%) between the extremes than now (paragraphs 3.3 to 3.4 and Figure 9).

### **11 NHS England is seeking to make funding to practices fairer but the underlying basis of the payments has not yet been updated as intended.**

NHS England is phasing out some payments, which are not based on the needs of the local population. For example, between 2014-15 and 2020-21 NHS England is phasing out the top-up payments – totalling £119 million in 2013-14 – given to some practices to ensure their funding did not decrease following the introduction of a new contract in 2004. NHS England is also redistributing the £235 million received by some practices commissioned through locally determined contracts that could not be linked to additional services. However, the funding formula used as the basis to allocate core funding to most practices may not reflect differences in workload across different populations and is out of date. In 2007 a working group recommended updating the formula although changes were not made (paragraphs 3.5 to 3.7).

## **Conclusion on value for money**

**12** The Department and NHS England have a high-level vision for access to general practice and have set some challenging objectives for achieving this. They have increased the funding available to general practice and NHS England has sought to make allocations to local areas fairer. However, they have not yet fully evaluated the cost-effectiveness of their commitments and are seeking to extend access despite failing to provide consistent value for money from existing services. The contractual requirements are limited and have not prevented wide variations in access, with evidence that those practices closing for extended periods during core hours may not be meeting the needs of their patients.

**13** Limited levers to performance manage and difficulty in restructuring services leave commissioners in a weak contractual position. Instead, the Department and NHS England, along with Health Education England, have used a range of softer initiatives intended to incentivise and encourage practices to improve access and deliver better value for money. These measures include piloting new ways of working and seeking to increase staff capacity. But there are considerable limitations in the current mechanisms for delivering improvements – including a failure to attract and retain sufficient staff numbers and misaligned incentives for practices to employ staff cost-effectively. Without a more coordinated approach and stronger incentives to secure the desired results, the NHS is unlikely to get optimal value for money.

## **Recommendations**

- a NHS England and commissioners should fully consider the consequences of their plans to extend access.** This assessment should cover the implications on continuity of care and existing arrangements for providing services outside core hours. NHS England and commissioners should also ensure that services provided outside of core hours are cost-effective and not paid for twice.
- b NHS England should seek greater assurance that services in core hours meet the reasonable needs of patients.** There are unexplained variations in practice opening hours. NHS England needs to assess and monitor what effect these variations have on patients and other health and care services.
- c NHS England should explore how it can encourage GP practices to employ a wider mix of staff to improve access in a sustainable way.** NHS England's vision for general practice relies on greater use of staff other than GPs, such as clinical pharmacists and physician associates. NHS England, along with Health Education England, needs to consider the key barriers to developing a more cost-effective mix of skills and set out a plan to overcome them.
- d NHS England should actively share examples of where commissioners or practices have successfully improved access or capacity in an effective and efficient manner.** There is scope for better sharing of good practice to commissioners and practices. NHS England should ensure that information on these examples is more readily available for all to benefit from.
- e The Department and NHS England should seek to improve the existing data from general practice to better understand the capacity of, pressures on, and demand for services.** A cost-effective service will balance access with demand; however, some of the Department's and NHS England's objectives are based on a crude understanding of the level of demand and what influences it. They need to continue to address the shortcomings in data highlighted in our first report.