

Monitor

Making the health sector
work for patients

Improving GP services: commissioners and patient choice



About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

Contents

Contents	3
Executive summary.....	4
1. Introduction	7
1.1 What we did	8
1.2 Work by other organisations on GP services	8
1.3 Sources of information	8
1.4 Structure of the report	9
2 Overview of GP services in England	10
2.1 GP services are vital to healthcare and the wider economy	10
2.2 Registering with a GP	12
2.3 How GP services are commissioned	13
2.4 Who provides GP services.....	18
2.5 Demand for GP services	19
2.6 Meeting patients' needs and expectations.....	20
3 Patients' ability to choose the practice that best meets their needs	26
3.1 The role of choice in helping patients get the best GP services for them.....	26
3.2 Aware and engaged patients	28
3.3 Informed patients	33
3.4 Patients able to register with the practice of their choice.....	36
3.5 Conclusions on patients' ability to register with the GP practice that best meets their needs	40
4. Providers' ability to meet patients' needs	41
4.1 Meeting increasing demand.....	41
4.2 Resources to help providers meet patients' needs	43
4.3 Providers' ability to establish new services	48
4.4 Flexibility to meet patients' needs	54
4.5 Concerns about conflicts of interest.....	59
4.6 Conclusions on providers' ability to meet patients' needs	60
5. Steps to improve how choice and competition is working in GP services	61
5.1 Steps our partners are taking that will help GP services work better for patients	61
5.2 Steps we are considering to complement the work of our partner organisations	62
Annexes.....	64
Annex 1: Regional variations in workforce and access.....	64
Annex 2: NHS England's and CQC's performance monitoring frameworks	66
Annex 3: Characteristics of practices with different outcomes	68
Annex 4: Comparing patient experience with other outcome standards	71
Annex 5: Availability of alternative GP sites	73
Annex 6: Payment per weighted patient in areas of different levels of income deprivation ..	76

Executive summary

Background

General practitioners (GPs) provide over 300 million consultations to patients in England each year. For most patients, their GP is their first and most regular point of contact with the NHS. As well as providing treatment and advice directly to patients, GPs act as gatekeepers to other NHS services and co-ordinate those services on behalf of patients.

Patients have been able to choose their GP since the establishment of the NHS in 1948 and this choice is a right set out in The NHS Constitution. Patient choice is reaffirmed in the Five Year Forward View which states that it will “make good on the NHS’ longstanding promise to give patients choice over where and how they receive care”. While patient choice is a factor that can help deliver better GP services, GPs also need sufficient resources and opportunities from commissioners to be able to respond to patients’ needs.

Monitor’s role is to make sure the whole health sector works for patients. This includes making sure the commissioning and provision of GP services works well for patients and a specific role in making sure that choice and competition operate in the best interests of patients.

How to use this report

This report presents the findings of our review of how GP services are working for patients, with a specific focus on the role of choice and competition. Our work is aligned with and complements other work on GP services by some of our partner organisations. Here, we focus on the role of patient choice in driving improvements in the quality of GP services, an area we have identified where further research would be useful.

We drew on a survey of 3,200 patients, interviews with 25 GP providers, and information from NHS England, the Care Quality Commission (CQC) and other stakeholders.

The information we gathered indicates that a substantial majority of patients are satisfied with their GP practice and the large majority of GP practices perform well against NHS England’s and the CQC’s quality indicators. However, there are variations in how readily patients can access GP services and in the quality of services provided.

This presents a particular opportunity for clinical commissioning groups (CCGs) to help improve GP services for patients as they have been eligible to co-commission GP services with NHS England since April 2015. We set out our findings below followed by next steps.

Our findings

Patients are aware of and value their ability to choose their GP practice but most do not access information that would help them choose a GP practice that would best meet their needs

Our patient survey found:

- More than 90% of patients know they have the right to choose a GP practice and think that choice is important.
- Few patients seek out information to inform themselves when choosing their GP practice. They typically choose their GP practice because it is close to their home, and not because of other things that they say they look for in their GP practice (such as the quality of diagnosis and treatment or how easy it is to make an appointment).
- Almost a third of patients think that they do not have alternative GP practices to choose from. Our analysis suggests that in many cases this stems from lack of awareness.
- Only a small minority of patients have been refused registration because of practice boundary areas and closed lists.

Resource constraints appear to restrict providers' ability to respond to patients' needs

- Most providers of GP services we spoke to told us that they find it challenging to meet the needs of their patients with existing resources because of an increase in the volume and complexity of consultations.
- GPs told us that workforce shortages and a lack of funding (eg for premises) are constraining their ability to expand capacity in response to patient needs.
- Some providers told us that the payment they receive does not allow them to operate on a financially viable basis.
- The evidence we reviewed suggests that the current level of supply of GPs is unlikely to keep pace with increasing demand and that workforce issues are particularly severe in economically deprived areas.
- There is also evidence that the distribution of funding for GP services creates a challenge for some GP practices in delivering good services to patients, particularly in economically deprived areas with challenging health needs.

There have been few recent opportunities for providers to set up new services or expand existing services

- Some providers told us there were few opportunities to set up new GP practices or expand with new surgeries in areas where they had identified patient need.
- The evidence suggests that commissioners have awarded few new contracts to provide GP services in the last few years.

Commissioners have an opportunity to improve providers' ability and incentives to meet patients' needs

Some providers told us that commissioners could be more transparent and flexible to help providers establish new GP services and expand existing ones. This is especially important when GPs want to work together for the benefit of patients and establish new models of care. In our view, this should involve ensuring that the contract length and renewal conditions are transparent and reflect local circumstances. Flexibility around where GP services are provided would be helpful for providers, particularly in tackling the challenges in deprived areas.

Next steps

Monitor and other national organisations, including NHS England, the Department of Health, CQC, Health Education England, the BMA and the RCGP, have launched initiatives aimed at addressing the resource constraints GPs are facing, developing contracting arrangements for the new models of care set out in the Five Year Forward View and informing patients about their choice of GP services.

We will continue to share and discuss our findings with NHS England and CCGs that are involved in co-commissioning GP services. CCGs co-commissioning GP services is an opportunity to strengthen resources and local knowledge in the commissioning of GP services. We will support CCGs in adopting approaches to commissioning GP services that draw on active engagement with providers and gathering accurate information about patient needs across different areas. We will encourage CCGs that are already doing this to share their best practices with other commissioners.

We will support CCGs and other organisations, such as patient groups, to communicate robust information to patients that will allow them to compare GP services on the basis of what matters to them (including those with different needs).

We will also integrate the findings of our research into Monitor's day-to-day work providing informal advice to providers and commissioners on the application of the Procurement, Patient Choice and Competition Regulations.

1. Introduction

General practice plays a central role in ensuring the delivery of universal, high quality care to NHS patients. For the majority of patients, general practice is among their first and most regular points of contact with the NHS.¹ As well as providing advice, diagnosis and treatment directly to patients, general practitioners (GPs) act as gatekeepers to services provided by other parts of the NHS and have a role in co-ordinating those services on behalf of patients.

As the sector regulator of healthcare, Monitor's role is to make the health sector work for patients. In line with this, we have been engaging with patients, providers and commissioners to understand how GP services are working for patients and how they could be improved.

GP services and primary care generally are expected to change significantly as the NHS makes the Five Year Forward View a reality. More patient care will be delivered locally and investment in primary and community care will increase. At the same time, the boundaries between primary and other forms of care will blur as integrated models of care, such as Multispecialty Community Providers and combined Primary and Acute Care Systems, develop.

The Five Year Forward View states “the foundation of NHS care will remain list-based primary care”² and says it will “make good on the NHS’ longstanding promise to give patients choice over where and how they receive care”. Ever since the NHS was set up in 1948 patients have been able to choose their GP. Based on the ambition set out in the Five Year Forward View, patients’ ability to choose the GP practice that best meets their needs will continue to be a factor in shaping the patient-centred NHS of the future. This report looks at whether patients can choose the GP practice that best meets their needs now and what might help them to do so in future.

The Five Year Forward View also sets out that “the NHS will take decisive steps to break down the barriers in how care is provided”.³ It suggests that delivering list-based primary care services in combination with other services will require different providers, for example acute hospitals, to begin offering list-based GP services to patients. This report looks at the ability of new providers and existing providers to develop existing services and set up new services to respond to patients’ needs.

¹ This constitutes approximately 90% of patient contacts with the NHS. Nuffield Trust. (2014) ‘Is general practice in crisis?’ Available from: www.nuffieldtrust.org.uk/publications/general-practice-crisis

² NHS England. (2014) ‘Five Year Forward View’ (hereafter ‘The Five Year Forward View’), page 4, Available from: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

³ See the Five Year Forward View, page 3

1.1 What we did

We launched a call for evidence about GP services in July 2013 to hear from patients, commissioners, providers and others about access to general practice and the quality of services. We followed this up in February 2014 with a [discussion document](#)⁴ describing what we learnt, which said we would carry out analysis to improve our understanding of variations in access and quality across England and how these may be addressed.

This report reviews the evidence on variations in access and quality and assesses why these variations are not being resolved by patients choosing alternative providers⁵ and by GP providers expanding and developing their provision of GP services and setting up new services where there are patient needs.⁶

1.2 Work by other organisations on GP services

Some of our partner organisations are looking at the performance and capacity of GP services, and the evolution of these services as part of an integrated healthcare landscape in line with the Five Year Forward View. For example, the Care Quality Commission (CQC) is in the process of inspecting every GP practice in England, while NHS England is seeking to work more closely with clinical commissioning groups (CCGs) in commissioning of GP services.

Our work is aligned with and complements this wider programme of work. Here, we focus on the role of patient choice in driving improvements in the quality of GP services, an area where we have identified that further research would be useful.

1.3 Sources of information

Our review drew on a variety of sources:

- 180 submissions from patients and stakeholders including providers, commissioners, GPs and patient groups received in response to our call for evidence in July 2013⁷
- an Ipsos MORI nationally representative survey we commissioned of around 3,200 patients in England in November 2014 who registered with a GP

⁴ Monitor (2014). 'Discussion document following Monitor's call for evidence on GP services' Available from: www.gov.uk/government/consultations/general-practice-services-call-for-evidence

⁵ Throughout this report we use the term 'providers' to mean current and potential providers of GP services and often use the term 'GP practice' rather than 'GP provider' when we refer to GP services from the patient's perspective. This is because choice at the patient level is at the practice rather than the provider level (for example, patients could choose between several GP practices owned by the same provider).

⁶ Our review focuses on services provided to patients under their registration with a GP practice. It does not cover optional extra services such as out-of-hours primary care services or community services that are provided by some GP practices.

⁷ Responses to our call for evidence are available at: www.gov.uk/government/consultations/general-practice-services-call-for-evidence

practice.⁸ Our aim was to understand more about what patients want from their GP services, whether they think about which GP practice would best meet their needs and why they might not then choose that practice. We have published [a report](#) containing the findings of the survey and an explanation of the methodology

- interviews with 25 GP providers, including GP partners, practice managers and chief executives of existing and potential providers in November and December 2014. Many of these interviewees also held senior positions in CCGs, local medical committees (LMCs) and the British Medical Association (BMA). We asked the interviewees about:
 - patients' needs and expectations
 - steps they have taken to manage these needs and expectations
 - obstacles they faced in starting to provide new services and expand existing ones
 - ways in which GP practices have collaborated with each other
- information about NHS England's commissioning of GP services based on discussions with senior staff there and their response to an information request from us
- engagement with a broad range of stakeholders including NHS England, the Department of Health, CQC, Healthwatch England, the BMA, the Royal College of General Practitioners (RCGP), the Competition and Markets Authority (CMA), Which? and the Cabinet Office.

We would like to thank all the interviewees, survey respondents and organisations that contributed their time and expertise to this project.

1.4 Structure of the report

- Section 2 describes the role GP services play in healthcare, how patients register with a GP practice and how GP services are commissioned, funded and provided. It also summarises evidence on how well GP practices meet patients' needs.

⁸ The main fieldwork took place between 7 and 25 November 2014 and consisted of face-to-face interviews carried out as part of Ipsos MORI's omnibus survey. The data is weighted by gender, age, working status and region to be representative of the population of adults registered with a GP in England. Throughout this report, when we list the survey findings we note the specific questions in the Ipsos MORI survey that each of our findings relates to (the questionnaire is published alongside the Ipsos MORI report). We also report the sample sizes and highlight when results should be interpreted with care (Ipsos MORI strongly recommends to interpret any samples of less than 100 respondents with caution).

- Section 3 sets out our findings on patients' ability to choose the GP practice that best meets their needs.
- Section 4 sets out our findings on providers' ability to meet patients' needs.
- Section 5 outlines steps other organisations are taking and we propose to take to help choice and competition work better for patients.

2 Overview of GP services in England

In this section we describe the role of GP services, how patients register with a GP and how GP services are commissioned, funded and provided. We also review the available evidence on how GP services are meeting patients' needs.

This information will be familiar to those engaged in the provision or commissioning of GP services. We think it is useful, however, to set out this information as context to our discussion of variations in quality and access, and patient choice.

2.1 GP services are vital to healthcare and the wider economy

For most patients GPs are among their first and most regular contacts with the NHS. They diagnose and treat patients, they can act as care co-ordinators and are the gatekeepers to other services. Patients' interaction with their GP providers affects their use of other healthcare services including urgent and emergency care and social care (we note that the provision of social care can also have knock-on effects on healthcare services).⁹ The provision of high quality, efficient and innovative GP services therefore can have a significant impact on the wellbeing of patients, the use of other NHS services and the wider economy.

Impact on wellbeing: Research suggests that an increase in the supply of GPs has a significant positive effect on self-reported individual health.¹⁰ Similarly, research suggests that patients with better access to GPs in the form of reduced list size per GP can improve the management of obesity.¹¹

Impact on the use of other health services: There is evidence to suggest that availability of GP services can have an impact on other health services:

⁹ For example, a recent study concluded that it is highly likely that reduced spending on social care for older adults is having a negative effect on the health and wellbeing of users and carers, although the impact is difficult to quantify. The Health Foundation and Nuffield Trust. (2014) 'Focus on: Social care for older people – Reductions in adult social services for older people in England'. Available from: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140326_qualitywatch_focus_on_social_care_older_people_0.pdf

¹⁰ A 10% increase in the number of GPs would increase the probability of reporting very good health by 6%. Gravelle, Morris and Sutton. (2008) 'Are family physicians good for you? Endogenous doctor supply and individual health', *Health Services Review*, August 2008, vol. 43, No.4 pp. 1128-44).

¹¹ For example, a 10% increase in GP supply is associated with reductions of around 4% in Body Mass Index. Morris & Gravelle. (2006) 'GP supply and obesity', *Centre for Health Economics Research Paper 13*, page 11, Available at: www.york.ac.uk/media/che/documents/papers/researchpapers/rp13_GP_supply_and_obesity.pdf

- A GP patient survey published by NHS England in 2015 and commissioned from Ipsos MORI asked patients what they did if they were not able to get an appointment with their GP or were offered an appointment at an inconvenient time: 10% said they went to a walk-in centre or A&E¹²
- Drawing on the NHS England / Ipsos MORI survey evidence, a recent study found that in 2012/13 there were approximately 5.77 million attendances at A&E as a result of patients being unable to make any appointment or a convenient appointment at their GP practice. Extra patients at A&E may lengthen waiting times, and so reduce the quality of services for patients there.¹³
- In the survey we commissioned from Ipsos MORI we asked patients what would they be most likely to do if they wanted to see a GP because they were unwell but were unable to make an appointment when they wanted.
 - 27% of patients that took part in our survey said they would go to a walk-in centre and 17% would go to an A&E/hospital¹⁴
 - 16% of patients said they would try to make an appointment at their GP practice for a different time
 - 12% said they would call NHS 111.
- We note that the differences between our survey and the GPPS may be because different questions were asked. The GPPS asks what patients actually *did* while our survey asked patients what they *would* be most likely to do if they were unwell. The GPPS does not indicate that this choice occurred when patients were feeling unwell (patients often visit their GP without feeling unwell in which case they may not need to be seen urgently.)¹⁵
- There is also research to suggest that improvements in the quality of GP services are associated with modest but measurable reductions in the costs of hospital inpatient and outpatient use.¹⁶

¹² Ipsos MORI. (2015) 'GP patient survey'. Available from: <https://gp-patient.co.uk/surveys-and-reports>

¹³ Cowling et al. (2014) 'Access to general practice and visits to accident and emergency departments in England: cross-sectional analysis of a national patient survey', *British Journal of General Practice*. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4073729/>

¹⁴ Ipsos MORI. (2014) 'Exploring patient choice in GP services', (hereafter 'Ipsos MORI survey'), responses to questions 8 and 29 (3,192 responses). Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430776/Exploring_choice_in_GP_services__Ipsos_MORI_survey.pdf

¹⁵ We also note the different methodologies of the two surveys. The GPPS is a postal self-completion survey while our survey is based on face-to-face interviews.

¹⁶ The Health Foundation. (2010) 'Do quality improvements in primary care reduce secondary care costs?' Available from: www.health.org.uk/public/cms/75/76/313/2194/Do_quality_improvements_in_primary_care_reduce_secondary_care_costs.pdf?realName=gdrj7N.pdf

- Finally, the King’s Fund has estimated that one in every six emergency hospital admissions in England is for conditions for which earlier intervention could reduce this. These admissions cost the NHS £1.42 billion each year. The Kings Fund estimates that these could be reduced by between 8% and 18% (leading to savings of up to £238 million per year).¹⁷

Impact on the wider economy: Research by the Patients’ Association found that 38% of working age people have taken time off from work for an appointment with their GP.¹⁸ The impact on patients and employers might be reduced if patients were able to receive care at times and locations that suit them better.

2.2 Registering with a GP

When the NHS was created in 1948 patients could choose their GP practice and GP. Since then, this ability to choose has been repeatedly reaffirmed¹⁹ and is a right set out in The NHS Constitution.²⁰ Patients (and parents or guardians acting on behalf of a dependant) exercise this choice by deciding which GP practice to register with.

To register with a GP practice, patients need to provide some basic information (eg name, address, date of birth) and may be required to show proof of identity and proof of address.²¹

A GP practice with a registered patient list will have a list that is open or closed (although closed lists are rare as we explain in section 3). GP practices with open lists are required to take onto their patient list anyone who lives within that practice’s boundary area,²² subject to certain exceptions. GP practices that have gone through the formal process to agree with NHS England to close their lists may not register any new patients other than immediate family members of existing patients.

A GP practice boundary is a geographic area located around a GP practice and GPs are required to provide home visits to patients on their list where a patient’s medical

¹⁷ The King’s Fund. (2012) ‘Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions’ Available from: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf

¹⁸ Patients Association. (2013) ‘Primary care: access denied?’, *Primary Care Review Vol. 2*, page 7.

¹⁹ For example, most recently in Department of Health. (2010) ‘Equity and excellence: Liberating the NHS’. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

²⁰ Department of Health. (2013) ‘The NHS Constitution’, page 8, Available from: www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

²¹ However, patients who are not registered with a GP practice can still receive GP services, such as emergency treatment from a GP surgery that they are not registered with for up to 14 days. They also do not need to be registered to access GP services at a GP-led health centre or a walk-in centre. See the NHS Choices website for more information.

²² For providers operating under GMS and PMS contracts, practice boundary areas must be agreed between NHS England and the provider. APMS contracts need not contain practice boundary areas but they may by agreement between NHS England and the provider.

condition means this is appropriate.²³ A GP practice can, if it wishes, decline to register a patient if they do not live within its practice boundary.

The rules on home visits have recently changed and now GP practices may register patients who live outside their practice boundary areas without taking on the corresponding obligation of providing home visits, provided this is appropriate for the patient.²⁴ NHS England has also introduced a new service to ensure that patients registered out of area (who will not receive home visits from their registered GP) have access to an urgent consultation when it is not clinically appropriate for the patient to attend their registered practice.²⁵

Patients often choose to register with a new GP practice when they move to a new area²⁶ but they are free to switch whenever they wish. In sections 2 and 3 we discuss in more detail the factors that influence patients' choice of GP.

2.3 How GP services are commissioned

Services commissioned

Providers of GP services are contracted by NHS England to provide essential GP services to registered lists of patients during the core hours of 8.00am to 6.30pm, Monday to Friday (except for certain holidays).²⁷ They include:

- service required for the management of patients who are, or believe themselves to be, ill or suffering from chronic disease
- appropriate ongoing treatment and care for patients and taking account of their specific needs including:
 - providing advice about the patient's health, including relevant health promotion advice
 - referring the patient for other services

²³ 'The National Health Service (General Medical Services Contracts) Regulations 2004' (hereafter 'the GMS regulations'), page 41, paragraph 15. Available from:

http://www.legislation.gov.uk/ukxi/2004/291/pdfs/ukxi_20040291_en.pdf

²⁴ See the NHS Choices website: <http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/patient-choice-GP-practices.aspx>

²⁵ NHS England. (2014) 'Out of area registration: In hours urgent primary medical care (including home visits) Enhanced Service'. Available from: <http://www.england.nhs.uk/wp-content/uploads/2014/11/gp-con-enhanced-service-out-area-reg.pdf>

²⁶ When moving home, patients may also choose to remain registered with their existing practice (eg if there is not a better service nearby and they are satisfied with the quality of service provided by their existing practice). All GP practices must have an outer practice boundary area where they will retain, where appropriate, existing patients who move to this area.

²⁷ Defined in the GMS regulations and 'The National Health Service (Personal Medical Services Agreements) Regulations' (hereafter 'the PMS regulations'). Available from: <http://www.legislation.gov.uk/ukxi/2004/627/contents/made>

- primary medical services required in core hours for the immediately necessary treatment of any person to whom the provider has been requested to provide treatment owing to an accident or emergency at any place in its practice area.

As discussed above, for some patients GPs have an obligation to undertake a home consultation, if medically appropriate, during normal surgery hours.²⁸

For its registered patient list, the GP provider is also responsible for acting as a gatekeeper to more specialist care. GPs can also provide urgent referrals to non-elective services where appropriate (eg A&E, maternity services).

Contracts awarded

To provide GP services, providers need to enter into a contract with NHS England. NHS England decides when to offer new GP contracts (or extend existing contracts) and what type of contracts to offer.²⁹ Any new contract (or material variation to an existing contract) must be awarded in accordance with the Procurement, Patient Choice and Competition Regulations and other applicable rules. NHS England is also responsible for ensuring that each provider complies with the terms of its contract. CCGs have a duty to assist and support NHS England in securing continuous improvement in the quality of primary medical services.³⁰ NHS England is working with CCGs to explore how to co-commission primary care services, and some CCGs have started co-commissioning as of April 2015.³¹ Co-commissioning can involve greater input from CCGs in primary care decision-making, joint commissioning with NHS England or commissioning being delegated to a CCG.³²

Approximately 96% of GP providers in England operate under a General Medical Services (GMS) or Personal Medical Services (PMS) contract.³³ Some GP services are also provided under Alternative Provider Medical Services (APMS) contracts. NHS England selects which form of contract is most appropriate, taking into account relevant legislation and local circumstances. Two key differences between these contract types are the types of providers who can hold them and the length of the contract. Table 1 summarises some key differences between these contracts.

²⁸ In 2008/09 approximately 3% of GP consultations took place in a patient's home (or nursing or residential homes). This had fallen from 9% in 1995/96. HSCIC. (2009) 'Trends in Consultation Rates in General Practice - 1995-2009'. Available from: <http://www.hscic.gov.uk/pubs/gpcons95-09>

²⁹ NHS Commissioning Board. (2012), 'NHS Commissioning Board: local area teams – staff briefing pack'. Available from: www.england.nhs.uk/wp-content/uploads/2012/06/lat-senates-pack.pdf

³⁰ This duty is set out in section 14S of the National Health Service Act 2006 as inserted by section 25 of the Health and Social Care Act 2012. Available from: <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

³¹ NHS England and NHS Clinical Commissioners. (2014) 'Next steps towards primary care co-commissioning'. Available from: www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf

³² See the NHS England website: www.england.nhs.uk/commissioning/pc-co-comms/

³³ In 2013/14 56% of contracts were GMS, 40% were PMS and 4% were APMS. Source: HSCIC. (2015) 'General and Personal Medical Services, England - 2004-2014'. Available from: <http://www.hscic.gov.uk/catalogue/PUB16934>

Table 1: Selected differences between types of GP services contracts

Contract type	General Medical Services (GMS)	Personal Medical Services (PMS)	Alternative Provider Medical Services (APMS)
Who can hold these contracts?	GPs, GP partnerships or companies limited by shares that are wholly owned by GPs or persons involved in the provision of NHS services.	GPs and other healthcare professionals or people involved in providing NHS services, NHS trusts and foundation trusts.	Any person that meets the requirements set out in the APMS Directions .
How are the contract terms and payment determined?	Most terms prescribed by regulation. ³⁴ Negotiated nationally between BMA General Practitioners Committee and NHS Employers and payment is based on a nationally agreed pay structure. ³⁵	Most terms prescribed by regulation. ³⁶ Some terms and payment subject to local negotiation by NHS England and individual GP providers (in practice contract terms follow GMS very closely).	Most terms and payment locally negotiated by NHS England and individual GP providers. Some terms prescribed by regulation. ³⁷
What is the length of the contract?	No end date.	Subject to negotiation (in practice we understand many have no end date or are renegotiated periodically). Holders of PMS agreements have the option to move to a GMS agreement under Part 6 of the PMS regulations. This operates as a constraint on the ability of NHS England to limit the length of a PMS agreement.	Contract length and renewal process subject to local agreement.

³⁴ GMS regulations

³⁵ Set out in the 'General Medical Services Statement of Financial Entitlements Directions 2013 Statement of Financial Entitlements' (hereafter 'GMS financial entitlements'). Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/233366/gen_med_servs_statement_financial_entitlements_directions_2013_acc.pdf

³⁶ PMS regulations

³⁷ 'Alternative Provider Medical Services Directions 2013' (the APMS Directions). Available from:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/183370/apms_directions_2013_acc.pdf

NHS England told us that as part of the implementation of new care models they are currently considering the commissioning and contracting models for Primary and Acute Care Systems and Multispecialty Community Providers.

Funding and payments

NHS England is responsible for commissioning core GP services as well as some other services for registered lists of patients.³⁸ CCGs are responsible for purchasing other GP services such as out-of-hours primary medical services.

In 2013/14, total spending on all general practice in England was approximately £8.75 billion³⁹ (8.2% of total healthcare spending in England).⁴⁰ This section explains the key elements of this spending.

Capitated payment

Capitated payments for GP services are made to a provider (or group of providers) for delivering all GP services to a group of patients. They are typically based on a level of payment per patient.

The payments GPs receive depend on their contract type. GMS contractors receive a payment based on the number of patients registered with the practice.⁴¹ The weighting of the list depends on the needs of the patients on the list and is calculated using a methodology known as the Carr-Hill formula. The Carr-Hill formula is a methodology for distributing funding to general practice under GMS contracts for essential services (and some additional services). It accounts for factors such as age, sex, other needs of the population relating to morbidities, adjustment for list turnover, and adjustments for unavoidable costs such as the Market Forces Factor and rurality.⁴² PMS contractors and APMS contractors that have a list of registered patients typically also receive a capitated payment which may be different from the capitated payment agreed nationally for GMS contractors.

³⁸ These include additional services, enhanced services and out of hours services where GPs have not opted-out under their GMS contract or PMS agreement for registered patients.

³⁹ See HSCIC. (2014) 'Investment in General Practice, 2009-10 to 2013-14, England, Wales, Northern Ireland and Scotland'. Available from: www.hscic.gov.uk/catalogue/PUB14900

⁴⁰ Total expenditure on health was £106.476 billion in 2013/2014. HM Treasury. (2014) 'HMT Public expenditure Statistical Analyses 2014'. Available from: www.gov.uk/government/statistics/public-expenditure-statistical-analyses-2014

⁴¹ This is called the global sum because in 1948 the global sum of the funding available for primary care was divided up between GP practices on the basis of the number of patients on their list. In 2013/14 this was calculated by multiplying weighted list size by £66.25. See GMS financial entitlements. GPs also receive other payments as detailed in the following paragraphs.

⁴² The Carr-Hill formula was developed in 2003 by a team led by Professor Roy Carr-Hill. For more information see: NHS Employers. (2003). 'New GMS contract: investing in general practice – Annex D: Carr-Hill resource allocation formula'. Available from:

www.nhsemployers.org/~media/Employers/Documents/Primary%20care%20contracts/QOF/QOF%202004/Anne%20D%20-%20Carr-Hill%20resource%20allocation%20formula.pdf

Quality and Outcomes Framework (QOF)

Extra payments known as QOF payments are a financial incentive for providers subject to them achieving consistent standards of care and quality outcomes in certain areas. They are available to all GP providers with a registered list of patients and are calculated based on points achieved across two domains: clinical and public health (including the sub-domain: public health – additional services).⁴³

Income guarantees

When the GMS contract was re-negotiated in 2004, existing providers agreed a guarantee that they would not receive less income under their new contracts than they had under their previous contracts. This transitional arrangement was called a Minimum Practice Income Guarantee (MPIG). We understand that some new contracts entered into after 2004 also contain income guarantees. Changes to the GMS contract in 2013/14 included the phased removal of the MPIG over seven years between April 2014 and April 2021.⁴⁴

Other payments

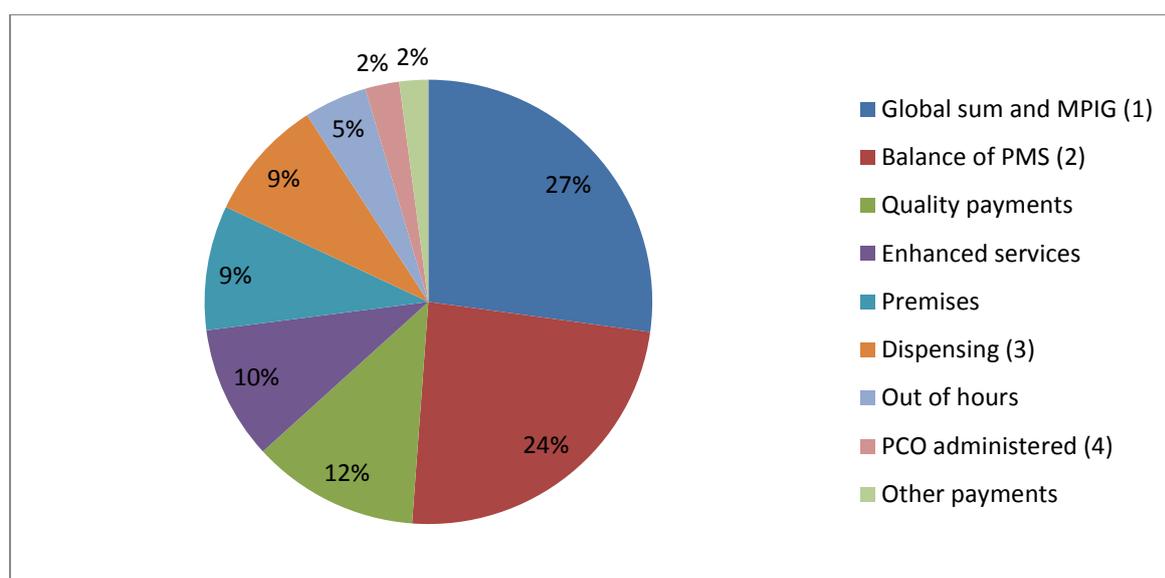
Other payments available to some GP providers include premises and IT payments, enhanced services payments and pharmacy dispensing payments. GPs also receive some activity based payments (eg for providing flu vaccinations).

Figure 1 below shows the breakdown of payments to general practice in 2013/14.

⁴³ QOF awards GP surgeries achievement points for things like managing chronic diseases (eg asthma), implementing preventative measures (eg, blood pressure checks) and providing extra services.

⁴⁴ Letter from Department of Health to Dr Laurence Buckman (Chairman, General Practitioners Committee, BMA). 6 December 2012. Available from: [/www.gov.uk/government/uploads/system/uploads/attachment_data/file/213224/GMS-Contract-letter.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213224/GMS-Contract-letter.pdf)

Figure 1 Breakdown of payments to general practice, 2013/2014



Source: Monitor using HSCIC data (Investment in General Practice, 2014)

- (1) Global sum payments refer to payments based on capitation. MPIG constituted 1.5% of the total payment to general practice.
- (2) Balance of PMS are payments to PMS practices that are equivalent to global sum payments.
- (3) Dispensing includes dispensing fees, quality schemes and reimbursement of dispensed drugs (14% of GP practices are authorised to dispense prescriptions).
- (4) Primary Care Organisation (PCO) administered payments include doctors retainer scheme, total locum allowances, prolonged study leave, appraisal and similar other payments.

As the figure shows, global sum and MPIG as well as balance of PMS are the largest category of payments GPs receive followed by quality payments, payments for enhanced services and premises payments.

2.4 Who provides GP services

In 2014 there were 7,875 GP practices in England.⁴⁵ Nearly all GP providers in England are owned by GPs who are partners in the practice. They are responsible for covering many of the running costs of the practice. They keep any surplus and are responsible for any deficit incurred by the practice. Some providers own the premises that their practice operates from while others rent them.

Some GP practices are part of a group of practices with a common owner. The largest GP-led companies operating several practices include: The Practice, SSP Health, Vitality Partnership, Malling Health and The Hurley Group. Other types of providers of GP services include social enterprises such as Salford Health Matters

⁴⁵ HSCIC. (2015) 'General and Personal Medical Services: England 2004-14'. Available from: <http://www.hscic.gov.uk/catalogue/PUB16934/nhs-staf-2004-2014-gene-prac-rep.pdf>

and publicly traded companies (for example as of May 2015 Virgin Care held 19 GP services contracts).⁴⁶

The structure of GP practices has been changing. The number of GP practices with a single GP⁴⁷ fell from around 1,900 in 2004 to under 900 in 2014, while the average patient list size has grown from around 6,000 in 2004 to 7,000 in 2014.⁴⁸

2.5 Demand for GP services

Providers and commissioners both told us that demand for GP services is increasing, although they also said that there is a lack of robust and up-to-date information to verify this (eg lack of local data, estimates of demand based on extrapolations of historical data). The evidence we reviewed indicates that demand is indeed increasing in both volume and complexity:

- The population in England is growing and the proportion of elderly people is increasing.⁴⁹ In 2014, around 54% of patients reported that they have a long-standing health condition, up from 43% in 2009.⁵⁰ The number of people with multiple long-term conditions is also rising, and the number of people with three or more long-term conditions is predicted to rise from 1.9 million in 2008 to 2.9 million in 2018.⁵¹ These trends are connected as elderly people are more likely to have a long-standing health condition.
- The NHS Information Centre estimated that, on average, each patient consulted their GP 3.9 times a year in 1995/96. This increased to 5.5 times a year in 2008/09. The increase in the average number of consultations for people over 75 was even higher, almost doubling during the same period.⁵² In a recent report commissioned by the Department of Health and Health Education England, the Centre for Workforce Intelligence (CfWI) reports that if the number of consultations has continued to increase since 2009 at its historic growth rates, there would have been around 340 million consultations (around 6.1 consultations per person) in 2013.⁵³

⁴⁶ See Virgin Care website: <http://www.virgincare.co.uk/service-hub/gps-practice/>

⁴⁷ A GP practice with a single GP may also employ GP registrars or GP retainers.

⁴⁸ HSCIC. (2015) 'General and Personal Medical Services, England - 2004-2014'. Available from: <http://www.hscic.gov.uk/catalogue/PUB16934>

⁴⁹ Office for National Statistics. (2014) 'Population Estimates for UK, England and Wales, Scotland and Northern Ireland'. Available from: <http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/index.html>

⁵⁰ Ipsos MORI. (2009 and 2015) 'GP patient survey – National summary results'. Available from: <https://gp-patient.co.uk/surveys-and-reports>

⁵¹ Department of Health (2012). 'Long-term conditions compendium of Information: 3rd edition' Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_134487

⁵² HSCIC. (2009) 'Trends in Consultation Rates in General Practice - 1995-2009'. Available from: <http://www.hscic.gov.uk/pubs/gpcons95-09>

⁵³ Centre for Workforce Intelligence. (2014) 'In-depth review of the general practitioner workforce' (hereafter 'Review of the general practice workforce'). Available from: <http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce>

- The most recent UK GP Workload Survey, carried out in 2006/07, showed that the average length of a GP consultation had increased from 8.4 minutes to 11.7 minutes between 1992/93 and 2006/07.⁵⁴ The CfWI's interviews with GPs suggested that the complexity of consultations has been increasing since then and almost all providers we spoke to told us this as well.⁵⁵

Although the available evidence strongly suggests that demand is increasing across England, it does not allow us to identify how it is changing across different areas. Accurate and up-to-date information on the volume and nature of services provided by GPs would help commissioners better understand demand for GP services in different areas. We discuss this further in section 4.

2.6 Meeting patients' needs and expectations

Below we summarise evidence on the extent to which GP practices are meeting patients' needs. We start by presenting what patients told us they look for in their GP practice, followed by a review of evidence on ease of making an appointment and other aspects of quality of service. Overall, evidence suggests that a significant majority of GPs are delivering good quality services to patients. However, there is some variability: CQC's ongoing inspections have identified that some GP practices have room for improvement and some practices perform lower on indicators of service quality.

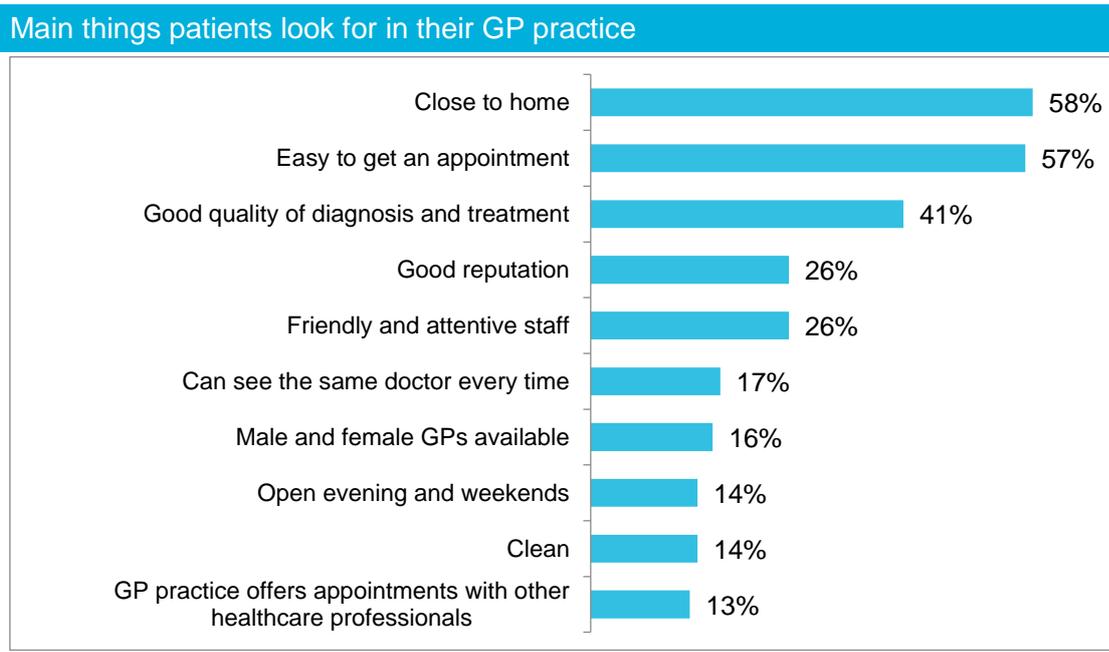
What patients look for in a GP practice

To better understand patients' priorities, we asked them what they looked for in a GP practice and reviewed other research on patients' preferences in primary care. Figure 2 summarises their responses to our survey on the main things patients look for in a GP practice (patients were asked to select up to five options).

⁵⁴ The Information Centre. (2007) '2006/07 UK General Practice Workload Survey'. Available from: <http://www.hscic.gov.uk/catalogue/PUB01028/gp-work-serv-rep.pdf>

⁵⁵ See Review of the general practice workforce.

Figure 2: Main things patients look for in their GP practice



Source: Ipsos MORI survey, responses to question 1a. Note: The question was: ‘What are the main things you look for in a GP practice?’ Patients were shown a list of 26 options and asked to select up to five options. Figure 2 shows top 10 responses. Sample size: 3,192

Having their GP practice close to home is one of the main things many patients say they look for (58%).⁵⁶ Ease of getting an appointment (57%) and good quality diagnosis and treatment (41%) also stand out as some of the main things patients look for. We also asked patients who have been with their practice for more than 10 years about the single most important aspect they value in their GP practice. Quality of diagnosis and treatment was the most common answer (25% of patients) followed by ease of getting an appointment (16%) and proximity to home (12%).⁵⁷ Therefore clinical quality, ease of getting an appointment and a location near home are characteristics that stand out as things patients look for and value in a GP practice.

There is research looking into patients’ preferences in primary care.⁵⁸ For example, a study evaluating the impact of the changes to practice boundary rules found that proximity is important to patients and many patients also care about other characteristics such as getting an appointment quickly and how well the practice

⁵⁶ Similarly, the online patient survey commissioned by Department of Health in 2009 shows that of patients who wanted to register with a new GP practice, 51% of respondents said that they would find the information on distance of the practice from home most important for choosing a practice to register with. The survey also shows that 55% of respondents who registered with a new practice in the last five years did so to be with a GP practice that is nearer their home. Source: Ipsos MORI. (2009) ‘GP Choice Survey – Final Topline Results’.

⁵⁷ Ipsos MORI survey, responses to question 28 (1,916 responses).

⁵⁸ For a concise summary, see Santos R, Gravelle H, Propper C (2013) ‘Does quality affect patients’ choice of doctor? Evidence from the UK’ CHE research paper. Available from:

http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP88_quality_choice_GP.pdf

meets their specific health needs.⁵⁹ Another study concluded that patients place a high priority on technical quality of care, continuity of care and patient-centred care.⁶⁰ Earlier research has also identified that patients have high expectations for easily accessible primary care and continuity of care.⁶¹

In section 3 we discuss how patients choose their GP, particularly how they often do not make choices on the basis of the aspects they say they value.

Patients' overall satisfaction

Around 81% of patients we surveyed said they are satisfied with their GP service; this is consistent with the findings of NHS England's GP Patient Survey (GPPS) where 78% of respondents said they would recommend their practice to someone who has moved to the local area.⁶² Patients' overall satisfaction is a subjective indicator of the standard of services but is likely to be useful in capturing aspects of quality. This may include, for example, patients' perception about clinical quality but also their experience in being treated with dignity and respect.

Patients' overall satisfaction is therefore an important measure, but not the only one of how a GP practice is meeting the needs of its patients. Patients told us that a GP practice where it's easy to get an appointment and one that provides good quality diagnosis and treatment are some of the main things they look for (Figure 2 above sets out some of the main things patients look for). We therefore also looked at the available evidence on ease of making an appointment and different aspects of clinical quality.

Ease of making appointments

We examined the available survey evidence to get an indication of how easy it is to access GP services when patients need them. The GPPS shows that in 2014, around 74% of patients said their experience was good when making an appointment when they need to see a GP (in 2012 the corresponding ratio was around 78%).⁶³ Our survey results show that around 70% of patients think their

⁵⁹ The researchers carried out econometric modelling based on a discrete choice experiment which allows for analysing patients' valuations of different attributes of the service by identifying whether and how people are willing to trade off different attributes with each other. For a detailed description of the analysis, see: Policy Innovation Research Unit (2014) 'Evaluation of the choice of GP practice pilot, 2012-13 – Final report' Available from: www.piru.ac.uk/assets/files/General%20Practice%20Choice%20Pilot%20Evaluation.pdf

⁶⁰ Cheraghi-Sohi S., Hole A.R., Mead N., McDonald R., Whalley D., Bower P., Roland M. (2008), 'What patients want from primary care consultations: A discrete choice experiment to identify patients' priorities', *Ann Fam Med*. 2008 Mar; 6(2): 107–115. Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC2267425/#r36.

⁶¹ Bower P., Roland M., Campbell J., Mead N. (2003) 'Setting standards based on patients' views on access and continuity: secondary analysis of data from the general practice assessment survey', *BMJ*. 2003 Feb 1; 326(7383): 258. Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC140766/

⁶² Ipsos MORI survey, responses to questions 21 and 36 (3,192 responses) and Ipsos MORI. (2015) 'GP Patient Survey'. Available from: <https://gp-patient.co.uk/surveys-and-reports>

⁶³ Ipsos MORI. (2015) 'GP patient survey – National summary report'.

practice meets their expectations in terms of how easy it is to get an appointment but it seems to vary significantly across the country.⁶⁴

Variations between practices and regions are also apparent from the GPPS. It shows that at CCG level, between 56% and 88% of patients had a good experience with making an appointment and relatively lower rates of good experience appear to be concentrated in Greater London as well as parts of the South East, the West Midlands and the North West. (See Annex 1 for more information).⁶⁵

According to our survey the share of patients who say their practice does not meet their expectations in terms of ease of making appointments is relatively high in London (38%) and the North East (44%). In the South West and East Midlands around 20% of patients say their ability to make appointments did not meet their expectations.⁶⁶

There is therefore evidence that in many parts of the country there is scope for improvement in patients' ability to get and make an appointment. These regional differences may be due to variability in the capacity of GP services and what patients expect from their GP practice. Their subjective experience can vary across the country due to, for example, differences in demographics (eg young working people might have higher expectations for getting appointments at times that suit their schedules).

Approaches to measuring quality

There are several indicators and data sources that can, and have been used to measure quality and access provided by GP practices across England, including QOF scores and GPPS responses. However, no single indicator can capture the overall standard of service provided by a practice. CQC has adopted an approach of undertaking comprehensive inspections of each practice to reach a balanced view on the quality of the service (see Annex 2). These inspections are currently underway and are expected to be completed by April 2016.

NHS England and the King's Fund have both pointed out that GP practices vary in terms of specific indicators of clinical quality (eg unplanned hospitalisations for chronic ambulatory care sensitive conditions and specific indicators within the QOF framework).⁶⁷ Given the multiple dimensions of good service in general practice,

⁶⁴ Ipsos MORI survey, responses to question 1b (1,836 responses).

⁶⁵ Ipsos MORI. (2015) 'GP patient survey'.

⁶⁶ Ipsos MORI survey, responses to question 1b. Sample sizes by region are as follows: London (320), North East (80), South West (164), East Midlands (119), Eastern (142). Patient satisfaction and whether a practice meets patients' expectations are subjective measures and expectations may be higher or lower among, for example, certain demographic groups.

⁶⁷ NHS England. (2013) 'Improving general practice – a call to action, Evidence Pack'. Available from: www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf and King's Fund. (2012) 'Improving GP practices in England: exploring the association between quality of care and the experience of patients'. Available

NHS England and CQC use large sets of indicators to measure quality. For example, NHS England developed the GP Outcome Standards (GPOS) framework to help with contract management and to assess quality improvement, while CQC uses ‘intelligent monitoring’ indicators to help prioritise inspections.⁶⁸ Both frameworks consist of a broad set of indicators most of which measure clinical quality. They include:

- measures of prevention (eg uptake of immunisations and smoking cessation)
- diagnosis (eg identifying the prevalence of coronary heart disease and dementia, early detection of cancer)
- effective management of long term conditions (eg effective prescribing and measuring cholesterol for patients with diabetes)
- avoided hospital admissions.

These quality monitoring frameworks are not used to rate practices; rather they indicate which practices might face the greatest challenges in delivering adequate services to patients (ie which practices deviate from their peers or accepted standards on several indicators). For example, NHS England specifies that a practice’s performance against their framework should be contextualised using data from other practices in similar locations, and/or with similar populations.

We summarise the results of CQC’s and NHS England’s approaches to measuring the performance of GP practices below:

- As of 15 May 2015, CQC has inspected 882⁶⁹ GP practices and found that the majority (82%) of them provide ‘good’ services. Around 3% have been rated as ‘outstanding’, around 11% of the GP practices ‘require improvement’ and around 4% are rated ‘inadequate’.⁷⁰
- NHS England’s GPOS framework indicates that the majority of GP practices provide adequate services. Around 17% of GP practices fall into the ‘review identified’ category (this is a group of GP practices that score lower than their peers on a range of indicators – so with room for improvement; the other performance categories under GPOS are ‘higher achieving’, ‘achieving’ and ‘approaching review’).

from: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-gp-services-in-england-the-kings-fund-nov-2012.pdf

⁶⁸ Annex 2 describes the main features of NHS England’s and CQC’s frameworks.

⁶⁹ See CQC website:

[www.cqc.org.uk/search/services/all?f\[0\]=im_field_inspection_rating%3A3925&f\[1\]=im_field_popular_services%3A3671](http://www.cqc.org.uk/search/services/all?f[0]=im_field_inspection_rating%3A3925&f[1]=im_field_popular_services%3A3671)

⁷⁰ Information provided by CQC, 15 May 2015.

Some GPs told us that it is difficult to measure quality in general practice in a robust way. As recognised by CQC and NHS England, sets of indicators may not always fully capture the different aspects of GP services and full inspections are likely to be more effective in identifying which practices face difficulties in providing adequate care.⁷¹ Indicators are still helpful however for identifying practices that regulators and commissioners should consider focusing on. In the rest of this report, although we recognise that the GPOS may not capture all aspects of the service and local circumstances, we use its results as an indication of the variations in the quality of services provided to patients by different GP practices. We consider that it provides a reasonable basis for indicative analysis as the CQC inspections are still underway.⁷²

Practices in deprived areas

Previous studies have found that socioeconomic status is a major determinant of health. In England people living in the poorest neighbourhoods will, on average, die seven years earlier and spend 17 more years living with a disability than people living in the richest neighbourhoods.⁷³ This is due to a range of complex social, economic and environmental factors including factors which lead to a higher prevalence of unhealthy behaviours and socioeconomic inequalities in the provision of healthcare.

The King's Fund has identified that GP practices that perform poorly on both patient experience and QOF clinical outcome indicators tend to be in areas with higher levels of deprivation.⁷⁴ Consistent with this, we found that 79% of practices that score lower on GPOS indicators (ie in the 'review identified' group) are located in relatively deprived areas.⁷⁵ Areas with more deprivation can represent a greater challenge to the local health system, and these results suggest that commissioners may need to explore whether practices in their more deprived areas have sufficient resources to address health inequalities. We also note that while a relatively high proportion of practices that score lower on GPOS indicators are located in more deprived areas, most GP practices in these areas have achieved adequate or good

⁷¹ See Annex 2 where we summarise the objectives of these frameworks.

⁷² The GPOS framework has been developed over several years (first launched in London in 2011) and can be accessed by all GPs (who can ask NHS England to correct any inaccuracies in the data).

⁷³ Marmot, M. (2010) 'Fair society, healthy lives (The Marmot review) – Strategic review of health inequalities in England post-2010' Available from:

<http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf>

⁷⁴ The King's Fund. (2012) 'Improving GP services in England: exploring the association between quality of care and the experience of patients'. Available from:

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-gp-services-in-england-the-kings-fund-nov-2012.pdf

⁷⁵ The analysis uses ONS data on income deprivation from 2010. We did not use the Index of Multiple Deprivation because it contains a health indicator. The income deprivation indicator has also been used in other studies as a measure of deprivation. We considered an area to be relatively deprived if it is among 50 % of the most deprived areas based on income deprivation.

outcomes based on these indicators. Conversely there are practices that score lower on quality indicators despite operating in less deprived areas.

We found that practices that scored lower on NHS England's GPOS indicators tend to employ fewer GPs (or clinical staff generally) per patient than GP practices with better scores. This may be because of recruitment difficulties at practices in deprived areas (see section 4.2 for more details of recruitment challenges).

We expect that CQC's ongoing inspections are likely to improve understanding of which GP providers are offering high quality services.

Conclusions on meeting patients' needs

The evidence shows that patients' overall satisfaction with their GP services is high. CQC's first inspections and various quality indicators also indicate that a significant majority of GP practices are meeting the needs of their patients. However, there is variability in terms of access and indicators of clinical quality. In the next section, we discuss the role of patient choice in helping patients access GP services that best meet their needs.

3 Patients' ability to choose the practice that best meets their needs

We expect patient choice to play an important role in GP services in the future. This will be the case in areas where patients continue to access GP services through traditional models as well as in areas where GP services are delivered through the new models of care proposed in the Five Year Forward View. In this section we describe the role of patient choice in helping patients get GP services that best meet their needs and assess how well patient choice is working for patients.

3.1 The role of choice in helping patients get the best GP services for them

In this section we examine factors that influence patients' ability to choose the practice that best meet their needs and preferences.

How choice in GP services can benefit patients

Different patients have different needs and GP practices vary in the services they offer. For example, some GPs have undertaken additional specialist training to develop their expertise in treating patients with certain conditions; while others have developed innovative ways to provide appointments. Some practices have implemented programmes specifically aimed at better supporting patients with complex needs. For example, some run programmes to empower their patients with long term conditions to better self-manage their health while others offer services to better support patients with carer responsibilities. Patients can therefore benefit from choosing the practice that best meets their specific needs and preferences, even if they are choosing between practices that all provide good services overall.

Over time, when more patients make informed choices, we hope GP practices will respond to those choices and develop their services to better meet patients' needs. We recognise GPs have many incentives to improve services, including an inherent drive to protect and promote the health of patients and provide good quality care, professional integrity, benchmarking against other GPs and financial incentives. Patient choice can further encourage providers' to improve their services based on what matters to patients.

Our engagement with providers shows that they hold a range of views on the role of GP practices responding to patient choice in developing services for patients. To date relatively few patients appear to have actively exercised their right to choose their GP but there is nevertheless empirical evidence suggesting that they can benefit from this choice.⁷⁶

Our approach to reviewing how patient choice is operating in general practice

We recognise that a variety of factors affect patients' decisions and they may not always choose what would objectively seem to be the best GP practice available to them even if they are able to do so (we discuss these factors below). Ideally, patients would be empowered and well informed so that they:

- are aware that they can choose their GP and consider alternatives
- can access information to allow them to compare available GP practices
- are able to register with the practice of their choice.⁷⁷

We set out what we found about each of these below drawing primarily on evidence from our patient survey. Ipsos MORI carried out face-to-face interviews with a nationally representative sample of around 3,200 patients. Although patient surveys provide a useful insight into patient preferences and behaviours, and are used extensively by regulators and competition authorities, some caution is needed when

⁷⁶ An academic study found that patients have, to some extent, been more likely to register with GP practices that perform better in terms of QOF scores. Santos R, Gravelle H, Propper C (2013) 'Does quality affect patients choice of a doctor? Evidence from the UK', *CHE Research Paper*. Available from: https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP88_quality_choice_GP.pdf Another study published by the Cooperation and Competition Panel found an association between competition between GP practices (proxied through proximity of practices) and quality. Pike C. (2010) 'An Empirical Analysis of the Effects of GP Competition' *Cooperation and Competition Panel, Working Paper Series – Volume 1 Number 2*. Available from: http://mpra.ub.uni-muenchen.de/27613/1/An_Empirical_Analysis_of_the_Effects_of_GP_Competition_v3.pdf

⁷⁷ This approach is in line with UK Regulators Network (UKRN) framework on consumer switching. It consists of three key elements: engage, assess and act. See UK Regulators Network. (2014) 'Consumer engagement and switching'. Available from: [/www.ukrn.org.uk/wp-content/uploads/2014/12/Statement-Consumer-engagement-and-switching.pdf](http://www.ukrn.org.uk/wp-content/uploads/2014/12/Statement-Consumer-engagement-and-switching.pdf)

interpreting findings.⁷⁸ We have provided supporting evidence such as econometric studies and other surveys where relevant.

3.2 Aware and engaged patients

Patients' awareness of choice and views on changing GP practice

Patients told us they are aware of their right to choose their GP practice and they value that choice. Our patient survey found that 91% of patients know they have the right to choose a GP practice and 92% think it is important to be able to make a choice of GP practice.⁷⁹

We asked patients what they look for in a GP practice. As we described in section 2, location is important but it is not the only factor they look for: ease of getting an appointment and clinical quality are important as well.⁸⁰ As a further indication of what matters to patients, we asked them about what would cause them to change practice rather than just about their awareness of choice; see Table 2 below.

Table 2: How likely patients would be to move to a different practice if particular aspects of their GP practice's performance deteriorated (0=very unlikely, 10=very likely)

Please tell me how likely or unlikely you would be to move to a different GP practice as a result	All patients
you found out that the diagnosis of a serious condition (such as cancer) became less accurate	6.7
you became less satisfied with the treatment you received for your condition (eg back pain)	6.0
the facilities at the GP practice became less clean (eg waiting room, toilets)	5.5
it became more difficult to get an appointment when you wanted one	5.5
it became less likely that you would be offered a choice of hospital for further care	5.0

⁷⁸ When we report the survey findings we note the specific questions in the Ipsos MORI survey that each of our findings relates to (the questionnaire is published alongside the Ipsos MORI report). We also report the sample sizes and highlight when results should be interpreted with care (Ipsos MORI strongly recommends interpreting any samples of fewer than 100 respondents with caution).

⁷⁹ Ipsos MORI survey, responses to questions 5, 6, 26 and 27 (all respondents registered with a GP practice (3,192)). Another survey (also Ipsos MORI) interviewed 1,004 residents in Fylde and Wyre CCG and found that 92% of respondents said they think it is fairly important or very important to choose the GP surgery you are registered at. The rate at which respondents said a choice of GP surgery was important was higher than any other type of choice of healthcare services explored in the survey (including choice of hospital, choice of date of appointment or choosing the treatment). See Ipsos MORI (2014) 'Public perceptions of the NHS in Fylde and Wyre'. Available from: <https://platform-ccg-live-eu-2.s3-eu-west-1.amazonaws.com/attachments/2488/original/13-086937-01%20-%20Public%20Perceptions%20report%20-%20FINAL%20-%20v4.0%20-%20060614%20-%20INTERNAL%20USE%20ONLY.PDF?AWSAccessKeyId=AKIAJ3TZGA3TUZPPHIWQ&Expires=1427302284&Signature=%2BIfPTNmMFYfhoQsIbrXpORelkew%3D>

⁸⁰ When we asked patients who had been with their GP practice for more than 10 years what was the (single) most important aspect of the service to them, 25% said good quality diagnosis and treatment, 16% said ease of getting an appointment and 12% said location. Ipsos MORI survey, responses to question 28 (1,916 responses).

Please tell me how likely or unlikely you would be to move to a different GP practice as a result	All patients
it became more difficult to order repeat prescriptions	4.8
it became more difficult to see the same GP/the GP you wanted to see	4.6
the receptionist became less polite/friendly	4.1

Source: Ipsos MORI survey, responses to questions 25 and 40, all respondents registered with a GP practice (3,192). Note: The survey results show that patients who have registered with their practice within the past 10 years report being more likely to respond to changes in quality.

The results set out in Table 2 above are based on what patients told us they would do rather than what they have actually done. They are consistent with what patients told us they look for in a GP practice: clinical quality and ease of getting an appointment are important to patients and things they say they would respond to.

Patients are therefore generally aware of the concept of choice and value it highly, and there are factors besides location that patients say they care about. However, as we discuss below, patients' actual choices may not follow what they said they would do.

How patients make choices

It is well established that consumers often do not make choices on the basis of what they say they value.⁸¹ We examined how patients actually choose their GP practice and what might explain their behaviour.

When patients choose their GP practice, they often do so primarily on the basis of location. According to our survey, 77% of patients who had registered with their GP practice within the past 10 years, stated that one of the reasons why they chose to register at their current GP practice was proximity to their home; 21% said ease of getting an appointment; 16% good reputation and 11% said good quality diagnosis and treatment.⁸² Research examining 3.4 million patients in the East Midlands found that patients' choices were strongly driven by location and, in part, by quality (among other factors).⁸³

In our survey we also asked patients whether they had considered any other GP practices available to them at the time when they registered with their current

⁸¹ For a discussion of consumers' preferences and choices see Office of Fair Trading (2010). 'What does behavioural economics mean for competition policy'. Available from: http://webarchive.nationalarchives.gov.uk/20140402142426/http://www.offt.gov.uk/shared_offt/economic_research/oft1224.pdf

⁸² Ipsos MORI survey, responses to question 7a (1,276 responses). Respondents could name multiple aspects (hence the percentages do not sum up to 100%).

⁸³ Specifically, this research estimated that scoring 10 additional QOF points was associated with gaining 163 patients. The study also found that patients are more likely to choose practices which are nearer to their home, have higher proportion of GPs qualified in Europe, have a higher proportion of female GPs and a lower average age of GPs. Santos R., Gravelle H., Propper C. (2013) 'Does quality affect patients choice of a doctor? Evidence from the UK', *CHE Research Paper*. Available from: https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP88_quality_choice_GP.pdf

practice. The results show that only 16% of patients (who had registered with their current practice within the last 10 years)⁸⁴ said they had.⁸⁵ The proportion of patients who said they considered other GP practices is slightly higher among patients who visit their GP frequently (22% of patients who visited their GP more than five times in the last six months) and patients with a long standing illness, disability or infirmity (20%).⁸⁶ The survey evidence does not suggest that the proportion of patients that have considered other GP practices has significantly changed over the last 10 years.⁸⁷

We asked patients why they did not consider alternatives at the time of registering with their current GP practice. Figure 3 below summarises the responses.

⁸⁴ In the survey, we distinguished between people who registered with their current practice within the past 10 years and those who registered longer ago because people who registered a long time ago may not remember why they registered.

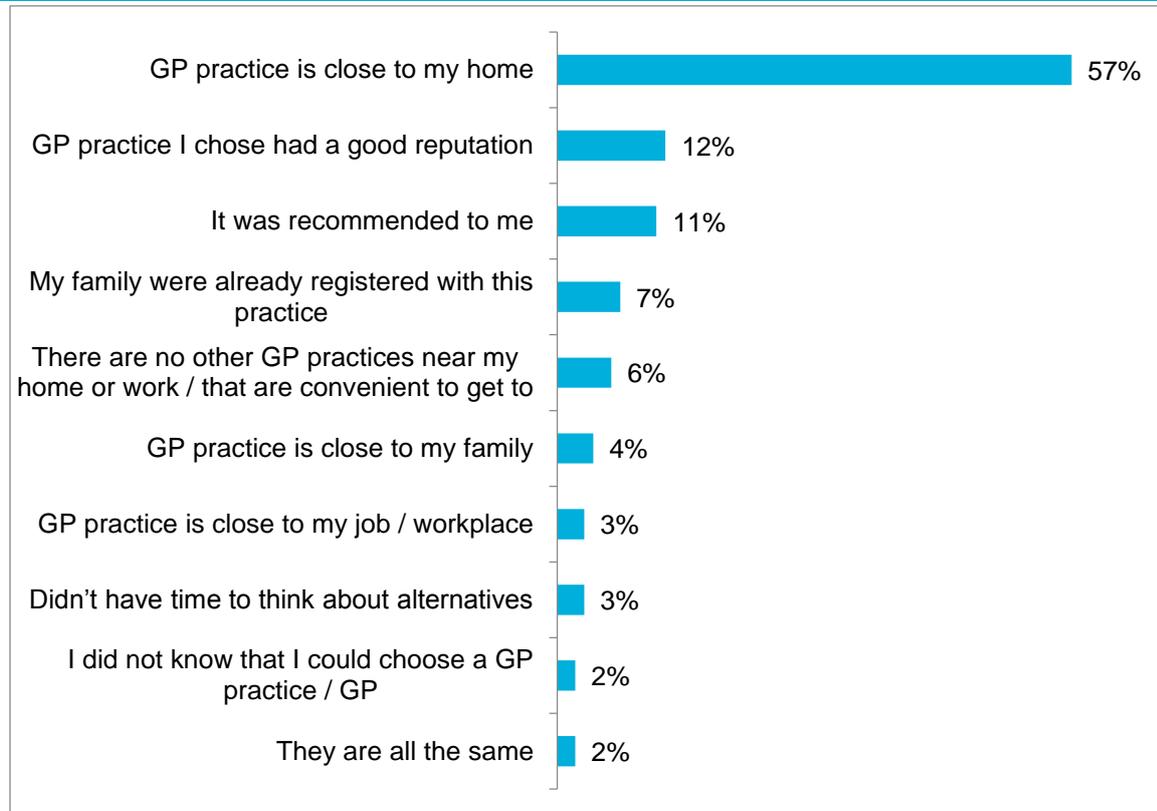
⁸⁵ Ipsos MORI survey, responses to question 11 (base: 1,276 patients who registered in the last 10 years of whom 204 considered alternative practices when they registered). Out of those who said they considered alternatives, 40% said they did not compare specific aspects of GP practices (eg patient satisfaction rates, opening times, quality of diagnosis). Ipsos MORI survey, responses to question 15 (base: 204 patients).

⁸⁶ The difference between patients with longstanding illness, disability or infirmity (277 respondents) and other patients (1,053 respondents) is statistically significant at 95% confidence level. The difference between patients who visited their GP more than five times in the last six months (162 respondents) compared with patients who did not visit their GP during that time (291 respondents) is statistically significant at 95% confidence level.

⁸⁷ There is no statistically significant difference between the proportion of patients who registered with their practice within the last year (231 respondents); within one to three years (357 respondents); within three to five years (300 respondents); or within five to ten years (443 respondents).

Figure 3: The main reasons patients said they did not consider any other GP practices when they registered with their current practice

The main reasons why patients said they did not consider any other GP practices at the time they registered with their current practice



Source: Ipsos MORI survey, responses to question 12. Sample size: 1,069 (all respondents who registered with their current practice in the last 10 years and did not consider any alternatives at that point). Figure 3 shows the top 10 responses. Respondents could select multiple responses so the total does not add up to 100%.

The survey results summarised in Figure 3 above suggest that the main reason patients did not consider alternatives is because the practice they chose is close to their home. Of patients who responded to this question, 12% said they did not consider alternatives because their practice had a good reputation and 11% because their practice was recommended. A recommendation by another patient can be useful if it captures aspects of service that are relevant to patients but not reflected in published information. A recommendation is more likely to indicate good quality if it comes from a patient that has visited other practices or used reliable sources of information to compare practices (which is rare as we explain below).

Our survey also shows that it is rare for patients to switch GP practice because of dissatisfaction: just 7% of patients who switched their GP provider in the last 10

years did so because they were dissatisfied with their GP provider.⁸⁸ Similarly, referring to their 2013 survey, Which? told us they found that only 3% of patients have ever switched because they were unhappy with their practice.⁸⁹ Our survey shows that less than a third (31%) of the minority of patients who are dissatisfied (or very dissatisfied) have even considered moving practice.⁹⁰

Low rates of switching are not surprising given that most patients are satisfied with their GP practice. Also, as having a practice close to their home is one thing patients say they look for in a GP practice they may be unlikely to switch if there are few alternatives close by. There are other reasons that may explain why most patients do not consider alternatives while they are registered with a practice even if they might, on the face of it, benefit from doing so (for example, by switching to a GP practice that has achieved a higher CQC inspection rating). Notably:

- Some patients value a long term relationship with their GP: 17% of all patients responding to our survey say that being able to see the same doctor is one of the main things they look for in their GP practice. 32% of patients who are dissatisfied with their practice, say they have not moved to another practice because they are satisfied with their individual GP, which suggests that they are dissatisfied with other aspects of the service.⁹¹
- Patients may take factors into account other than just how different GP practices meet their needs. They may not want to invest time in assessing their specific needs are (eg many patients do not have specific healthcare needs such as long term conditions) or in finding information about different practices. They may also stay with their current practice rather than take the risk of registering with a new practice which may or may not be better in meeting their needs.⁹² Moreover, some patients may not view choice as a meaningful way of obtaining better care.

These factors partly explain why few patients consider alternative practices. However, patients often have to choose a new GP practice when they move to a new area; 84% of those patients who registered with their practice in the last 10

⁸⁸ Ipsos MORI survey, responses to question 4 (all patients who registered with their practice in the last 10 years; 1,276 patients).

⁸⁹ Which? (2013) 'Response to Monitor's call for evidence on the general practice services sector in England' (hereafter 'Which? response to call for evidence'). Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/288452/RepresentativeBodiesSubmissionFinal.pdf

⁹⁰ Ipsos MORI survey, responses to questions 22 and 37 compared against responses to questions 21 and 36 (318 patients responding to our survey say they are fairly dissatisfied or very dissatisfied). The difference compared to patients who are not dissatisfied is statistically significant at 95% confidence level.

⁹¹ Ipsos MORI survey, responses to questions 23 and 38. The rate is 18% among dissatisfied patients who registered with their practice in the last 10 years (129 patients).

⁹² Behavioural economics uses insights from psychology to explain how consumers (or patients) make decisions. For examples of behavioural biases that may affect decision-making, see UKRN. (2014) 'Consumer engagement and switching', pages 35-36. Available from: <http://www.ukrn.org.uk/wp-content/uploads/2014/12/Statement-Consumer-engagement-and-switching.pdf>

years, said moving home was the main reason to register with a new practice.⁹³ Moving home is therefore a natural point when patients change to another GP practice and when they have an opportunity to compare their options.

In conclusion, patients are aware they can choose their GP practice. However, fairly few appear to actively engage in choosing the GP practice that would best meet their needs on the basis of the characteristics they say they look for in a GP practice (with the exception of location).

3.3 Informed patients

When patients access and understand information about different GP practices, they are better placed to identify what the practices have to offer (and if there are differences between GP practices). Some aspects of GP services may be easier for patients to understand (and inform themselves about) than others; for example, they may find it easy to understand whether they need extended opening hours but more difficult to understand information related to the clinical quality of services. We looked at how well patients are informed about services offered by GP practices and how they use comparative information that can help them in choosing their GP practice.

Awareness about differences between GP practices

Most patients do not appear to be aware of differences between GP practices. This, in part, explains why they rarely consider which practice would best meet their needs.

We compared patients' perceptions of the quality of their practice against the performance of their practice on the basis of various quality indicators (based on the practice's GPOS rating). We found that, on the whole, patients tend to be more satisfied and report they would recommend their practice if their practice performs well against various quality indicators. However, in many cases GP practices had very high rates of patients who would recommend their practice (or said their experience was good or very good), but where the practice scored lower against GPOS indicators when compared against their peers (or accepted standards).⁹⁴ Our patient survey asked patients how they would describe their GP practice relative to other GP practices in the area: only 3% thought their practice was below average.⁹⁵ This is not consistent with the available evidence on quality. For example, NHS

⁹³ Ipsos Mori survey, responses to question 4 (base: 1,276 patients)

⁹⁴ See Annex 4. There is also academic research suggesting that, based on limited correlation between patient assessed survey scores for technical quality and the objective records based measures of good clinical practice, older patients' (the group examined in this study) own assessments are not a sufficient basis for assessing the technical quality of their primary care. Rao M., Clarke A., Sanderson C., Hammersley R. (2006), 'Patients' own assessments of quality of primary care compared with objective records based measures of technical quality of care: cross sectional study'. *BMJ*. 2006 Jul 1; 333(7557): 19. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1488754/>

⁹⁵ Ipsos MORI survey, responses to questions 19 and 34 (base: 3,192 patients).

England's GPOS framework suggests that around 17% of practices fall into the 'review identified' category (which means they perform lower than their peers across several outcome standards).

This suggests that many patients see little benefit in comparing different practices because they are not confident in their ability to assess the quality of their current GP practice against alternatives and they think their practice is already average or better than average. However, it also suggests that often this view may not be based on an informed assessment of different GP practices available. Many patients will only have first-hand experience of their own practice and are also unlikely to have the clinical knowledge and skills required to assess all aspects of their care. This is supported by a recent Which? survey that found only 56% of patients agree that they know what good looks like from their GP provider.⁹⁶ Below we discuss how patients use information to assess which GP practice would best meet their needs.

Comparative information

Our survey shows that only around one in 10 patients tried to compare GP practices (in terms of different aspects of the service such as quality of treatment).⁹⁷ The majority of these patients relied on information from family and friends (60%); while fewer than one in five said phoning (14%) or visiting a practice (17%) was their main source of information. These sources of information can be useful in capturing aspects of GP services that are relevant to patients but may not be objective or provide reliable comparisons between local practices.

There are several sources of information that enable patients to find and compare GP practices in their area. They include NHS Choices, GPPS results, My Health London and local Healthwatch reports (in some areas). New online services are also being developed (eg MyNHS⁹⁸) to help patients identify and compare GP practices on the basis of factors that matter to different types of patients. See section 5 for more details.

Our survey results suggest that of the minority of patients who had compared practices, 15% said their main source was the NHS Choices website, and 5% looked at GP patient survey results.⁹⁹ This suggests that fewer than 3% of all patients used the published comparative information available online as their main source of information to compare practices available to them. In line with this, when we asked

⁹⁶ Which? polling data. Populus, on behalf of Which? surveyed 4,162 UK Adults online between 10 and 14 September 2014.

⁹⁷ Ipsos MORI survey, response to questions 15 and 30 (357 patients). This includes patients who registered in the last 10 years and said they had considered alternatives (of which 40% said they did not compare different aspects of the service across practices) and patients who have been registered with their GP practice for more than 10 years.

⁹⁸ The information available on My NHS is compiled by the Department of Health and NHS England with Public Health England and the Care Quality Commission. See the My NHS website: [/www.nhs.uk/Service-Search/performance/search](http://www.nhs.uk/Service-Search/performance/search)

⁹⁹ Ipsos MORI survey, responses to questions 16 and 31 (357 patients).

patients how their practice compared with other local practices, only 4% of patients based their response on the information published online about performance of their own and other GP practices (eg NHS Choices or GPPS).¹⁰⁰

The fact that most patients do not use the available information about differences between GP practices appears to stem, to some extent, from their difficulties in accessing and understanding that information. For example, our survey suggests that around 43% of the small minority of patients looking for information on the quality of diagnosis of different GP practices did not consider it easy to find; 39% of these patients did not find the information on the quality of diagnosis easy to understand.¹⁰¹ Similarly, based on their 2013 survey, Which? told us patients do not feel particularly confident or knowledgeable about deciding which GP practice to register with.¹⁰²

The main reason patients do not make full use of available information appears not to be difficulty in finding information but the fact that most of them are not looking for it. Therefore, in our view, the information can only be effective if patients look for it or it is communicated to them so that they can compare GP services based on what matters to them.

The patients we surveyed told us that good quality diagnosis and treatment is one of the main things they look for in a GP practice. However, a feature of GP services is that patients (or their carers) are often not able to assess the quality of care they receive. Without easily understandable information on quality it is likely to be difficult for them to make informed choices (compared to sectors where a key factor is often price, which is easier to understand than aspects of clinical quality). This suggests a need for easily understandable information to help patients compare GP practices.

It is important that any information published about GP practices is based on robust and impartial information and that patients' responses to this information are well

¹⁰⁰ Ipsos MORI survey, responses to questions 25 and 40 (2,734 patients). We note that a survey commissioned by the Department of Health found that, when prompted, 25% of patients would first go to the 'NHS website' to look for information about local practices (this is in response to a question on what patients would do, rather than what they actually did). Ipsos MORI. (2009) 'GP Choice Survey – Final Topline Results'. A survey by NHS Choices suggested that 4% of respondents had gone online in the last 12 months to look up information to help them choose which GP practice to join. The question did not ask whether and how patients used NHS Choices to compare GP practices. NHS Choices (2014) Public Omnibus Survey, Wave 6 January 2014. Available from: www.slideshare.net/NHSChoices/jan-2014-nhs-choices-awareness-and-usage-tracking-survey

¹⁰¹ Ipsos MORI survey, responses to questions 17, 18, 32 and 33 (sample size for the question about the quality of diagnosis: 128 patients). 16% of patients said that it was fairly or very difficult to find information on the quality of diagnosis, and 12% of patients said this information was fairly or very difficult to understand. Patients were asked two questions: whether it was easy or difficult to find the information on different aspects of GP services (opening times, quality of diagnosis, quality of treatment and reputation/patient satisfaction rates) and whether it was easy or difficult to understand this information.

¹⁰² According to Which?, the proportion of people feeling confident that they are able make the best choice is 54%. Which? response to call for evidence.

understood.¹⁰³ For example, interview-based research published by NHS Choices found that information on performance relating to specific conditions (eg diabetes) could be very relevant for patients. However, the patients they interviewed held mixed views about the usefulness of publishing composite scores on GP practice's overall performance, given that these do not take into account practices' competency in different areas and variability in local circumstances.¹⁰⁴ Different patient groups may need different information and there is evidence that there is room for better engagement with, for example, elderly patients and patients from lower socioeconomic backgrounds.¹⁰⁵ See section 5 for more discussion of ongoing initiatives and next steps in communicating information to patients (including new ways of communicating information to patients).

Another factor that may limit patient awareness of information about GP services is that some GPs feel they are prevented from communicating information about their services to patients (eg restricted from publishing comparative information about the quality of their services). As we discuss in section 4, this appears to stem from misconceptions rather than real restrictions.

Although patients' ability to make an informed assessment is key to effective patient choice, transparency about differences between GP providers does not necessarily mean that patients will engage with the information and make choices based on that information. The international evidence on the extent to which patients engage with the available information and the format of publishing most likely to influence patients' selection of providers is mixed.¹⁰⁶ Regardless of this, in our view there appears to be significant scope for more patients to base their choices on objective information.

3.4 Patients able to register with the practice of their choice

If there are factors that prevent patients from registering with their preferred GP practice, this may prevent them from receiving services from the practice that best meets their needs. It may also prevent GP practices from registering new patients, which could reduce the incentives for them to invest in improving services for patients. Patients' ability to register with the GP practice of their choice could be

¹⁰³ For example, CQC withdrew its GP banding system based on its intelligent monitoring (see section 2 and Annex 2) having encountered methodological and data quality issues. Some stakeholders also had concerns about possible misconceptions of the banding system and an associated reputational risk.

¹⁰⁴ NHS Choices (2012) 'Choosing a GP & NHS Choices data'. Available from:

www.slideshare.net/NHSChoices/choosing-a-gp-and-nhs-choices-data

¹⁰⁵ NHS Choices (2014) Public Omnibus Survey, Wave 6 January 2014. Available from:

www.slideshare.net/NHSChoices/jan-2014-nhs-choices-awareness-and-usage-tracking-survey

¹⁰⁶ For a systematic review of the evidence see for example: Shekelle P., Lim Y-W., Mattke S., Damberg S. (2008), 'Does public release of performance results improve quality of care? A systematic review', RAND Corporation. Available from:

www.health.org.uk/public/cms/75/76/313/554/Public%20release%20of%20performance%20result.pdf?realName=UWXIXp.pdf. See also: Marshall M., Shekelle P., Leatherman S., Brook R. (2000), 'Public disclosure of performance data: learning from the US experience', Available from: <http://qualitysafety.bmj.com/content/9/1/53.full>.

constrained because of difficulties with the registration process, the perception that there are no alternatives, or due to GP practices not being able to accommodate more patients. We discuss these factors below.

The process for changing GP practice

We examined whether the process of changing GP practice discourages patients from registering with a GP practice that better meets their needs. This could be the case if the process is difficult or perceived as difficult. 88% of surveyed patients who registered with their GP practice in the last 10 years told us that the process was easy.¹⁰⁷ Our survey also asked patients who were dissatisfied with their current practice for the main reason why they have not moved to a different GP practice. We found that just 15% of patients who were dissatisfied with their current GP practice did not move to a different GP practice because they thought that registering with a new practice would require too much effort.¹⁰⁸ Only a small number of patients told us that aspects of the process could have been improved (eg the time it takes to transfer patient records and the inconvenience of paperwork), although, as very few patients found registering difficult (around 3% of patients), the sample size is small and the findings are indicative only.¹⁰⁹ However, the use of technology has the potential to further improve the process for changing GP practice.

Perceived lack of alternatives

Patients cannot choose between GP practices if there are no alternatives. Therefore, there may be a problem caused by a real lack of alternatives or by patients' perceptions that there are a lack of alternatives.

Our survey results suggest that some patients do not consider alternatives because they think there are no other conveniently located GP practices. All survey respondents were asked whether they think they would have a choice if they wanted to change their provider and 29% of patients did not feel that they do.¹¹⁰ Further, 14% of patients who are dissatisfied with their current GP practice cited a lack of alternative GP practices as their main reason for not registering with another GP

¹⁰⁷ Ipsos MORI survey, responses to question 9 (1,276 responses).

¹⁰⁸ Ipsos MORI survey, responses to questions 23 and 38 (318 responses).

¹⁰⁹ Ipsos MORI survey, responses to question 10 (34 responses; should be interpreted with caution).

Respondents could choose multiple responses to this question, hence responses may not add up to 100%. We note that the GP2GP project, which all practices are contractually required to enable (providing they are able to), means registering practices will usually have full and detailed medical records available to them for a new patient's first consultation.

¹¹⁰ Ipsos MORI survey, responses to questions 24 and 39 (3,192 responses).

practice.¹¹¹ This is supported by a recent Which? Survey that found only 30% of patients agree that they have a ‘real, meaningful choice’ when choosing their GP.¹¹²

We attempted to estimate whether most patients have alternative practice sites available to them within a convenient distance. NHS England told us that it does not hold centrally collated national data on GP practice boundary areas.¹¹³ We were therefore unable to estimate how many patients live in areas where they do not have a choice of alternative providers (ie they live inside the practice boundary of only one GP practice). As a proxy, we estimated that around 81% of patients – and around 93% of patients in urban areas – have two or more GP practice sites within a two-kilometre distance, which indicates that some patients may have alternatives within convenient travel times.¹¹⁴ In addition, a recent study found that around 85% of patients in England live within a 20-minute walk of a GP premises and there are more GP practices in relatively deprived areas (the methodology used in this study was broadly consistent with ours).¹¹⁵

We also attempted to estimate whether some patients have higher scoring practices nearby that they could switch to. Using NHS England’s GPOS framework,¹¹⁶ we estimated that some patients appear to have a choice of a GP practice that scores better than the one they are currently registered with on a range of quality indicators within a fairly close distance. Around half of GP practices that score lower than their peers on GPOS indicators¹¹⁷ (a clear majority of which are located in relatively deprived areas) have a relatively higher scoring practice within one kilometre. Around 85% have a practice in one of the higher scoring groups within two kilometres. This indicates that there are differences between practices that are

¹¹¹ Ipsos MORI survey, responses to questions 23 and 38 (318 responses). The patient survey carried out by Which? found that only 28% of patients thought they had a choice of GP, whereas 40% thought they did not. Which? response to call for evidence.

¹¹² Which? polling data. Populus, on behalf of Which?, surveyed 4,162 UK adults online between 10 and 14 September 2014.

¹¹³ It also told us that GP practices are required to submit their agreed practice boundary areas as part of their annual self-declaration. The Primary Care Webtool is being developed to include an overlay function at CCG level.

¹¹⁴ Estimate based on Local Super Output Areas which are an aggregation of Output Areas, the smallest unit for which census data are published, which are geographically adjacent and likely to share similar characteristics. Monitor analysis based on HSCIC data from 2010 (accessed in November 2014). The travel time within which patients can be expected to consider alternatives varies between different areas and patients (for example, for a sample of 3.4 million patients and nearly 1,000 GP practices in East Midlands, the mean distance to patients’ chosen GP practice was 1.9 km). Santos R., Gravelle H., Propper C. (2013) ‘Does quality affect patients’ choice of a doctor? Evidence from the UK’, *CHE Research Paper*. Available from: www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP88_quality_choice_GP.pdf

¹¹⁵ Similarly to our analysis, Todd et al (2015) assumed straight line distances. They also assumed an average walking speed of four kilometres per hour (this implies a walking distance of 1.6km in 20 minutes). Todd A., Copeland A., Husband A., Kasim A., Bamba C. (2015) ‘Access all areas? An area-level analysis of accessibility to general practice and community pharmacy services in England by urbanity and social deprivation’, *BMJ Open*.

¹¹⁶ This is based on NHS England’s GPOS data. This can be accessed by GP practice staff, CCGs, area and regional teams of NHS England and other approved stakeholder organisations through the Primary Care Web Tool: www.primarycare.nhs.uk/

¹¹⁷ As reported in section 2, this is a group of GP practices that underperform in comparison with their peers on a range of indicators; the other performance categories under GPOS are ‘higher achieving’, ‘achieving’ and ‘approaching review’.

relatively close to each other and from which patients could, in principle, choose (the analysis takes into account closed lists but not practice boundary areas).¹¹⁸

If patients do have alternatives, the perceived lack of choice may be because they are not aware of the GP practices that are available. As noted above, we found that few patients have ever compared GP practices and a small fraction of patients used published information as their main source of information to compare practices in the area. Many may therefore not know about the options available to them.¹¹⁹

Finally, some patients told us they are aware of alternative practices but do not think they can register with them.¹²⁰ As we discuss below this may be because they think there are barriers to choosing their preferred practice or because practices do not register new patients.

Inability to register with alternative GP practices

Patients are unable to register with the practice of their choice if that practice is unable to accept them onto their patient list. When a practice determines it can no longer accept more patients, it can apply for NHS England's permission to close its list. This is a formal process which requires consultation with patients and other local stakeholders and involves considering what could be done to keep the list open. As a practice approaches full capacity it may also not register patients living outside its practice boundary in order to retain the ability to register patients within the practice boundary (and hence avoid closing its list entirely).¹²¹ We looked at the available evidence on the extent to which these factors have restricted patients' ability to register with the practice of their choice:

- **Closed lists:** We estimated that around 1.5% of all GP practices in England have reached full capacity and are not accepting any new patients onto their registered lists.¹²² These practices are dispersed across the country. According to our survey, 12% of the minority of patients who had considered

¹¹⁸ A research paper by Santos R., Gravelle H., Propper C. (2013) also indicates that the closest GP practice may not always be the best in terms of QOF scores as measured in this study. See Santos R., Gravelle H., Propper C. (2013) 'Does quality affect patients' choice of a doctor? Evidence from the UK', *CHE Research Paper*. Available from: www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP88_quality_choice_GP.pdf

¹¹⁹ We also note that those who live in metropolitan areas are more likely to think they do not have a choice than those living in rural, urban and suburban areas (39% v 25%; statistically significant at 5% risk level). This is based on the Ipsos MORI survey, responses to questions 24 and 39 (3,192 responses). This is not consistent with our findings on the proximity of GP practices in rural and urban areas and may indicate misconceptions.

¹²⁰ Ipsos MORI survey, responses to questions 13 (204 responses).

¹²¹ In the past the cost of having to offer home visits to those located further away was also a factor in practices not registering patients outside their practice boundary area. However, as reported in section 2, since January 2015, practices been free to register patients outside their practice boundary area without being required to provide home visits.

¹²² Monitor calculations based on data from NHS Choices gathered in January 2015. This number only includes GP practices in the GPOS framework but GPOS covers nearly all GP practices in England.

alternative practices registered with their current practice because they were not accepted for registration by their preferred practice.¹²³

- **Practice boundary areas.** An online patient choice survey conducted in 2009 (commissioned by the Department of Health) found that 8% of all patients have been not accepted for registration and around half of these patients were not accepted for registration because of practice boundary areas.¹²⁴ We also found that approximately 21% of patients who considered alternative providers told us they did not register with another practice because their current GP practice was the only one they were in the catchment area for. This is however a small minority of patients (less than 4%) as few patients looked for alternatives. We welcome the recent changes that make it easier for GP practices to register patients who live outside their practice boundary areas (we describe these changes in section 2.2).

The inability of some practices to register new patients risks preventing patients from choosing their preferred provider. It is therefore welcome that NHS England has begun work to build extra capacity and address these issues. We discuss this further in section 5.

3.5 Conclusions on patients' ability to register with the GP practice that best meets their needs

A number of factors affect patients' choices and patients may not always choose the practice that best meets their needs even if they are empowered to do so. However, patients are better placed to choose the best practice available to them if they are aware of choice and engaged in exercising their right to choose; if they have access to and understand information that enables them to assess differences between practices; and if there are no barriers to choosing the practice they prefer. We found that:

- **Patients are aware of and value their ability to choose their GP practice but relatively few compare GP practices.** Patients told us that location is not the only thing they look for in a GP practice; they also look for good clinical quality and ease of making an appointment. However, in practice, a large majority of patients choose their practice on the basis of location and do not compare alternatives even when moving to a new area.
- **Most patients do not look for information that would help them choose a GP practice that best meets their needs.** This means patients may not be aware of differences between GP practices or availability of alternative

¹²³ Ipsos MORI survey, responses to question 13 (204 respondents who registered in the last 10 years and said they considered alternatives when they registered).

¹²⁴ Ipsos MORI survey, responses to question 13 (204 respondents). Ipsos MORI. (2009) 'GP Choice Survey – Final Topline Results'.

practices. We found that there is information already available to help patients compare GP practices, and that CQC and the Department of Health are taking steps to inform patients. In our view, information about GP practices can be useful for patients if it is based on impartial and robust information, adequately captures what matters to different patients, and is effectively communicated to patients (including vulnerable patients who might otherwise not seek information).

- **Registering with a GP practice does not seem to be difficult.** 88% of patients from our survey who registered with their current GP practice in the last ten years told us that it was easy.

4. Providers' ability to meet patients' needs

We found that many GP providers have developed new ways of working to provide more efficient and effective services to their patients. Some providers have expanded by registering new patients, setting up new practices or expanding to new or larger premises and by taking over practices that have found it challenging to provide good care. However, we also found that some providers have encountered obstacles in meeting patients' needs.

In this section we:

- describe the steps GP practices are taking to meet the increasing demand for GP services
- describe the difficulties GP practices face in recruiting staff and funding arrangements; and steps being taken by Health Education England and NHS England, the BMA and the RCGP to address these difficulties
- present our conclusions on factors that may be creating extra challenges for providers in responding to patient needs. We have identified these factors in line with our role in ensuring the commissioning of services works well for patients. They are based on what GP providers and NHS England told us as well as other evidence we reviewed. These factors are:
 - opportunities to start providing services in new areas
 - flexibility to provide services that meet patients' needs
 - concerns about conflicts of interest in commissioning decisions.

4.1 Meeting increasing demand

Many GP practices are exploring new ways of working. Providers told us about the increasing use of other clinical staff (eg nurses and allied health professionals), triage systems, phone consultations, automated online services and mobile phone applications to help patients manage their bookings and adopt approaches aimed at

improving self-care. GP practices are also increasingly working together to meet demand (eg working in federations to disseminate best practice, share back-office functions and bidding together for contracts to provide other services).¹²⁵

The Five Year Forward View suggests that primary care will increasingly involve nurses, therapists and other community-based professionals, and fuller use of digital technologies.¹²⁶ We found that practices vary in the extent to which they are exploring potentially more efficient ways of delivering GP services. Table 3 below provides examples for which there is data available.

Table 3: Examples of steps GPs are taking to meet increasing demand

Action taken	How this might help	How different practices are taking these steps
Changes in GP/nurse staff mix	Employing nurses to manage certain aspects of patient care can free GP time to deal with more complex cases.	On average, there are around 2.7 full-time equivalent (FTE) GPs for each FTE nurse working in a GP practice but there is wide variation across practices (for example, some practices employ more nurses than GPs and some do not employ any nurses).
Telephone consultations and telephone triage systems	<p>Phone consultations may save time so that GPs can have face-to-face consultations with patients who need them most.</p> <p>GP/nurse triage systems also aim to help manage workload.¹²⁷</p>	Some practices use phone consultations extensively. The GPPS suggests that around 7% of patients who managed to get an appointment spoke to a GP over the phone the last time they tried to get an appointment. In a small number of practices (1% of all practices), around 30% of patients received a consultation over the phone at least once. Most however conduct fewer phone consultations and some do not provide any.

¹²⁵ We discuss the regulatory implications of GP collaboration in a set of scenarios for GPs working together [published alongside this report](#). Different ways in which GPs are working together are well documented. See, for example, the Nuffield Trust’s work on the future of general practice: www.nuffieldtrust.org.uk/our-work/projects/future-of-general-practice

¹²⁶ The Five Year Forward View, page 19.

¹²⁷ The effects of triage systems may not be straightforward; a recent empirical study concluded that the introduction of triage systems in a sample of practices had increased the mean number of contacts per person. Lancet. (2014) ‘Telephone triage for management of same-day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis’. Available from: [www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(14\)61058-8.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)61058-8.pdf)

Action taken	How this might help	How different practices are taking these steps
Online systems for appointment booking and prescriptions	Where patients use these services they can save time for GPs and practice staff.	More than 80% of practices had adopted at least one of these systems in the first quarter of 2014/15. ¹²⁸ The GPPS suggests that around 26% of patients are aware they can book appointments online, 6% say they have done this recently.
Care planning	Can potentially save time by promoting self-care for patients with long-term conditions.	On average, the proportion of patients with long term conditions that have a care plan is 6% and ranges from zero to 37% across practices. ¹²⁹

Source: Monitor analysis based on Health and Social Care Information Centre (2014) and Ipsos MORI GP Patient Survey (January 2015).

There are also examples of innovative practices emerging from the Prime Minister's Challenge Fund which was established in 2014 to improve access and boost innovation in GP practices.¹³⁰ This fund has facilitated pilots allowing GP practices to explore, for example, extended opening times, longer appointment times, phone, email and online video consultations, greater use of online services,¹³¹ and working with other primary, community and acute care providers.¹³²

4.2 Resources to help providers meet patients' needs

Some GPs told us they find it challenging to meet the demands of their existing patients and need to increase their staff numbers and expand premises. They also told us they do not receive sufficient funding, especially in deprived areas.

Shortage of GPs

GP providers and NHS England told us that GP recruitment and retention is a significant problem in many parts of the country. GPs told us that medical students view the GP profession as less attractive than it used to be compared with career

¹²⁸ Both GMS and PMS contracts require GP practices to offer and promote to patients: online booking and prescriptions and, by 31 March 2015, online access to summary information in their patient record as a minimum. NHS England. (2014) 'Patient online support and resources'. Available from: [/www.england.nhs.uk/wp-content/uploads/2014/10/npo-guidance-291014.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/10/npo-guidance-291014.pdf)

¹²⁹ For each practice the figure is derived by dividing the share of patients who have reported they have a care plan by the share of patients who have reported a long term condition (assuming that care plans are intended for patients with a long term conditions).

¹³⁰ This fund was initially established in April 2014 and extended in September 2014. The first wave made £50 million available for 20 pilot schemes and approximately 1,100 GP practices took part. The second wave made an additional £100 million available for practices that did not take part in the first wave.

¹³¹ For example: telecare, healthy living applications for patients to manage their own health, online appointment bookings, prescription ordering systems and online access to patient records.

¹³² See the NHS England website: [/www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/](http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/)

options in other parts of the healthcare sector. Some GPs told us that this is because expected earnings have fallen and the workload has increased.¹³³

We found that the numbers of GPs and nurses have increased over time both in terms of overall numbers and per patient. The number of FTE GPs increased by about 15% between 2004 and 2014 (from around 28,000 to 33,000).¹³⁴ The CfWI reports that the number of consultants in other medical specialties more than doubled over the same period.¹³⁵ In 2014, on average across England, there were about 1,700 patients for every FTE GP. This has fallen from around 1,900 patients per GP in 2004.¹³⁶ The number of FTE nurses and other direct patient care specialists increased by about 10% between 2010 and 2014 (from around 22,000 to 24,000).¹³⁷

Despite these increases in workforce numbers, both the CfWI and the GP Taskforce¹³⁸ suggest that the current level of increase in the number of GPs is unlikely to keep up with demand in the future. This is because the number of new GPs is expected to be too low to keep pace with the increasing demand at a time when many GPs are seeking to retire.

In addition, the supply of GPs varies considerably across the country. For example, the average number of patients per FTE GP varies from around 1,300 to 2,500 across CCGs (see Annex 1).¹³⁹ Variations in the number of patients per FTE GP do not necessarily mean that some practices have more capacity than others. Population needs vary between different areas (eg because of smoking-related long-term conditions and/or a higher proportion of patients with mental health conditions). Some practices may also be more efficient than others. Some practices may use a different staff mix of nurses and practitioners to others. However, it seems that the variations in patients per GP are not in line with patient needs in different areas. In particular, there are more patients per GP in deprived areas than in less deprived areas.¹⁴⁰ This is partly explained by regional training capacity, as most GPs take

¹³³ We found that GP provider income before tax has declined by 6% since 2006/7 in cash terms. Monitor calculations based on HSCIC. HSCIC. (2014) 'GP Earnings and Expenses Time Series'. Available from: www.hscic.gov.uk/catalogue/PUB12625

¹³⁴ This is GPs excluding registrars and retainers. HSCIC. (2015) 'General and Personal Medical Services, England - 2004-2014, As at 30 September'. Available from: www.hscic.gov.uk/catalogue/PUB16934

¹³⁵ Centre for Workforce Intelligence. (2014). 'In-depth review of the general practitioner workforce'. Page 6. Available from: [/www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce](http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce)

¹³⁶ We found that the number of patients per GP has remained almost at the same level since 2010 (there are only small differences in the numbers of patients per headcount and FTE GP between 2010 and 2014).

¹³⁷ Note that because of changes to methodology, data on practice nurses before 2010 may not be directly comparable with subsequent years. HSCIC. (2015) 'General and Personal Medical Services, England - 2004-2014, As at 30 September'. Available from: www.hscic.gov.uk/catalogue/PUB16934

¹³⁸ GP Taskforce. (2014) 'Securing the future GP workforce delivering the mandate on GP expansion – GP taskforce final report'. Available from: <http://hee.nhs.uk/wp-content/uploads/sites/321/2014/07/GP-Taskforce-report.pdf>

¹³⁹ Monitor's calculation using HSCIC data. HSCIC. (2015) 'General and Personal Medical Services, England - 2004-2014, As at 30 September' Available from: <http://www.hscic.gov.uk/catalogue/PUB16934>

¹⁴⁰ The CfWI study estimated that the poorest quintile of PCTs has a much lower number of GPs (62.5 per 100,000) than the richest quintile (76.2 per 100,000). Centre for Workforce Intelligence. (2014). 'In-depth review

their first job in the region they trained in.¹⁴¹ It has also been acknowledged that deprived areas may be less attractive to GPs because of higher workload, poor premises, poor equipment and poor local amenities as well as fewer employment opportunities for spouses of GPs.¹⁴²

As a result of these developments, recent studies have concluded that the sector is very unlikely to have enough GPs to meet the increasing demand in some parts of the country unless actions are taken to significantly boost the number of GPs in training.¹⁴³ The Kings Fund concluded that, as the supply of GP workforce has not kept pace with demand and the morale among GPs is worsening, this poses a risk to the development of new care models.¹⁴⁴ It is also reported that, as the workload increases, GPs have less time to devote to their other responsibilities, such as clinical commissioning.¹⁴⁵

The Department of Health has set Health Education England the long term objective of ensuring that 50% of specialist trainees choose to enter GP specialty training programmes.¹⁴⁶ This means an increase of around 20% from the average of approximately 2,700 trainees that entered GP training programmes per year between 2008 and 2013.¹⁴⁷ A £10 million investment to kickstart a new plan to expand the general practice workforce to better meet the needs of patients now and for the future has recently been announced. The funding will be used to recruit new GPs, find approaches for retaining those that are thinking of leaving the profession and encourage doctors to return to general practice. NHS England funding will be used to develop a range of initiatives in collaboration with Health Education England,

of the general practitioner workforce'. Available from: <http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce>. Also, National Audit Office. (2010) 'Tackling Inequalities in Life Expectancy in Areas with the Worst Health and Deprivation'. Available at: www.nao.org.uk/report/tackling-inequalities-in-life-expectancy-in-areas-with-the-worst-health-and-deprivation/

¹⁴¹ Goldacre, M. Davidson, J. Maisonneuve, J., Lambert, T. (2013) 'Geographical movement of doctors from education to training and eventual career post: UK cohort studies' *Journal of the Royal Society of Medicine*, 106:3, pages 96-104. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3595409/>

¹⁴² Sibbald. (2005) 'Putting general practitioners where they are needed: an overview of strategies to correct maldistribution' Available from: <http://www.population-health.manchester.ac.uk/primarycare/npcrdc-archive/Publications/overview%20of%20strategies%20to%20correct%20maldistribution.pdf>

¹⁴³ In the demand estimation, the CfWI accounts for population growth and ageing, changes in healthcare needs, and increasing productivity. Centre for Workforce Intelligence. (2014). 'In-depth review of the general practitioner workforce'. Available from: <http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce>

¹⁴⁴ The King's Fund found that the fact that the rate of increase in GPs has been outstripped by increases in medical workforce increases in secondary care is at odds with ambitions to deliver more care in the community. The King's Fund (2014), 'Workforce planning in the NHS'. Available from: www.kingsfund.org.uk/sites/files/kt/field/field_publication_file/Workforce-planning-NHS-Kings-Fund-Apr-15.pdf

¹⁴⁵ The King's Fund and the Nuffield Trust. (2015), 'Risk or reward? The changing role of CCGs in general practice'. Available from: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/nt_ccgs_one_year_on_report_web.pdf

¹⁴⁶ Department of Health. (2013) 'Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2013 to March 2015'. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203332/29257_2900971_Delivering_Accessible.pdf

¹⁴⁷ House of Commons Library. (2015) 'General practice in England'.

the RCGP and the BMA to increase the number of GPs and develop the role of other primary care staff such as nurses and pharmacists.¹⁴⁸

Funding

Providers told us that in their view the funding of general practice is too low, uncertain and generally has not reflected increasing demand. Some providers also told us that they do not have incentives to actively try to register new patients, because the funding they get with each extra patient does not cover the extra costs of treating those patients. The BMA told us that the funding mechanism means that recent changes to practice boundary rules could threaten the financial viability of certain GP practices (ie practices can register out of boundary patients without having to provide them with home visits as described in section 2.2). The BMA told us that there is a risk that practices in inner-city areas may receive registrations from commuting patients¹⁴⁹ while practices outside city centres may be left with a higher proportion of patients with more complex needs for whom the funding formula does not reflect the cost of treatment (eg elderly people).

NHS England told us that in its view, low profitability may discourage expansion in some areas. We have not carried out an assessment of whether prices in different areas cover the efficient costs of providing services in those areas. However, we note that total spending on general practice was 3% lower in 2013/14 than it was in 2006/07 (in real terms).¹⁵⁰ How much providers of GP services are paid is an important factor in determining whether they can deliver good services to patients. From the information we have it is not clear to us that payment levels are sufficient in all cases to enable GPs to recover the costs of providing treatment to different types of patients and to give them an incentive to attract new patients:

- We looked at the available evidence on GP practice funding. The total revenue of each GP practice divided by the number of weighted patients on their list tends to be lower in relatively deprived areas compared to wealthier areas.¹⁵¹ This is because of variations across the different types of payments

¹⁴⁸ See NHS England's website: <http://www.england.nhs.uk/2015/01/26/boost-gp-workforce/>

¹⁴⁹ Providers told us that commuters are likely to be lower cost because they are of working age and generally healthy enough to be routinely working away from home.

¹⁵⁰ Total investment in general practice excluding dispensing. Available from:

<http://www.hscic.gov.uk/catalogue/PUB14900> and <http://www.hscic.gov.uk/catalogue/PUB01378>. Converted to real terms using GDP deflator available at <https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-december-2014-autumn-statement>.

¹⁵¹ Monitor analysis based on HSCIC data on GP payment (2015) and ONS data on income deprivation (2010). See Annex 6 for details. The HSCIC uses the term average payments per weighted patient which means revenues divided by the number of weighted patients (weighting means adjusting for factors such as age, sex, and other needs of the population). We note that these revenues are not a measure of profits. We also note that the HSCIC recently estimated that in more deprived areas a lower proportion of GPs' gross earnings are taken up by expenses and therefore a GP is receiving, on average, a higher proportion of their earnings as income before tax. Health and Social Care Information Centre. (2015) 'GP Earnings and Expenses by Deprivation Score'.

Available from:

<http://www.hscic.gov.uk/searchcatalogue?productid=17506&q=title%3A%22GP+Earnings+and+Expenses%22&ort=Relevance&size=10&page=1>

GP practices receive. Practices in deprived areas tend to receive lower prescribing payments and slightly lower MPIG payments (there are small variations in other payment categories such as premises payments).¹⁵² The phasing out and redistribution of MPIG payments may address some of the inequities in funding to the extent the funding mechanism is appropriately geared to meeting differences in GP workload across different patient mixes. Moreover, recent research suggests that the Carr-Hill formula may not reflect the difference between patients' needs in deprived areas and wealthier areas (this analysis was based on a sample of around 1 million patients' GP practices).¹⁵³ Further evidence on GP practices' activity across different patient mixes (eg the number and complexity of consultations) will be necessary to give a better understanding of differences in workload and therefore the level of funding required.

- NHS England told us that it has recognised the inequities in some of the current funding arrangements.¹⁵⁴ It is about to begin a wide-ranging review of the funding to primary care, including a review of the Carr-Hill formula. As an interim measure to stabilise funding, NHS England has published criteria for assessing eligibility of GP practices for support during 2014/15 and 2015/16. This applies where GP practices are losing £3 per weighted patient per annum or more for seven years as a result of changes to GMS funding arrangements, including the phasing out of MPIG. NHS England told us that the Carr-Hill formula allocates an extra £185 million to practices in the most deprived areas.

We welcome NHS England's current work to review the Carr-Hill formula. It is important that a revised Carr-Hill formula, as well as locally negotiated prices (eg for APMS contracts), ensure that efficient GP practices can operate on a financially viable basis and have incentives to register patients with different needs.¹⁵⁵

Finally, some GP providers also told us that where they wanted to expand their premises to treat more patients, they found it difficult to secure funding from

¹⁵² There are also small variations across areas with different levels of deprivation in terms of premises payments, seniority payments, QOF payments, payments for enhanced services and other payments.

¹⁵³ Researchers of the Clinical Effectiveness Group (CEG) at Queen Mary University of London found that practices in one of the most deprived areas in the UK (Tower Hamlets) have been underfunded by 33% because the Carr-Hill formula does not recognise how deprivation affects GP workload. Boomla K., Hull S., Robson J. (2014) 'GP funding formula masks major inequalities for practices in deprived areas', *BMJ*.

¹⁵⁴ NHS England found evidence of premiums that do not reflect the circumstances of locations in which these services are provided and is in the process of addressing these disparities. NHS England. (2014) 'Review of PMS contracts'. Available from: <http://www.england.nhs.uk/wp-content/uploads/2014/02/rev-pms-cont.pdf>

¹⁵⁵ Efficient costs, as defined by Monitor and NHS England in the context of the National Tariff, mean the costs that a reasonably efficient provider should expect to incur in supplying services to the level of quality expected by commissioners. These costs include provisions for the depreciation and financing of capital expenditure, as well as operating expenditure. Monitor and NHS England. (2014). '2015/16 National Tariff Payment System: Engagement on national prices'. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332217/NationalTariff2015-16_EngagementNationalPrices.pdf

commissioners to cover the cost of that investment. The Five Year Forward View recognises the need to invest in primary care (including infrastructure).¹⁵⁶ In line with this, NHS England has recently announced a four-year £1 billion investment programme to accelerate improvements in GP premises and infrastructure.¹⁵⁷

Other factors we looked at

In addition to the issues surrounding the resources GP practices need to deliver services, we asked NHS England and a range of existing and potential GP providers what, if anything, might be stopping new providers from starting to provide GP services or preventing existing providers expanding services to respond to patient need. As the provision and commissioning of primary care are undergoing changes, there is an opportunity for commissioners¹⁵⁸ to consider whether addressing factors that have limited providers' ability to respond to patient demand in the past could help shape primary care services in line with the Five Year Forward View.

We identified three issues that can be explored further as the sector develops new models of care in line with the Five Year Forward View: first, opportunities to set up new services; second, providers' flexibility to offer new services or expand existing ones; third, concerns about conflicts of interest. We discuss our findings on each of these.

4.3 Providers' ability to establish new services

NHS England is responsible for commissioning GP services that meet the needs of patients and must act with a view to improving the quality and efficiency of GP services.¹⁵⁹ Commissioners may commission new GP services, or expand existing ones, in order to respond to patients' choices and meet unmet demand. Commissioners could also enable providers to respond to patient need by establishing new services or expanding existing ones. Commissioners are responsible for making new GP contracts available where they have identified a need for a new GP contract and for deciding whether and where existing or new providers can open new branches of existing ones (together with NHS Property Services).

¹⁵⁶ 'Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years.', The Five Year Forward View, page 4.

¹⁵⁷ See the NHS England website: www.england.nhs.uk/commissioning/primary-care-comm/infrastructure-fund/

¹⁵⁸ When we use the term commissioners in this sub-section, we use the term generally as it may refer to NHS England, primary care trusts (that were previously responsible for commissioning GP services) or CCGs (as co-commissioning between NHS England and CCGs began in April 2015). Where we mean a particular commissioner (eg NHS England), we say so.

¹⁵⁹ See Regulations 2 and 3(4) of the National Health Service (Procurement, Patient Choice and Competition Regulations) (No.2) Regulations 2013.

What NHS England told us about opportunities to provide GP services

We asked NHS England what might inhibit providers from setting up new services. NHS England told us:

- new providers have limited opportunities to begin providing services in new areas as most existing contracts (GMS and PMS) with incumbent GP practices do not have end dates at which they may become available to new providers
- it is rare for primary care providers to approach commissioners about where new services are needed, or how services could be provided.

NHS England told us that existing primary care provision currently allows for the registration of all residents and the need to commission new services is generally in response to a change in circumstances. This may include a growth in population in a specific locality or the closure of an existing facility. NHS England told us that it would agree a procurement decision with the local CCG and advertise it as part of a transparent procurement process.

We also asked NHS England about potential advantages and disadvantages of a system in which any provider that can provide adequate care (and holds CQC registration) is able to set up GP services. NHS England told us that this might result in more new GP services being provided in non-traditional locations as set out in the Five Year Forward View, and more competitive pressure on existing providers to improve services. However, it noted that potential disadvantages include the risk of destabilising existing providers. In addition, many existing contracts include some fixed infrastructure reimbursements (for example for premises costs) which could not be reduced if patients decided to move to other providers.

What providers told us about opportunities to provide GP services

Some providers told us they had concerns about the way in which GP services have been commissioned to date. Notably:

- they are often unable to set up new GP practices (even where they consider there to be patient demand for improved services) as the number of new contracts offered by NHS England has been low relative to patients' needs as identified by some providers
- they see a need for greater transparency and responsiveness in commissioning decisions (eg how commissioners decide where new practices or branches are needed)

- it is difficult to take over existing contracts that have no end date and the circumstances under which existing contracts could be taken over by new providers are not clear.¹⁶⁰

However, we were told that in some areas, commissioners have taken flexible approaches to how services were provided. We were also told that NHS England is likely to be in a position to improve commissioning approaches.¹⁶¹

Some providers also told us that they would be likely to start providing GP services (or expand into new areas) if they could enter into new areas freely where and when they identify patient need (subject to meeting requirements including CQC registration).

Our findings

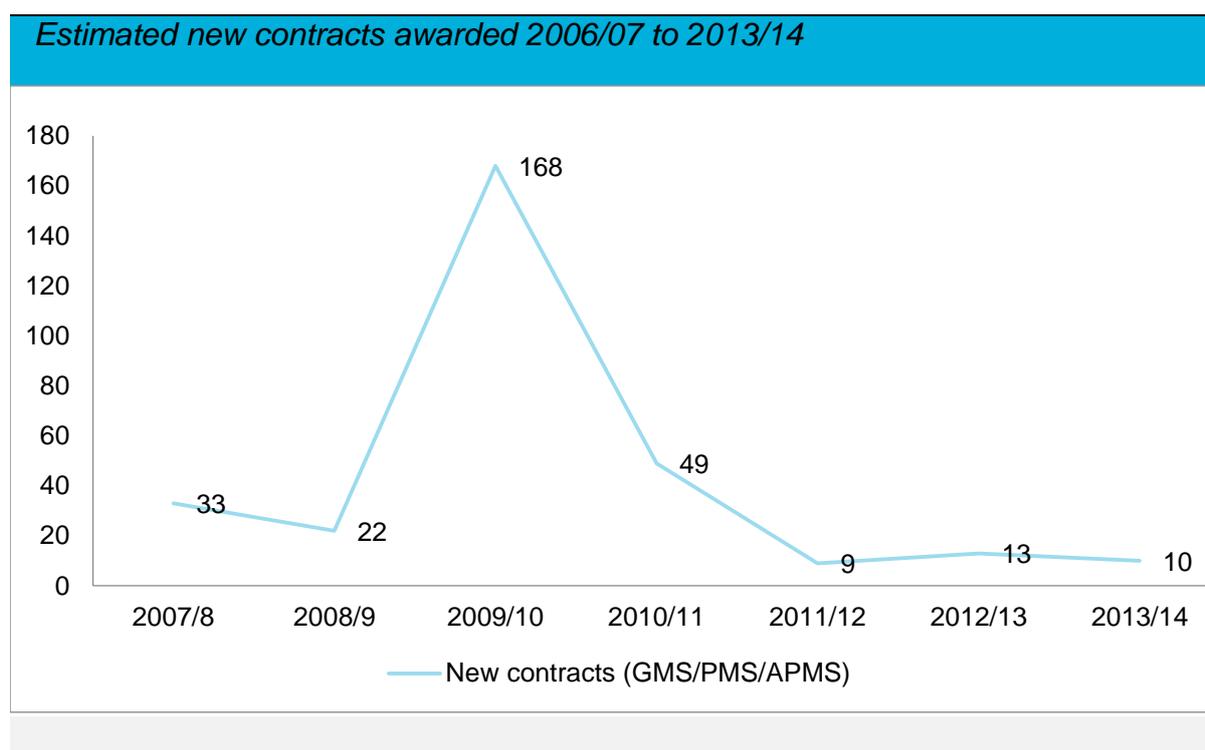
We estimated that commissioners (NHS England and before that PCTs) have awarded between 9 and 13 new contracts in each of the last three years (see Figure 4).¹⁶²

¹⁶⁰ For example, one provider told us that it has identified areas where it would like to open new practices but is unable to as there are no contracts tendered. It is currently engaging with existing providers about potential takeovers. This depends on building relationships with GMS/PMS contract holders and takes time (even if a GP willing to have their contract taken over was found).

¹⁶¹ NHS Partners Network. (2014) 'NHS Partner's Network response to Monitor's call for evidence on general practice services in England' (hereafter 'NHS Partner's Network response to call for evidence'). Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/288452/RepresentativeBodiesSubmissionFinal.pdf

¹⁶² The graph in figure 4 shows the estimated number of new contracts issued every year. These contracts may represent where existing providers change location. They may also represent the entry of a new provider (possibly by replacing an existing provider). However, this may also represent instances where a new contract was awarded but the provider did not change (ie when a provider's existing contract is replaced with a new one).

Figure 4: Estimated new contracts awarded 2006/07 to 2013/14



Source: HSCIC; Monitor analysis based on QOF dataset for 2006-2014.

The number of new contracts increased substantially between 2008/09 and 2009/10 under the government’s Equitable Access Programme.¹⁶³ Since then, we estimated that relatively few have been awarded, while (as reported in section 2) demand for GP services has been increasing and some GP practices appear to be facing increasing challenges in delivering high quality services. As reported in section 2, a significant majority of the GP practices that score lower on various quality indicators are located in deprived areas.¹⁶⁴

We recognise that commissioners’ ability to award new contracts, or enable expansion of existing providers, is to some extent constrained by the funding available. As reported in section 2, most of the funding GP providers receive is related to the number and type of patients they have on their registered list. As the funding follows patients (ie is based on the number of patients who choose to register with a GP), the overall capitated payment should not change if new contracts are awarded (provided that the capitated funding is equal across providers in a given

¹⁶³Letter from Department of Health to all chief executives of Primary Care Trusts in England. 3 February 2011. Available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215793/dh_123926.pdf

¹⁶⁴We also note that the number of contracts may not always reflect commissioners’ attempts to provide opportunities for providers. In our view the number of contracts awarded reasonably reflects the number of opportunities that providers have found viable to pursue (or bid for). For example, some providers may decide not to bid for contracts if they consider that it would not be financially viable to provide services in certain circumstances depending on the contract terms.

area). However, some of the funding is fixed: in particular, premises reimbursement and IT costs are unrelated to a practice's patient list size and constitute around 12% of the total funding of GP services.¹⁶⁵ Commissioners also sometimes provide additional funding to new practices while they are growing their list sizes to enable them to recover their fixed costs as growing list size may take time.

As is also recognised by NHS England, enabling GP providers to set up new services can be in patients' interest where current practices are unlikely to be able to absorb increasing demand and where CQC inspections indicate that the quality of services is inadequate.¹⁶⁶ Although there are some disadvantages to a system in which any provider that can provide adequate care (and holds CQC registration) is able to set up GP services (such as those identified by NHS England above), this system could help address challenges in meeting patients' needs, particularly in under-doctored areas.

We identified two important elements in allowing providers to set up new services where patients need them:

Identifying service needs based on transparent assessments: Where implemented, co-commissioning with CCGs is expected to strengthen resources and local knowledge in the commissioning of primary care.¹⁶⁷ There is therefore an opportunity for commissioners to identify where new practices are in patients' interest and to monitor the performance of existing providers. There are examples of commissioners enabling providers to meet unmet demand and address variations in quality and ease of making appointments. Notably:

- Since the Equitable Access Programme, new contracts have been awarded broadly in line with the overall distribution of practices across different levels of deprivation (over the past three years around two thirds of new contracts have been awarded in deprivation deciles 6 to 10 which correspond to more deprived areas).¹⁶⁸
- NHS England has stated it will bring in new providers where existing practices are unlikely to be able to meet the growing demand (at adequate levels of quality).¹⁶⁹ It is our view, as well as NHS England's, that it is likely to be in patients' interest that commissioning of GP services builds on transparent criteria and open engagement with GPs and other potential providers.

¹⁶⁵ HSCIC. (2014) 'Investment in General Practice, 2009-10 to 2013-14, England, Wales, Northern Ireland and Scotland'. Available from: www.hscic.gov.uk/catalogue/PUB14900

¹⁶⁶ NHS England. (2014). 'Improving general practice, a call to action: Phase I report', paragraphs 88-91. Available from: <http://www.england.nhs.uk/wp-content/uploads/2014/03/emerging-findings-rep.pdf>

¹⁶⁷ NHS England. (2014). 'Next steps towards primary care co-commissioning'. Available from: <http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf>

¹⁶⁸ Monitor analysis based on Office of National Statistics deprivation statistics (2010) and Monitor analysis based on QOF dataset for 2006-2014

¹⁶⁹ NHS England. (2014). 'Improving general practice, a call to action: Phase I report', paragraphs 88-91. Available from: www.england.nhs.uk/wp-content/uploads/2014/03/emerging-findings-rep.pdf

- NHS England does not generally collect data on the volume or nature of consultations and this may have added to the difficulty of identifying where existing practices need more resources to meet demand and where new GP services are needed.¹⁷⁰ In our view, the assessment of where there are service needs (as well as the appropriate level and distribution of funding and workforce needs) should build on accurate and up-to-date information (eg on the number and type of consultations carried out across different types of patient). For example, one CCG told us they have been seeking to monitor the activity carried out by GPs in their area (more local organisations may be doing so but were not part of our interview programmes). We welcome initiatives aimed at building an evidence-based picture of local and national commissioning priorities.¹⁷¹

Ensuring that the best possible providers are providing GP services: In a large majority of the locations where commissioners have awarded a contract, GP practices hold either GMS contracts, which have no end date, or PMS contracts which allow the provider to convert to an indefinite GMS contract (as reported in section 2).¹⁷² We were told by providers that commissioners have rarely intervened and replaced a provider due to inadequate service quality but we have been unable to find information to verify this. Where GP practices provide good care (as a large majority of them do) commissioners are likely to have no reasons to intervene. However, CQC inspections show that some practices have scope for improvement and a small number of practices have been rated inadequate. CQC and NHS England are taking steps to identify and support practices that require improvement. In accordance with NHS England’s framework to respond to CQC inspections, where a practice has been placed into special measures or failed to comply with earlier contractual notices, NHS England must urgently assess the risk to patients and the NHS of allowing the contract to continue. In the event of termination of the contract, NHS England would undertake all expected steps with regard to procurement for new permanent contract arrangements, a merger with another practice or dispersal of patients on the provider’s list.¹⁷³ This would include ensuring any new GP services are commissioned from the provider most capable of securing the needs of patients and improving the quality and efficiency of services.¹⁷⁴

¹⁷⁰ This issue was raised by some providers (and sector representatives we spoke to) and confirmed by NHS England.

¹⁷¹ Maintaining comprehensive information about practice boundary areas of existing GP practices may also help NHS England to identify areas that need extra GP services and help patients to identify which practices they can choose from.

¹⁷² Around 4% of GP contracts are APMS contracts. HSCIC. (2014) ‘General and Personal Medical Services, England - 2003-2013, As at 30 September’. Available from: www.hscic.gov.uk/catalogue/PUB13849

¹⁷³ NHS England. (2014) ‘Framework for responding to CQC inspections of GP practices’. Available from: <http://www.england.nhs.uk/wp-content/uploads/2014/10/frmwk-respond-cqc-insp.pdf>

¹⁷⁴ Procurement, Patient Choice and Competition Regulations, Regulation 3(3).

We expect that the steps taken by CQC and NHS England will result in more support to practices providing inadequate care and more opportunities for other providers to take over contracts, or win new ones, where it is in the interest of patients.

4.4 Flexibility to meet patients' needs

We identified extra factors that can limit the ability of providers to offer new services and expand existing ones. These relate to which types of providers provide GP services and certain features of how GP services are commissioned and provided. The extent to which these factors are present varies across the country as PCTs (historically) and NHS England have adopted different approaches, depending on local circumstances. Increasing clarity on these aspects may help commissioners (NHS England and some CCGs) to “design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities” as envisaged in the Five Year Forward View.¹⁷⁵

A recent study suggests that the performance of providers under APMS contracts has been worse across many quality indicators than the performance of GMS and PMS providers, even when differences in certain patient and practice characteristics are taken into account.¹⁷⁶ The study concludes that regulators should ensure that new entrants to GP services are performing adequately. As we described above, NHS England and CQC are taking steps to address inadequate performance. More evidence is needed to understand why APMS providers have generally performed worse than GMS and PMS providers. Below we discuss other factors that commissioners can take into account to secure good quality services: ensuring that the best possible providers hold contracts by commissioning services through different contracting routes available; and designing contract terms that enable providers to provide good care.

Features of contract available

What NHS England and providers told us

NHS England told us that a factor inhibiting some providers from establishing new services is that only certain types of providers can hold GMS and PMS contracts (GPs and NHS providers respectively, see Table 1 in section 2 for more information about the differences between different contract types). NHS England told us that when it decides to tender for GP contracts it determines which type of contract to offer on a case by case basis. NHS England told us that it will explore the most appropriate option for securing high quality general practice services for all patients, depending on legislation and local circumstances. Some providers told us that there

¹⁷⁵ The Five Year Forward View, page 18.

¹⁷⁶ Greaves F., Laverty A., Pape U., Ratnezwaren A., Majeed A. and Millett C. (2015) 'Performance of new alternative providers of primary care services in England: and observational study', *Journal of the Royal Society of Medicine*, Available from: <http://jrs.sagepub.com/content/early/2015/03/31/0141076815583303.abstract>

is no transparent mechanism through which certain types of providers (for example, those not owned by clinicians) could take over existing practices holding GMS and PMS contracts.

Our findings

We found that commissioners have used all three different types of contracts over the past six years. Table 4 summarises our estimates of new contracts awarded over this period by contract type.¹⁷⁷

Table 4: Estimated new contracts awarded 2008-13 by type of contract

Financial year	APMS	GMS	PMS
2008/09	9	4	6
2009/10	104	10	28
2010/11	21	5	14
2011/12	5	1	2
2012/13	5	2	4
2013/14	2	2	2

Source: Monitor estimates based on QOF data available at HSCIC. Note: The table shows the type of new contracts, comparing them with the data from 2013. It only shows the contracts that were still active in 2013. It relies on the assumption that the contract type has not changed from when they were awarded to 2013.

As the table shows, commissioners have frequently used APMS contracts, which are available for all types of providers. GMS and PMS contracts have also been awarded in recent years.

In our view, the development of new care models is likely to mean that GP services will be increasingly provided by different types of organisations although, as recognised in the Five Year Forward View, standalone GP practices will continue in their current form where patients want that.¹⁷⁸ We found that some commissioners have already created opportunities for different types of providers to offer GP services including, for example, community interest companies, community providers and foundation trusts.¹⁷⁹

The Procurement, Patient Choice and Competition Regulations do not dictate the contractual form required (GMS, PMS or APMS). They do, however, require commissioners to procure services from the providers that are most capable of securing the needs of patients and improving the quality and efficiency of services.

¹⁷⁷ The total number of contracts in Table 4 is slightly less than the total number of contracts in Figure 4. This is because Table 4 only contains contracts that were still active in 2013 whereas Figure 4 shows all new contracts awarded in each year.

¹⁷⁸ The Five Year Forward View, page 18.

¹⁷⁹ NHS England told us that as part of the implementation of new care models they are currently considering the commissioning and contracting models for Primary and Acute Care Systems and Multispecialty Community Providers.

Commissioners should be mindful of this obligation in selecting the contractual construct to be used in commissioning GP services. We note that the APMS construct allows flexibility in the type of provider that can hold the contract and in determining pricing and location of services that can help in tailoring services to meet patients' needs.¹⁸⁰ However, we recognise that GMS and PMS contracts may still be the most appropriate to encourage providers to start providing services in some areas (for example, as they may offer more attractive contract terms) and therefore be in the best interest of patients.

Restrictions on the location of services

Providers need to be able to provide services at locations that are accessible to patients and where services can be provided cost effectively.

What providers and NHS England told us

Some GP providers told us that in their view commissioners have, in some cases, taken an overly restrictive approach in prescribing the location from which GP services can be provided. Two community providers told us that if contracts were more focused on outcomes than, for example, on locations where services are provided, they might be better placed to integrate GP services with community services. This would make these contracts more attractive to providers.

NHS England told us that the location of GP services is currently informed by the local Health and Wellbeing Board and is agreed by local overview and scrutiny committees. Therefore any change to the agreed location would need public consultation. However, going forward, NHS England told us that the new models of care envisaged in the Five Year Forward View will focus more on how patients receive their care and the type of care provided rather than the location from which care is provided.

Our findings

In our view commissioners may need to prescribe the location from which services are provided to meet the specific patient needs they identify. For example, if a high proportion of a certain population are likely to have limited access to transport, commissioners may need to prescribe that services are delivered from a specific location to ensure patients can access them via public transport. Commissioners also need to ensure that the premises at which GP services are provided are appropriate for the services. However, to get the best services for patients, commissioners will need to remain open to proposals from providers to expand or relocate services to improve them. Failure to do so risks inhibiting the development of the types of Multispecialty Community Providers and Primary and Acute Care

¹⁸⁰ NHS England. (2014) 'NHS England Standard Alternative Provider Medical Services Contract 2014/15'. Available from: <http://www.england.nhs.uk/wp-content/uploads/2014/06/apms-standard-contract-june14.pdf>

Systems envisaged in the Five Year Forward View. Remaining open to proposals from providers will also help commissioners ensure they have acted transparently and fairly, and procured services from the providers that are most capable of securing the needs of patients and improving the quality and efficiency of services.

Perceived restrictions on informing patients about services

To explain how their service offer is well suited to meet the needs of patients, GP practices need to be able to inform patients about their services.

What providers told us

Some providers told us that they believe they are restricted in how they can inform patients about their services, for example by publishing information about the quality of their services. Some of these providers told us that this is due to contractual restrictions prohibiting providers from promoting their services and others because of perceptions among local GPs. Some providers told us that these rules are set out in the national GMS and PMS contracts. Some providers holding APMS contracts told us that their contracts contained provisions restricting their ability to promote their services.

However, no one has been able to show us a restriction on informing patients in any type of contract. We are not aware of any other restrictions on producing comparative information. There is no such restriction in the APMS directions or standard APMS contract template, nor were providers who told us about these restrictions able to provide us with contracts (of any type) setting out such restrictions.¹⁸¹

Our findings

The GMC's Good Medical Practice Guide requires that providers, when advertising their services, make sure the information they publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge. Similarly, a code of practice for the promotion of NHS-funded services published by the Department of Health in 2008 requires that providers ensure that information they publish is not misleading or offensive.¹⁸²

It appears to us that some providers perceive restrictions on informing patients about their services as existing where they do not. Therefore there is an opportunity to make it clear to providers that they can provide patients with information about their services, provided that it is consistent with the guidance noted above. In our view, if

¹⁸¹ NHS England. (2014) 'NHS England Standard Alternative Provider Medical Services Contract 2014/15'. Available from: <http://www.england.nhs.uk/wp-content/uploads/2014/06/apms-standard-contract-june14.pdf>

¹⁸² Department of Health. (2008) 'Code of practice for the promotion of NHS-funded services'. Available from: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_083557.pdf

providers perceive they are restricted in how they inform patients about their services, they will find it difficult to tell patients about the services they offer or the standard of care they provide (for example, if they have received an ‘outstanding’ CQC rating). Where information communicated to patients is informative and focuses on what is relevant to patients, it is likely to benefit patients by improving their ability to choose the provider that best meets their needs.

Uncertainty around contract duration

What providers and NHS England told us

Some providers told us that the relatively short length of some APMS contracts (typically five, sometimes three years, according to providers) discourages investment in services (and/or bidding for contracts) as it takes time to achieve sufficient patient list size and hence revenues. Some providers told us that short contracts are a barrier to establishing long-term care relationships with patients and that the typically short duration of APMS contracts means that practices can find it difficult to recruit staff who prefer long-term stability. In addition, some providers had concerns about some commissioners’ approaches to contract renewal.¹⁸³

NHS England told us that the duration of APMS contracts is currently typically around five years. NHS England also told us that contracts for longer than five years need a more robust response to performance failure in the contract terms. They told us that, where significant investment is needed, payments set out in contracts are intended to reflect any high upfront costs associated with starting to provide the services. In addition, NHS England also clarified that it funds IT system costs through CCGs, and providers often use premises funded by commissioners (through NHS Property Services).¹⁸⁴ NHS England has recognised that short duration contracts can be problematic and has indicated that in future it will likely issue longer duration contracts where it is appropriate.¹⁸⁵

Our findings

In our view, the appropriate contract length depends on the specific circumstances of the local area. We note that fixed-term contracts can give commissioners opportunities to ensure that the best possible providers offer services to patients. There are examples where commissioners have switched providers after finding a

¹⁸³ One provider told us that the approaches NHS England area teams have taken on contract length and renewal vary significantly across the country. Another provider told us that some NHS England area teams have extended contracts on a year-to-year basis and provided documentation supporting this.

¹⁸⁴ The N3 Network is a system connecting GP practices with NHS networks and is generally funded by commissioners.

¹⁸⁵ NHS England has noted that it will introduce long-term contracts where it is in the interest of continuity of care and value for money. NHS England (2014) Improving General Practice – A Call to Action, Phase 1 Report, paragraph 91. Available from: www.england.nhs.uk/wp-content/uploads/2014/04/emerging-findings-report.pdf

provider that was better able meet patients' needs than the initially selected APMS contractor (eg by awarding the contract to a new provider at the end of the contract).

While the fixed investment costs of providing GP services may be low relative to many other healthcare services, there are features of the provision of GP services that commissioners should take into account when determining the contract length and renewal conditions:

- In some cases providers start from zero list size and may face significant running costs from the outset (eg when implementing a new model of care involving GP services). Therefore, the contract length should be sufficient to allow the provider to grow their list and recoup their costs.
- A long-term contract could reduce incentives for providers to improve services depending on the contractual obligations and commissioners' ability to intervene.
- We found that some patients value long term relationships with their GPs (for example, 17% of patients who responded to our survey said that being able to see the same doctor every time is one of the main things they look for in their GP practice).¹⁸⁶ Providers are better placed to meet the needs of patients that value long term stability if they can be clear about the prospect of providing services over time.
- Long-term contracts may limit the opportunities that new providers, or existing providers who wish to expand, have to establish new GP practices as contracts will be tendered less frequently.

We recommend that commissioners take these factors into account when designing contracts and, where fixed-term contracts are entered into, that they give providers clarity about if and when contracts will come up for renewal.

4.5 Concerns about conflicts of interest

Many GPs are increasingly playing an important role in commissioning GP services in their area as co-commissioning of GP services by CCGs begins.¹⁸⁷ Co-commissioning is welcome in light of the need to enhance resources and local knowledge in the commissioning of primary care. At the same time, it creates a risk that practices not involved in commissioning decisions will find it increasingly difficult to set up and expand services that pose a threat to the income of other local GPs.

¹⁸⁶ Ipsos MORI survey, responses to question 1a. Respondents could choose multiple responses, hence total may not add up to 100%.

¹⁸⁷ It is mandatory for every GP practice to be a member of its local CCG.

What providers told us

Some GP providers told us that it will be challenging to manage conflicts of interest when co-commissioning is implemented by some CCGs. Some GP providers told us that conflicts of interest risk limiting their ability to set up new or develop existing GP services. Some of these GP providers told us they were willing to provide wider sets of services, including community services, so their concerns relate to both the commissioning of list-based GP services and the commissioning of other services GP practices could bid for.

Our findings

CCGs are specifically prohibited from awarding contracts for services where conflicts of interest affect, or appear to affect, the integrity of the contract award.¹⁸⁸ There is a variety of guidance available on managing conflicts. For example, we have produced advice on managing conflicts in our guidance on the Procurement Patient Choice and Competition Regulations.¹⁸⁹ NHS England has also published guidance on managing conflicts of interest and will work with local CCGs on managing conflict of interest.¹⁹⁰

4.6 Conclusions on providers' ability to meet patients' needs

Workforce shortages and lack of funding are two issues that GP providers say are constraining their ability to expand capacity in response to patient needs. It has been estimated that the current level of supply of GPs is unlikely to keep pace with increasing demand and that workforce issues are particularly severe in deprived areas. The Department of Health has set Health Education England the long term objective of ensuring that 50% of specialist trainees choose to enter GP specialty training programmes. NHS England has also recognised that GP premises and infrastructure require significant investment. There is evidence to suggest that payment level and distribution may be one of the challenges in delivering good services to patients. In our view, the level of capitated payment is important in enabling GP providers to recover their costs and in providing GP practices with incentives to meet different types of patients' needs. It is therefore important to review the level and distribution of funding for GP services.

Some providers told us they had concerns that few opportunities are being made available to set up new GP practices (or expand with new surgeries) in areas where

¹⁸⁸ Regulation 6 of the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Available from: <http://www.legislation.gov.uk/ukxi/2013/500/contents/made>

¹⁸⁹ Monitor. (2013) 'Substantive guidance on Procurement, Patient Choice and Competition Regulations'. Available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf

¹⁹⁰ NHS England. (2014) 'Managing conflicts of interest: statutory guidance for CCGs'. Available from: <http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confil-int-guid-1214.pdf>

they had identified patient need and that they would prefer greater transparency in commissioning decisions. In our view, commissioners are best able to identify and respond to patients' needs when they actively assess which areas need additional or improved GP services.

There are also opportunities for commissioners to be more transparent and flexible to help providers establish new GP services and move or expand existing ones. This involves, for example, ensuring that the contract duration and renewal conditions are transparent and reflect local circumstances and that there is flexibility in determining the location from which GP services are provided.

5. Steps to improve how choice and competition is working in GP services

As we explained in section 1, patients' ability to choose their GP has been a feature of the NHS since it was established and, consistent with the Five Year Forward View, it can play a role in shaping the patient-centred NHS of the future. In addition, there is an opportunity for commissioners to maximise the benefits of existing patient choice policies as a way to drive the development of the care models described in the Five Year Forward View.

There is scope for more patients to be engaged and informed in choosing the GP practice that best meets their needs. Patient choice is a factor that can help patients get better GP services but it is not sufficient in itself. GP providers need to be able to respond to patients' needs and choices. A key factor that appears to be limiting GP providers' ability to do so relates to their ability to recruit and retain workforce. The level and distribution of funding GP practices receive may also constitute a challenge some GPs face in expanding to meet the increasing demand. We also identified opportunities for commissioners to address factors that appear to have limited providers' ability to respond to patient demand in the past, which could help shape primary care services in future in line with the Five Year Forward View.

5.1 Steps our partners are taking that will help GP services work better for patients

Our partner organisations are taking a number of steps to address some of the issues we identified:

- **Staffing:** The Department of Health has asked Health Education England to ensure that sufficient numbers of medical students enter GP training programmes to keep pace with increasing demand. A £10 million investment to kick start a new plan to expand the general practice workforce to better meet the needs of patients now and for the future has recently been announced. The money will be used to recruit new GPs, find approaches for retaining those that are thinking of leaving the profession and encourage doctors to return to general practice. NHS England funding will be used to

develop a range of initiatives in collaboration with Health Education England, the RCGP and the BMA to increase the number of GPs and develop the role of other primary care staff such as nurses and pharmacists.

- **Premises:** The need to invest in primary care infrastructure is recognised in the Five Year Forward View. In line with this, NHS England has recently announced a four-year £1 billion investment programme to accelerate improvements in GP premises and infrastructure.¹⁹¹
- **Payment:** NHS England told us it is about to begin a wide-ranging review of the funding for primary care, including a review of the Carr-Hill formula underlying the capitated payments providers with GMS contracts receive.
- **Access to GP services:** The Department of Health established the Prime Minister's Challenge Fund in 2014 to improve access and boost innovation in GP practices.¹⁹² This fund has facilitated a number of pilots which allow GP practices to explore: extended opening; longer appointment times; phone, email and online video consultations; greater use of online services; and working with other primary, community and acute care providers.
- **Regulating quality of service:** CQC is in the process of inspecting every GP practice in England.
- **Informing patients:** The Department of Health and NHS England (in collaboration with CQC and Public Health England) are developing a new MyNHS website, which is aimed at helping the public to compare the performance of healthcare services, including GP practices, over a range of measures.¹⁹³ CQC now requires GP practices to display their CQC rating to improve transparency for patients.¹⁹⁴

5.2 Steps we are considering to complement the work of our partner organisations

We will share and discuss the findings of our research with other organisations to help inform their ongoing work on GP services. For example, we will engage with NHS England to inform the work they are doing to implement a framework for the co-commissioning of GP services between NHS England and CCGs.

¹⁹¹ See NHS England': <https://www.england.nhs.uk/commissioning/primary-care-comm/infrastructure-fund/>

¹⁹² The Fund was initially established in April 2014, and extended in September 2014. The first wave made £50 million available for 20 pilot schemes, and approximately 1,100 GP practices participated. The second wave made an additional £100 million available for practices that did not participate in the first wave. See NHS England's website: <http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/>

¹⁹³ For more information about the My NHS website: www.gov.uk/government/publications/improving-transparency-in-the-nhs

¹⁹⁴ See CQC's website for more information about this requirement: <http://www.cqc.org.uk/content/display-ratings>

Monitor is also working to help the adoption of new care models on the ground, by seeking to remove barriers to change and being flexible in our approach to regulation. We will provide support and advice on how competition and choice can contribute to the implementation of new models of care.

We will support other organisations, including CQC, NHS England, the Department of Health and Healthwatch, in their initiatives to raise patient awareness about choosing their GP practice and the potential benefits of doing so. We will support them to communicate information to patients that will allow them to compare GP services on the basis of robust information. This may include considering how the information could be communicated to different types of patients, including the most vulnerable patients who might otherwise not actively look for information (but would benefit from choosing the practice that best meets their potentially complex needs).

In addition, we will integrate the findings of our research into Monitor's day-to-day work. For example, Monitor regularly provides advice to providers and commissioners on the application of the Procurement, Patient Choice and Competition Regulations.

Annexes

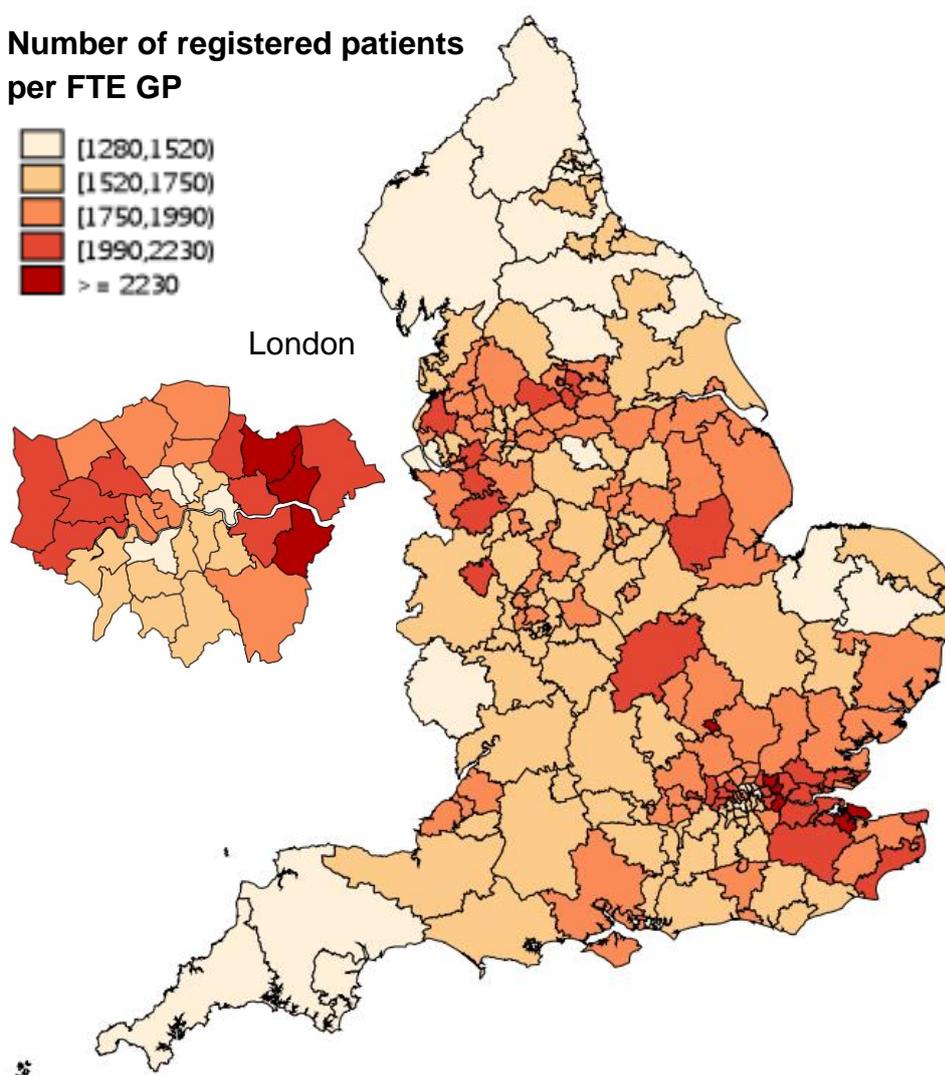
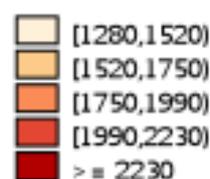
Annex 1: Regional variations in workforce and access

Patients per FTE GP

In 2014, on average across England, there were around 1,700 registered patients for every full-time equivalent (FTE) GP. Figure A1.1 illustrates how the number of patients per GP varies across clinical commissioning groups (CCGs).

Figure A1.1 Registered patients per FTE GP across CCGs (2014)

Number of registered patients per FTE GP



Source: Monitor analysis based on HSCIC (2015). Note: The number of patients per FTE GP is calculated by summing the registered patients for all the GP practices in each CCG and dividing this number by the total number of FTE GPs in each CCG (the sum of all FTE GPs working at the practices in the CCG; locums, retainers and registrars are not included).

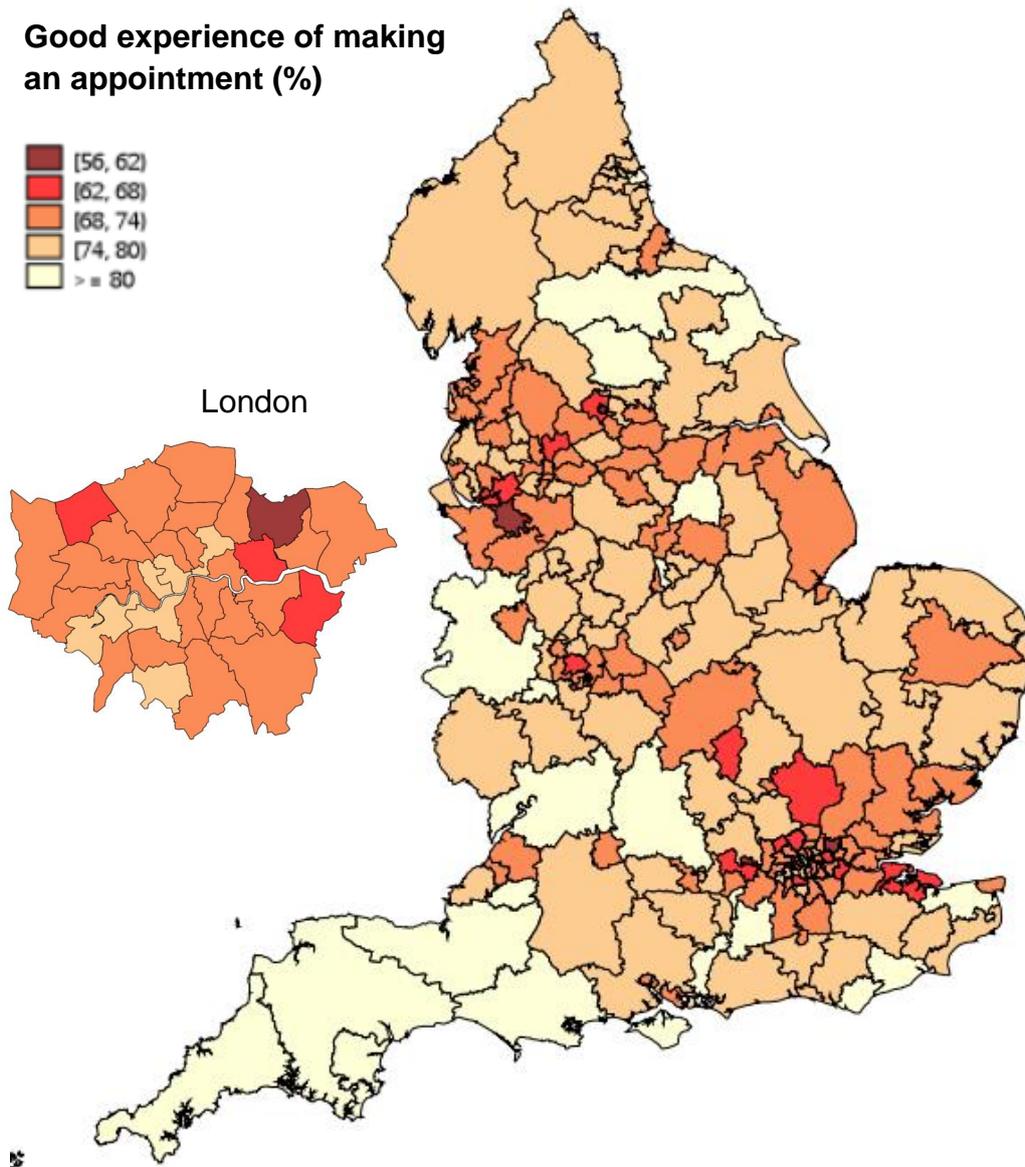
The average number of patients per FTE GP varies from around 1,300 to around 2,500 across CCGs. The areas with the highest number of patients per GP are concentrated mainly in parts of Greater London, the South East, the North West and

in the East Midlands. The areas with the least patients per FTE GP are mainly in the South West, the East of England and parts of Greater London and northern England.

Patients' experience of making an appointment

Figure A1.2 illustrates how patients' overall experience of making an appointment at their GP practice varies across CCGs.

Figure A1.2 Proportion of patients who describe their experience of making an appointment as very good or fairly good (2014)



Source: Monitor analysis based on GP Patient Survey data for 2014 (using the latest release in January 2015). Note 1: Patients were asked: 'Overall, how would you describe your overall experience of making an appointment'. Note 2: We used the proportion of patients that described their experience as 'very good' or 'fairly good'.

On average 74% of patients say they had a good (very good or fairly good) overall experience of making an appointment. This average rate of good experience ranges

from 56% in NHS Slough CCG to around 88% in NHS Hambleton, Richmondshire and Whitby CCG. The regions where relatively high proportions of patients report their experience of making an appointment as good include the South West and parts of Yorkshire and the Humber, South East and West Midlands. The regions where relatively low proportions of patients report their experience of making an appointment as good include parts of Greater London, the South East, the West Midlands and the North West.

Annex 2: NHS England's and CQC's performance monitoring frameworks

NHS England and the CQC have developed performance monitoring frameworks that draw on a broad range of quality and access indicators.

The GP Outcome Standards (GPOS) framework (which we use in parts of our analysis) is accessible via NHS England's Primary Care Webtool and was developed with a range of stakeholders including the Department of Health and Local Medical Committees (LMCs).¹⁹⁵ The purpose of the framework is to help commissioners improve quality, access and patient experience in general practice, and to reduce the variation that exists across England.¹⁹⁶ It allows them to identify practices that score lower relative to their peers across 28 quality and access outcome standards.¹⁹⁷ These outcome standards include, for example, measures of prevention (eg uptake of immunisations and smoking cessation), diagnosis (eg identifying the prevalence of coronary heart disease and dementia), avoidable hospital admissions and patient experience.¹⁹⁸ NHS England specifies that a GP practice's performance against their framework should be contextualised using data from other practices in similar location, and with similar populations.

Where a GP practice's performance deviates (in terms of standard deviations) from the national average or an accepted standard, it is assigned certain triggers. This includes both level 1 or level 2 triggers depending on how significant the deviation is (ie level 2 triggers are assigned for more significant deviations). Under the GPOS framework, GP practices fall into one of four categories:

- Higher Achieving Practices: the practice has between 0–1 triggers in total and 0 level two triggers.

¹⁹⁵ GPs, pharmacists, practice managers, nurses and think tanks have contributed to the process of designing the GPOS methodology. GPOS was first introduced in London in 2011 and scaled up to a nation-wide coverage in 2013. We note that NHS England also uses General Practice High Level Indicators (GPHLI) to monitor and improve quality. GPHLI is primarily an assurance tool that allows users such as commissioners and GP practices to monitor that services are being delivered to a high standard and to monitor improvements in quality and outcomes.

¹⁹⁶ NHS England (2013). 'Approach to Improve Quality, Access and Patient Experience in General Practice An agreed methodology for assessing variation, Interim version', December.

¹⁹⁷ Some standards are split into different specific measures. Some standards and measures are not used in the calculation of overall rating.

¹⁹⁸ The GPOS technical appendix provides an explanation of how the outcome score thresholds have been calculated for each indicator. General Practice Outcome Standards: Technical Annex (August 2014, (v2.1)). General Practice Outcome Standards: Methodology (August 2014) provides description of how practices are categorised.

- Achieving Practices: the practice has between 2–5 triggers in total or 1 level two trigger.
- Practices approaching review: the practice has between 6–8 triggers in total or no more than 2 level two triggers.
- Practices with review identified: the practice has 9 or more triggers in total or 3 or more level two triggers.

Table A2.1 summarises the GPOS categories of GP practices in England by region.

Table A2.1 GPOS overview by region

	Higher Achieving Practices %	Achieving Practices %	Practices Approaching Review %	Practices with Review Identified %
England overall	8	48	27	17
<i>Regions</i>				
North of England	9	52	27	12
Midlands and East of England	9	51	25	15
London	2	27	35	36
South of England	11	59	22	9

Source: NHS England Primary Care Webtool; release version 3.9.1 (extracted in December 2014).

Notes: The reported numbers have been extracted from the Primary Care Webtool and may not add up to 100% due to rounding errors. The data in the table was extracted in December 2014 (which is the dataset we use in this report). We note that the Primary Care Webtool (GPOS) data was updated since then (release version 3.9.2, extracted in April 2015). There are slight differences in proportions of practices falling in different groups. Except for practices in the 'review identified' group in London (where the proportion of these practices was 31% in April 2015), the changes are no more than 3% in each group in different regions.

As summarised in the table, there are differences across regions. For example, in the South of England a relatively high proportion of GP practices are in the 'higher achieving' and 'achieving' categories. In London around a third of practices are in the 'review identified' group, while on a national level only 17% of practices are in this GPOS group.

CQC is inspecting GP providers to ensure that they deliver high quality care to patients. The purpose of CQC's inspections is to make sure that services are up to

standard across several dimensions of quality and to encourage quality improvements.¹⁹⁹ The domains for CQC's inspection framework are:²⁰⁰

- Safe: patients are protected from abuse and avoidable harm
- Effective: people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best
- Caring: staff involve and treat people with compassion, kindness, dignity and respect
- Responsive: services are organised so that they meet people's needs
- Well led: the leadership, management and governance of the organisation assure the delivery of high-quality care, supports learning and innovation, and promotes an open and fair culture

CQC has developed the Intelligent Monitoring Framework to help prioritise its inspections.²⁰¹ The framework incorporates feedback from a wide range of stakeholders, including think tanks, government departments, regulators, arm's length bodies, commissioners, providers and members of the public. Drawing on 37 indicators, the Intelligent Monitoring Framework identifies the difference between a practice's actual performance against indicators and what would be expected (much like GPOS).

Annex 3: Characteristics of practices with different outcomes

In this annex we summarise how practices in different GPOS categories are distributed across areas with different levels of deprivation and in terms of their ratios of patients to GPs and other clinical staff. We have not conducted statistical analysis to identify which factors drive variation in performance.²⁰² For example, our analysis does not control for all the various factors that would be expected to affect the quality of service.

Deprived areas

Figure A3.1 shows how GP practices with different outcomes (ie in different GPOS groups) are dispersed between more and less deprived areas (based on Office for National Statistics data on income deprivation).

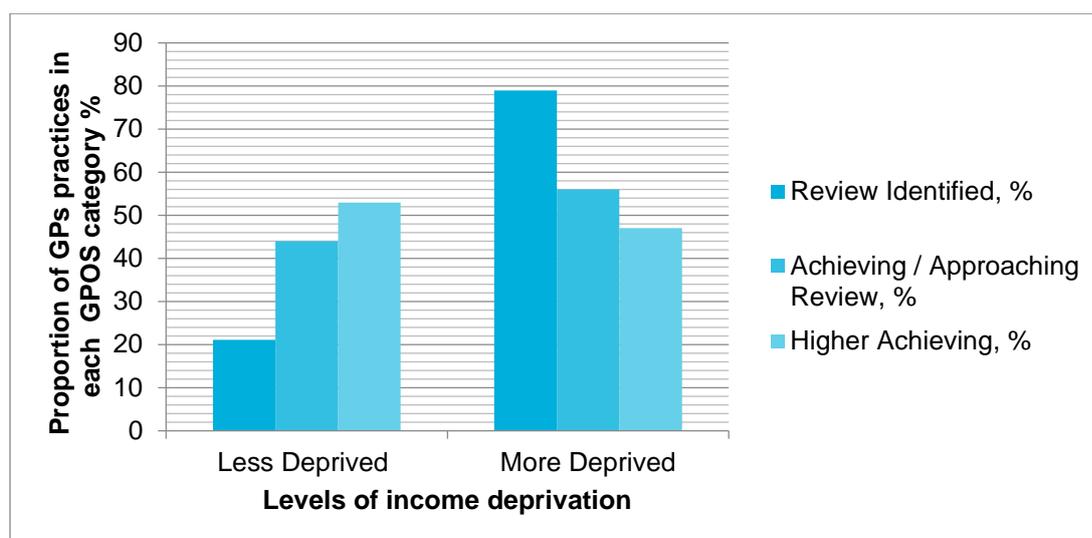
¹⁹⁹ Care Quality Commission (2013). 'A fresh start for the regulation and inspection of GP practices and GP out-of-hours services'. Available from: www.cqc.org.uk/sites/default/files/documents/20131211_-_gp_signposting_statement_-_final.pdf

²⁰⁰ The definitions of these terms are available from: <http://www.cqc.org.uk/content/glossary-terms-used-guidance-providers-and-managers>

²⁰¹ For more information, see: www.cqc.org.uk/content/our-intelligent-monitoring-gp-practices

²⁰² For example, a study published by the Cooperation and Competition Panel examined whether and to what extent proximity between GP practices is associated with their quality outcomes, taking into account other factors that may impact upon performance. Pike C. (2010), 'An Empirical Analysis of the Effects of GP Competition' Cooperation and Competition Panel, Working Paper Series – Volume 1 Number 2.

Figure A3.1 GP practices in relatively deprived and less deprived areas



Source: Monitor analysis based on Primary Care Webtool data (2014) and ONS data on income deprivation (2010).²⁰³ 'Less deprived' means income deprivation deciles between 1 and 5; 'more deprived' means between deciles 6 and 10.

As shown in the figure, 79% of practices in the 'review identified' group are located in relatively deprived areas (income deprivation deciles 6 to 10).²⁰⁴ The proportion of GP practices in the 'higher achieving' category located in relatively deprived areas is lower than in less deprived areas. Around 21% of 'review identified' practices are located in less deprived areas while the corresponding rate is 53% amongst 'higher achieving' practices.

While a significant majority of 'review identified' practices are located in more deprived areas, they account for only 21% of practices in those areas. Table A3.1 below shows the proportions of practices in different GPOS categories in more deprived and less deprived areas.

Table A3.1 Distribution of practices in more deprived and less deprived areas

Practice Achievement	Higher Achieving Practice	Achieving Practice	Practice Approaching Review	Practice with Review Identified	Number of total practices
Less Deprived, %	12	58	20	10	2870
More Deprived, %	6	43	30	21	4978

²⁰³ The graph combines data on deprivation indices (ONS, 2010, Available from: www.gov.uk/government/statistics/english-indices-of-deprivation-2010) with GPOS data extracted from the Primary Care Webtool in December 2014).

²⁰⁴ 1 means least deprived, 10 means most deprived.

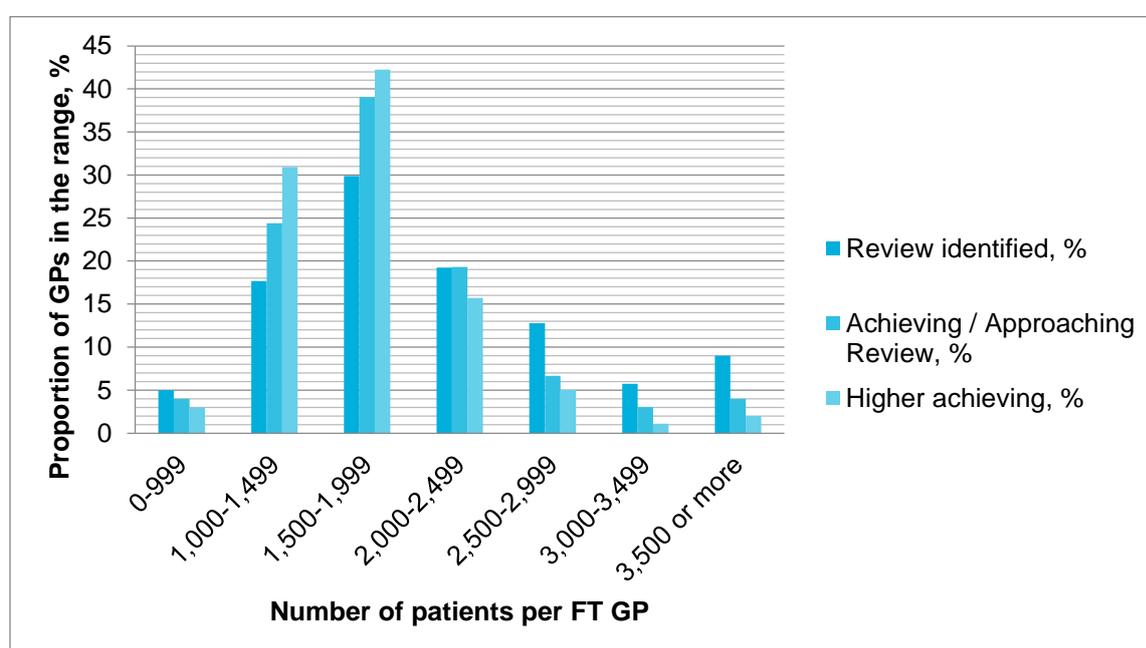
Source: Monitor analysis based on Primary Care Webtool data (2014) and ONS data on income deprivation (2010).²⁰⁵ 'Less deprived' means income deprivation deciles between 1 and 5; 'more deprived' means income deprivation deciles between 6 and 10.

Around half (49%) of the practices located in more deprived areas are either in the 'high achieving' or 'achieving' category, and 30% in the 'approaching review' group.

Ratio of patients to GPs and other clinical staff

The figures below show how GP practices in different GPOS groups compare in terms of how many patients they have per FTE GP (Figure A3.2) and FTE clinician (Figure A3.3).

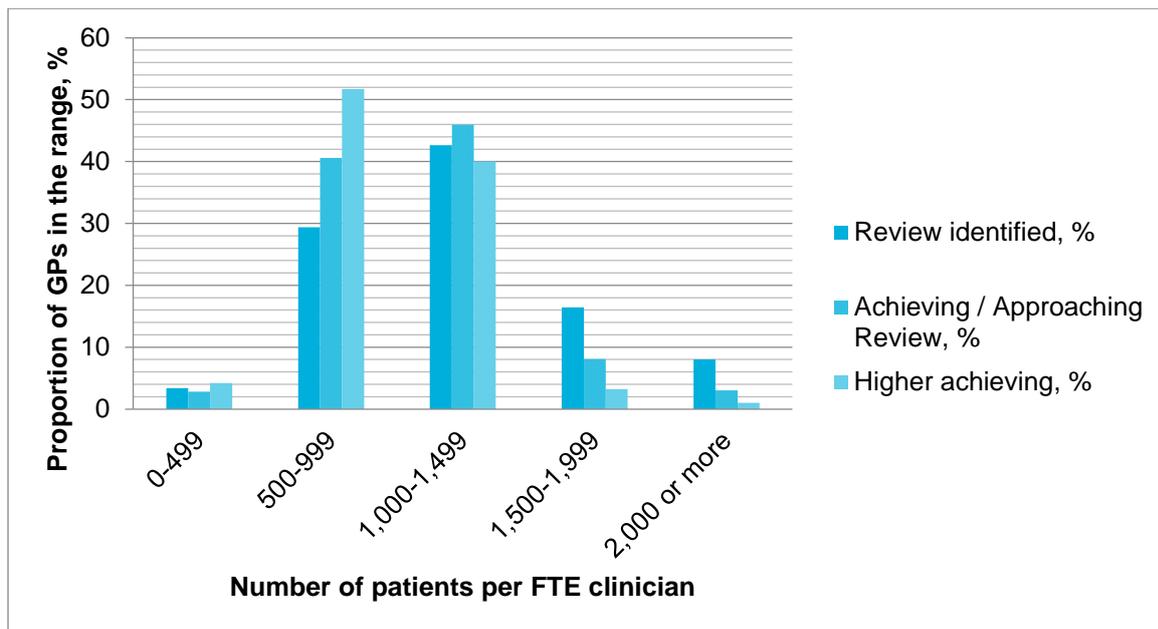
Figure A3.2 Number of registered patients per FTE GP



Source: Monitor analysis based on GPOS data (NHS England's Primary Care Webtool; extracted in December 2014) and HSCIC data (2015; www.hscic.gov.uk/catalogue/PUB16934, data for 2014) excluding GP locums, registrars and retainers.

²⁰⁵ The table combines data on deprivation indices (ONS, 2010, available at www.gov.uk/government/statistics/english-indices-of-deprivation-2010) with GPOS data extracted from the Primary Care Webtool in December 2014).

Figure A3.3 Number of registered patients per FTE clinician



Source: Monitor analysis based on GPOS data (NHS England's Primary Care Webtool; extracted in December 2014) and HSCIC data (2015; www.hscic.gov.uk/catalogue/PUB16934, data for 2014) excluding GP locums, registrars and retainers and including nurses and other clinical staff.

We found that the GP practices that score higher on GPOS indicators tend to have fewer registered patients per FTE GP (or FTE clinician) than those in the 'review identified' group.

Annex 4: Comparing patient experience with other outcome standards

Table A4.1 shows patients' experience of their GP practice compared to that practice's GPOS category. As a measure of patients' experience, we looked at how the average proportion of patients who considered their overall experience of a GP practice to be very good or fairly good, and separately patients who would recommend their GP practice.

Table A4.1 Patients' overall experience in different GPOS groups

Practice achievement based on GPOS (2014)	GPPS good overall experience (2014)				GPPS would recommend a practice (2014)			
	Average, %	Min, %	Max, %	Standard deviation, %	Average, %	Min, %	Max, %	Standard deviation, %
All practices	85	26	100	9	77	17	100	12
Higher Achieving Practice	91	74	100	5	86	53	100	7
Achieving Practice	88	58	100	6	82	43	100	9
Practice Approaching Review	83	52	100	9	74	37	100	12
Practice with Review Identified	77	26	100	11	66	17	98	13

Source: Monitor analysis based on NHS England's Primary Care Webtool (data extracted in December 2014) and Ipsos MORI (2015) GP Patient Survey. Note1: Patients were asked: 'Overall, how would you describe your experience of your GP surgery?'; and 'Would you recommend your GP surgery to someone who has just moved to your local area?'. Note 2: GPOS framework also includes indicators based on GPPS and hence the measures are related, albeit to a limited extent (given the large number of other indicators). Note 3: The proportions given in this table are statistically significantly different from each other at 99% confidence level.

The table shows that, on average, patients' overall experience corresponds broadly in line with the GPOS groups. On average, a relatively high proportion of patients describe their overall experience as good and say they would recommend their GP practice in 'achieving' and 'higher achieving' groups. In all GPOS groups, most patients said they had a good overall experience and would recommend their practice including in the 'review identified' category where practices score lower than their peers on many quality indicators.

As reported in section 2, patients' experiences and views about their GP practice are useful indicators of how well GP practices meet patients' needs. However, further evidence on performance is needed to obtain a full understanding of the quality of care provided by each practice.

Annex 5: Availability of alternative GP sites

Proximity of alternative GP practice sites

In Tables A5.1 and A5.2 we estimate what proportion of patients²⁰⁶ have alternative GP practice sites within one and two kilometres.²⁰⁷ We do not test whether patients are able to register with each of these alternatives, only that these alternatives exist and are located nearby (this is because centrally collated national data on GP practice boundary areas is not available).

Table A5.1 Estimated proportion of patients with a given number of GP sites within one kilometre

Number of GP practice sites within 1 km	Proportion of all patients, %	Proportion of patients in urban areas, %	Proportion of patients in rural areas, %
0	21	15	49
1	27	24	41
2	18	20	9
3	11	13	1
4	7	9	0
5	5	6	0
6 or more	11	13	0

Source: Monitor analysis based on HSCIC and NHS England's Primary Care Webtool (data extracted in December 2014), and from ONS (2011). Distances are reported as straight line distances. The proportions of patients are estimated using LSOAs areas. The population size of each LSOA is on average 1,500 residents although it varies between 1,000 and 3,000 residents. The analysis is done at site level (around 10,000 GP practice sites).

For example, the first column indicates that approximately 21% of patients do not have any GP practice site within one kilometre, while 27% have one GP practice site within one kilometre (and altogether 79% have at least one GP practice site within one kilometre).

²⁰⁶ We estimated this using LSOAs. A LSOA is a geographical area with an average of 1,500 residents and 650 households.
<http://neighbourhood.statistics.gov.uk/HTMLDocs/nessgeography/superoutputareasexplained/output-areas-explained.htm>

²⁰⁷ Santos et al. (2013) found that the average travel distance in East Midlands to a GP practice was 1.9 km. See Santos R., Gravelle H., Propper C. (2013). 'Does quality affect patients' choice of a doctor? Evidence from the UK', CHE Research Paper.

Table A5.2 Estimated proportion of patients with a given number of GP sites within two kilometres

Number of GP practice sites within 2 km	Proportion of all patients, %	Proportion of patients in urban areas, %	Proportion of patients in rural areas %
0	7	1	34
1	12	6	45
2	11	10	16
3	10	11	3
4	8	9	1
5	7	8	0
6 or more	46	55	0

Source: Monitor analysis based on HSCIC and NHS England's Primary Care Webtool (data extracted in December 2014), and from ONS (2011). The percentages may not add up to 100% due to rounding. Distances are reported as straight line distances. The proportions of patients are estimated using LSOAs areas. The population size of each LSOA is on average 1,500 residents although it varies between 1,000 and 3,000 residents. The analysis is done at site level (around 10,000 GP practice sites).

Together, the tables above show that 52% of patients have two or more GP practice sites within one kilometre and around 81% of patients have two or more GP practice sites within two kilometres. 10% of rural patients have at least two GP practice sites within one kilometre (61% for urban patients). Similarly, around 21% of rural patients have at least two alternative GP practice sites within two kilometres, while the corresponding rate is 93% for those in urban areas.

Proximity of alternative GP providers in different GPOS groups

Separately, we also looked at the extent to which patients registered with a 'review identified' practice may have a choice of practices that score higher on GPOS within relatively close distances (we recognise that GPOS may not fully capture the various dimensions of GP practices' performance and the analysis is therefore indicative). The analysis was not able to explore whether patients were able to register with each of these alternatives, only that these alternatives exist and are located nearby and had not closed their list (we describe potential constraints on patient choice in section 3 of the main report). Table A5.3 shows our estimates of the proportion of practices in the 'review identified' group that have at least one alternative provider within different distances that scores higher on GPOS.

Table A5.3 Estimated percentage of ‘review identified’ practices by quality and distance of the closest alternative provider

Distance	Higher Achieving Practice, %	Achieving Practice, %	Approaching Review Practice, %	Either Achieving or Higher Achieving, %
Within 0.5 km	3	27	34	28
Within 1 km	6	52	60	54
Within 2 km	19	84	86	85
Within 5 km	64	97	95	97
Beyond 5km	36	3	5	3

Source: Monitor analysis based on data from NHS England’s Primary Care Webtool (data extracted in December 2014) and ONS (2011). Note: Distances are reported as straight line distances. The practices that have closed lists are excluded. The last column measures the distance to the nearest practice that is either “Achieving” or “Higher Achieving”.

As the table shows, more than half (54%) of ‘review identified’ practices have at least one ‘achieving’ or ‘higher achieving’ practice within one kilometre distance; 85% of ‘review identified’ practices have at least one ‘achieving’ or ‘higher achieving’ within two kilometres.²⁰⁸

²⁰⁸ The review identified practices are often located in relatively deprived areas.

Annex 6: Payment per weighted patient in areas of different levels of income deprivation

In this annex we review the evidence on payments per weighted patient across areas of different levels of income deprivation. A weighted patient list is the number of patients registered on the list of a practice after adjustments have been made for factors that are likely to affect the cost of treating each of the patients on the list.²⁰⁹

Table A6.1 shows the average payment per weighted patient to GP practices located in areas with different levels of income deprivation.²¹⁰

Table A6.1 Average payments per weighted patient by income deprivation deciles²¹¹

Income deprivation decile (1 means least deprived, 10 most deprived)	Average pay per weighted patient (£, 2013/14)	Median pay per weighted patient (£, 2013/14)
1	144	133
2	153	136
3	148	132
4	147	131
5	144	131
6	139	128
7	135	127
8	130	125
9	129	123
10	131	123

Source: Monitor based on HSCIC (2015), 'NHS Payments to General Practice, England, 2013-14: Experimental Statistics', February (<http://www.hscic.gov.uk/catalogue/PUB16847>); ONS data on income deprivation (2010); available at: www.gov.uk/government/statistics/english-indices-of-deprivation-2010. Income decile 1 means least deprived; income decile 10 means most deprived. Note: Practices that were not in GPOS framework and those that closed in the financial year 2013/14 are not included. 124 outlier practices were dropped. We considered outlier practices are those that

²⁰⁹ Average payment per weighted patient is calculated by dividing the total payments a practice receives by the number of weighted patients. Weighted patients are calculated as a total number of registered patients multiplied by an index that accounts for factors such as age, sex, other needs of the population relating to morbidities, adjustment for list turnover, and adjustments for unavoidable costs such as Market Forces Factor and rurality. See: <http://systems.hscic.gov.uk/ssd/downloads/newgpcontractpay/ngms-contents/appaglobalsum>

²¹⁰ The average payments include capitated payments (eg Global sum payments), quality payments (ie Quality Outcomes Framework payments), payments for enhanced services, premises and dispensing, and other payments.

²¹¹ Practices that were not in GPOS framework and that closed at some point in 2014 are not included in the table.

receive less than £70 per weighted patient and those that receive more than £500 per weighted patient.

The table indicates that GP practices located in more economically deprived areas received on average slightly lower payments per weighted patient than GP practices in less economically deprived areas (the findings are consistent if we compare the median pay per weighted patient).²¹² This is because of variations across different types of payment categories. Practices in deprived areas tend to receive lower prescribing payments and slightly lower MPIG payments (there are small variations across other types of payment such as premises payments).²¹³

²¹² We also tested the statistical significance (at 99% confidence level) of the difference in the average between the practices located in areas which deprivation decile is 1-5 (least deprived) and practices located in areas which deprivation decile is 6-10 (most deprived). The difference between average pay in these two groups was £14 and this difference was statistically significant.

²¹³ We calculated the average and the median payments for different payment groups (MPIG payments, premises payments, seniority payments, QOF payments, payments for enhanced services and other payments) across different deprivation deciles. For the MPIG payments we only considered practices that hold GMS contract. We excluded practices that had less than 100 registered patients, closed at some point in 2013/2014, that were not in GPOS framework and that received negative payments for the category we considered. 124 outlier practices were dropped. We considered outlier practices are those that receive less than £70 per weighted patient and those that receive more than £500 per weighted patient Analysis based on HSCIC (2015), 'NHS Payments to General Practice, England, 2013-14: Experimental Statistics', February (<http://www.hscic.gov.uk/catalogue/PUB16847>); ONS data on income deprivation (2010); Available from: www.gov.uk/government/statistics/english-indices-of-deprivation-2010



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