CHAPTER 6: GENERAL MEDICAL PRACTITIONERS

Introduction

6.1 This chapter relates to information on general medical practitioners (GMPs) providing NHS primary care services and to salaried GMPs directly employed by NHS organisations in England.

6.2 Following the Government's announcement of a pay freeze for 2011-12 and 2012-13, DDRB will not be required to make recommendations for independent contractors in this period.

6.3 The material in this chapter is for information only and is intended to provide a background to ongoing developments in general practice for this period.

Background

6.4 Most doctors working in General Medical Services (GMS) are independent contractors: self-employed individuals or partnerships running their own practices as a small business. There were 8,324 GP practices in England in 2010, and of these around 58% of practices (52% of GMPs) operated under the national GMS contract.

6.5 Contractors with Personal Medical Services (PMS) arrangements operate within locally agreed contracts, and any uplifts in investment for PMS contracts are currently a matter for Primary Care Trusts to decide. DH remains committed to ensuring an equitable approach for PMS and other local primary medical care contracts.

Recruitment, retention and motivation of GMPs

6.6 As at September 2010, in headcount terms (as opposed to whole time equivalent figures), there were 35,120 GPs, an increase of 142 (0.4%) since 2009 and an estimated increase of 6,527 (22.8%) since 2000 (an annual average increase of 2.1%).

6.7 Of these, there were 27,036 GP providers, a slight decrease of 158 (0.6%) since 2009 and an estimated decrease of 755 (2.7%) since 2000 (an annual average decrease of 0.3%).

6.8 The number of ‘other’ GPs (typically salaried practitioners and locums) now stands at 8,319, an increase of 334 (4.2%) since 2009 and an estimated increase of 7,517 (937.3%) since 2000.

6.9 The average age of the workforce continues to grow, with 42.5% of practitioners in 2010 under the age of 45 compared with 49.1% in 2000 and 22.2% over the age of 55 compared with 17.5% in 2000.

6.10 The current estimated three-month vacancy rate for GMPs has fallen from 2.6% in 2005 to 0.5% in 2010.

6.11 There are now 3,995 GMP registrars, compared with 1,659 in 2000.

6.12 There were 5,800 applicants for 2,658 GP training places in 2010 with the application to post ratio for GPs remaining stable at 2:1.

6.13 The work life survey conducted by the National Primary Care Research & Development Centre in the autumn of 2010 on working conditions and job satisfaction of GPs remains the most up to date evidence in measuring GP satisfaction based on the 1,633 responses from 3,000 GMPs (in England). This showed:

- On a seven-point scale, overall job satisfaction had increased slightly, from 4.7 points in 2008 to 4.9 points in 2010.

- Average working hours were 41.4 hours per week and had remained unchanged from the previous 2009 survey. There were also significantly fewer GPs undertaking out-of-hours work in 2010, declining from 32% to 21%.

- The proportion of GPs expecting to quit direct patient care in the next five years fell from 7.1% to 6.4% amongst GPs under 50 years old and from 43.2% to 41.7% amongst GPs aged 50 and over.

6.14 The NHS Pension Scheme forms a significant part of the overall GP reward package. As set out in Chapter 9 of our original information document, uniquely amongst self-employed people, GMPs have access to a defined benefit pension scheme effectively guaranteed by the Exchequer. GMP earnings can fluctuate widely from year to year, according to the work that the individual practitioners carry out and how much is taken as net income. To take account of these fluctuations in earnings, GPs have a Career Average Pension arrangement in which their pensionable earnings are revalued by an annual uprating factor, in a process known as 'dynamisation'. Since April 2008, the NHS Pension Scheme has revalued GP earnings for pension purposes by the Retail Prices Index plus 1.5%. Further details on the scheme are set out in Chapter 9.

Workload of GMPs

6.15 The average number of patients per medical practitioner in England has fallen from 1,795 in 2000 to 1,567 (12.7%) in 2010 because of the number of GPs growing faster than the number of patients.

6.16 The number of patients per practice has risen from 5,726 in 2000 to 6,610 in 2010. The number of practices has decreased from 8,965 to 8,324 over the same period, reflecting a move towards larger practices employing more GPs. This trend is also evident in the decline of single-handed GPs from 2,662 in 2000 to 1,203 in 2010.

6.17 There remains a significant increase in numbers of practice staff between 2000 and 2010, with total practice staff numbers increasing by 17,385 (16.9%) and numbers of practice nurses increasing by 2,456 (22.9%).

GMP trainers' grant

6.18 Last year we explained that the view of the way the GP trainers' grant operates at local level is far removed from that which pertained when the GP trainers' grant was removed from the General Medical Services contract and GMS funding stream in April 2000. At that time, funding for the GP Trainers' Grant transferred to the medical and

dental education levy (MADEL) element of the Multi Professional Education and Training (MPET) budget.

6.19 In 2000 the GP Trainers' Grant would have been seen as part of an individual GP's remuneration package, in the same way that all the other elements of funding in the GMS Statement of Fees and Allowances (the red book) were based on fees and allowances payable in respect of individual GPs.

6.20 As growing numbers of GP training practices moved onto Personal Medical Services (PMS) contracts, and even more so, since the introduction of the new GMS Statement of Financial Entitlements contract from April 2004, the GP trainers' grant is no longer treated at local level as an individual GP's remuneration. Instead, it is generally treated as a GP practice income stream, the allocation of which is decided collectively by the GP practice.

Modernising Medical Careers GP specialty training programmes

6.21 Since MMC implementation in August 2007, virtually all General Practice Specialty Trainees enter three-year training programmes. This is a significant change from before, when less than half the doctors undertaking GP Registrar training had been on a three-year GP vocational training scheme.

6.22 The Department understands that in a significant number of SHAs/deaneries, the GP trainer is now responsible for overseeing a trainee's progress for the whole of the three-year Specialty Training in General Practice programme, and not just the period they are on placement in a GP practice. Many such trainees are now referred to as General Practice Specialty Trainees (GPSTs) throughout the whole of their training programme, and are only infrequently referred to as GP Registrars.

6.23 The Department is aware through information emerging as part of the MPET Review, and its associated review of primary care training funding, that a significant number of deaneries are already making payments from the MPET budget to GP practices, in addition to the GP Trainers' Grant. These payments reflect that GP trainers are operating as educational supervisors to GPSTs, when they are on their Hospital and Community Health Services (HCHS) placements, and not just when they are in GP practice placements.

6.24 It depends on the way the Specialty Training in General Practice programme is operated in any given SHA/deanery as to whether GP trainers are expected to take on the role of education supervisor to GPSTs when they are on their HCHS placements. Where it is happening, it is clear that SHAs/deaneries are supporting this as a part of the MPET funded educational budget provided to GP practices, and not as a specific element of an individual doctor's remuneration package.

White Paper – "Liberating the NHS: Developing the Healthcare Workforce"

6.25 The White Paper, 'Liberating the NHS: Developing the Healthcare Workforce' set out the Government's commitment to the principle of "tariffs for education and training as the foundation to a transparent funding regime that provides genuine incentives within the health sector and minimises transaction costs". There is widespread agreement among stakeholders that the existing MPET funding arrangements lack transparency and are not fit for purpose.

6.26 The Department continues to believe that the GP Trainers' Grant should fall within the ambit of this review. A work stream has been set up to look at the funding arrangements for education and training across all aspects of primary care. The Department continues to work with the SHAs, staff organisations and other partners to consider the implications of changes to current funding arrangements. If supported, the Department will begin the introduction of these tariffs from, April 2012 at the earliest, with appropriate transitional arrangements. We will provide details of the impact on the GP Trainers' Grant, once the future funding model is confirmed.

NHS commissioning reforms

6.27 Subject to the passage of the Health and Social Care Bill, clinical commissioning groups (CCGs) will be responsible from April 2013 for commissioning most healthcare services for local populations. Subject to the Bill, the BMA and NHS Employers have agreed that it will be a contractual duty for holders of primary medical services contracts (i.e. each GP practice) in England to be members of CCGs.

6.28 Clinical commissioning will enable GPs, working closely with patients and the public, with a range of other health and care professionals and with local authorities, to use their understanding of local health needs to ensure that the services commissioned for patients meet those needs and contribute to better health outcomes

6.29 CCGs will be statutory public bodies and will be accountable to the NHS Commissioning Board for how they use the resources allotted to them to commission high-quality services. CCGs will have a running costs allowance to meet the administration costs that they incur in commissioning services, for instance by employing staff or by buying in external commissioning support. With the exception of this running costs allowance, the annual budget allotted to CCGs will have to be spent wholly on healthcare services for patients. It will be distinct from the NHS income that GP practices receive under their primary medical services contracts.

6.30 Subject to the Bill, the NHS Commissioning Board will be able to give payments to CCGs to reward them for the quality of the services they commission and the contribution that these services make to improving health outcomes and reducing inequalities. Regulations made under the Bill will make provision for how CCGs can use any quality payment awarded to them, including how far they can use it to make payments to GP practices.

6.31 'Developing clinical commissioning groups: towards authorisation' sets out the proposed framework for authorisation of CCGs and is available on the DH website on the following page:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_130293

6.32 Subject to the Bill, the NHS Commissioning Board will from April 2013 take over the responsibilities of primary care trusts (PCTs) for commissioning primary care services, including primary medical care. The NHS Commissioning Board will then have responsibility for developing primary medical care contracts and for the negotiations with the General Practitioners Committee (GPC) of the BMA on improvements to the General Medical Services contract.

GP Pay

6.33 The changes to the GMS contract agreed with the GPC both for 2011-12 and for 2012-13 have been designed to deliver a freeze in GPs' net income, in line with Government policy on public sector pay, whilst delivering improvements in quality and efficiency.

6.34 In both years, the overall value of contract payments to GP contractors has been increased by 0.5 per cent to contribute to increases in expenses and to enable practices to give pay increases of £250 for employed staff earning the equivalent of a full-time salary of under £21,000 per year in line with the wider public sector pay policy.

6.35 In both years, this uplift is delivered through an increase in the value of QOF points (a 2.53 per cent increase in 2011-12 and a 2.49 per cent increase in 2012-13) with no increase in the value of 'global sum' payments or Directed Enhanced Service payments.

GMS contract 2011-12

6.36 The 2011-12 changes to the GMS contract included a number of improvements to quality and productivity, in particular:

QOF Indicators

- A total of 116.5 points have been released of which 96.5 are reinvested in new quality and productivity indicators (see below) and 20 reinvested in new and revised indicators recommended by NICE.

- QOF indicators worth 32 points are retired (identified by the National Institute for Health and Clinical Excellence (NICE) as fit for retirement), together with a further 26 points identified in discussions between GPC and NHS Employers negotiators (Records21, Information4, DEP1, DEP2, DEP3 and BP4). Twelve of these retired points are to be used to pay for the implementation of the new clinical indicators recommended by NICE (for epilepsy, learning disability and dementia). A further eight are used to support NICE's recommendations for changes to existing indicators.

Improving Quality and Productivity in the NHS

- The remaining 96.5 QOF points released as part of this agreement are used to pay for new Quality and Productivity indicators in QOF. The Quality and Productivity indicators now contribute to better care through the review of current practice by GPs (both within the practice and with external peers), prompted by the analysis of practice specific data that looks to understand the reasons for and if appropriate, address outlier performance by a practice in three areas:
    - Prescribing
    - First Outpatient Referrals
    - Emergency Admissions

- The Quality and Productivity indicators also support practices to deliver care in line with locally agreed pathways.

Full details of all 2011/12 contract changes are set out in the '2012/13 GMS Contract Negotiations' letter (Gateway reference 15500) available on the DH website

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125039.pdf

6.37 Taken together with the below-inflation increase for expenses, these changes delivered an estimated efficiency gain of around 4 per cent.

GMS contract 2012-13

6.38 The 2012-13 changes to the GMS contract announced on 2 November 2011 included further improvements to quality and productivity, in particular:

QOF Indicators: NICE recommendations

- Two indicators (CHD13 and AF4 – worth in total 17 points) are retired from the NICE menu of recommendations and a further 26 points will be released (from BP4, BP5, CKD2, DM2, DM22, Smoking 3 and Smoking 4).

- Seventeen of the NICE recommendations for new and replacement indicators are to be implemented covering 141 points. Included within these indicators are two new disease areas, osteoporosis and peripheral arterial disease.

QOF: Changes to Thresholds

- A number of threshold changes for 2012/13 will apply as follows:
    - Raise all lower thresholds for indicators currently 40-90% to 50-90%
    - Raise all lower thresholds for indicators currently with an upper threshold between 70-85% to 45%.
    - A number of upper threshold changes for indicators CHD6, CHD10, PP1, PP2, HF4, STROKE6, STROKE8, DM17, DM31 and COPD10
    - Lower and upper threshold changes for BP5, MH10 and DEM2

Quality and Productivity indicators

- The current QOF Quality and Productivity prescribing indicators will be replaced with new indicators which aim to reduce avoidable Accident and Emergency (A&E) attendances. The new A&E indicators will be worth 31points (28 points from QP prescribing and three points from other QOF changes), for one year (from 1 April 2012 until 31 March 2013). The Quality and Productivity indicators covering emergency admissions and outpatient referrals will continue for a further year until 31 March 2013.

Full details of all 2012/13 contract changes are set out in the '2012/13 GMS Contract Negotiations' letter (Gateway reference 16837) available on the DH website: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130951.pdf

6.39 In addition, some £1m will be invested into Global Sum payments as a result of the Osteoporosis Diagnosis and Prevention Scheme Directed Enhanced Service (DES) being discontinued in 2012-13. This, along with released correction factor payments through corresponding reductions in the Minimum Practice Income Guarantee (MPIG) - will be reinvested in the Global Sum, further uplifting Global Sum funding and reducing the number of practices on MPIG from 61.4% to 61.0%. Global Sum payments per weighted patient will increase from £64.59 to £64.67 in 2012-13.

6.40 Taken together with the below-inflation increase for expenses, these changes will deliver an estimated efficiency gain of around 3.5 per cent

Trends in the Earnings and Expenses of GMPs

6.41 In 2010-11, the NHS in England spent £8.3 billion on primary medical services compared to £5 billion in 2002-03, an increase of 44%.

6.42 The following points set out the trends in GP earnings and expenses in England since 2002-03:

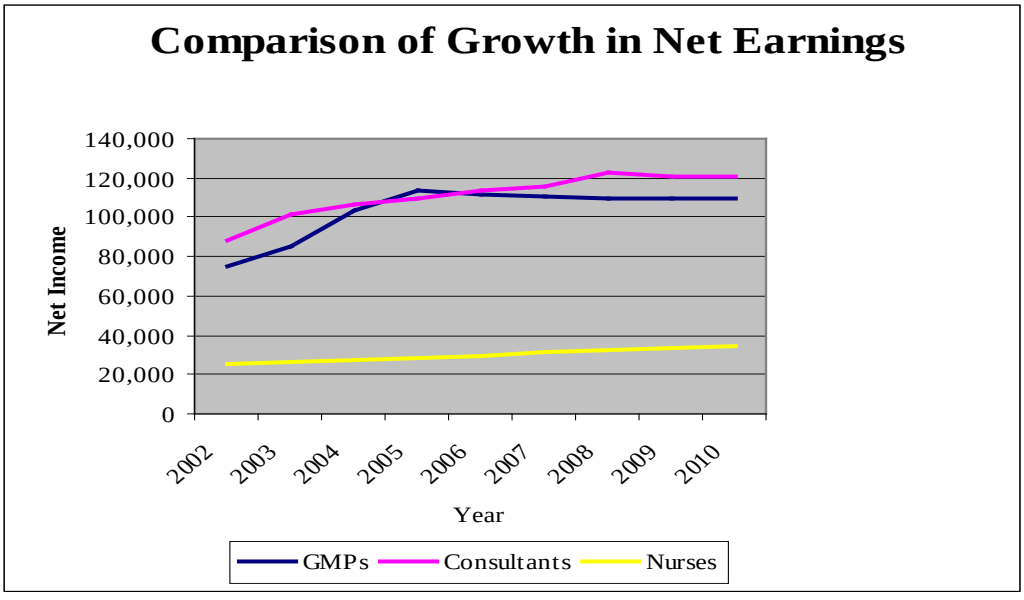
- GMP pay has increased in cash and real terms relative to other NHS staff groups. Figure 6.1 shows the comparison of pay growth between GMPs, nurses and consultants. On a cash basis, pay has increased by 46% over the period 2002-03 to 2009-10 (2009-10 being the latest year for which figures are available). This compares to an increase of 36.4% for consultants and 29.9% for nurses over the same period;

- in real terms pay has increased by more than 24% over the same period, compared to 16.1% for consultants and 10.5% for nurses;

- based on the Department's forecasts of GMPs', consultants' and nurses' earnings for 2009-10 and 2010-11, GMP real terms pay has increased by 22% for England over the period 2002-03 to 2010-11, compared to 19.7% for consultants and 10.7% for nurses;

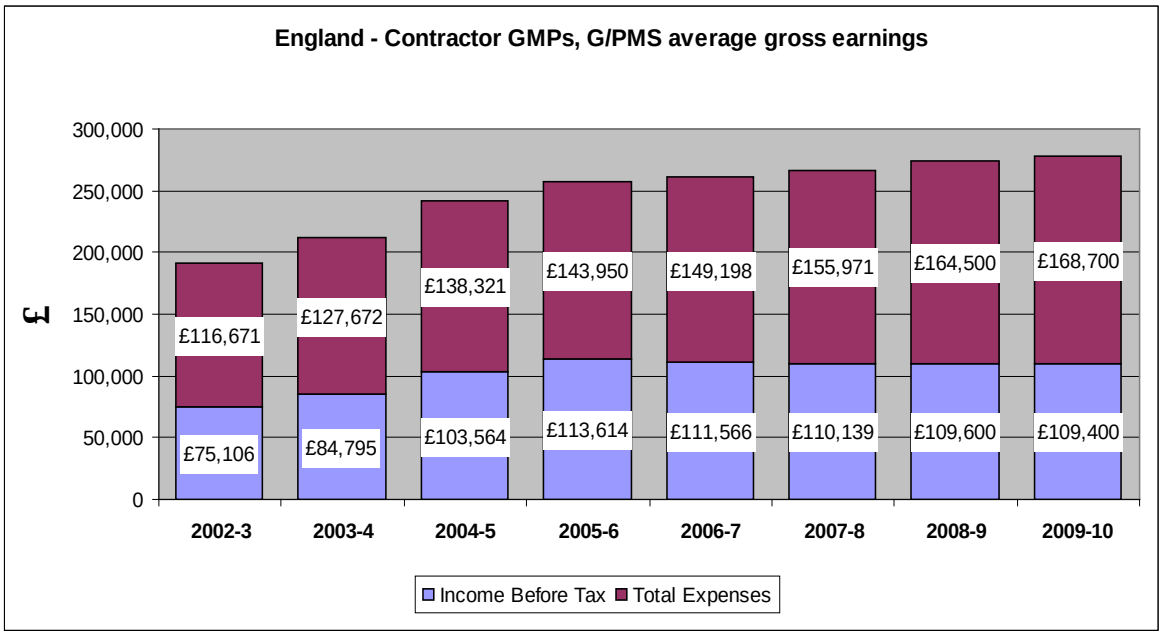
- increases in GMPs' pay were concentrated in the three years from 2003-04 to 2005-06 following introduction of a new GMS contract. Since 2005-06, there have been small year-on-year falls in net income.

Figure 6.1



6.43 Figure 6.2 below is based on data provided by Her Majesty's Revenue & Customs (HMRC) that shows increases in gross earnings and net income for the average GMP in England during the period 2002-03 to 2009-10 (the latest year for which data are available).

Figure 6.2



6.44 The figures in Table 6.3 below represent the position for the average GMP and show the distribution of net income received by groups of contractor GMPs on a UK basis (England figures are not available for this analysis).

Table 6.3

Numbers of UK GPMS GPs in different net income brackets (before tax)						
Financial Year	**Less than £50k**	**£50k - £100k**	**£100k - £150k**	**£150k - £200k**	**£200k - £250k**	**More than £250k**
2002/03	7,842	20,493	3,875	221	0	0
2003/04	5,138	19,883	6,469	904	222	0
2004/05	3,060	15,442	12,264	2,492	475	154
2005/06	2,001	12,342	14,534	3,876	816	307
2006/07	2,048	13,387	13,832	3,623	739	258
2007/08	2,320	13,610	13,220	3,560	650	260
2008/09	2,310	14,020	12,820	3,280	700	250
2009/10	2,280	13,410	13,180	3,280	680	210

6.45 There are likely to be several factors affecting the increasing number of GPs in the higher income brackets, including a growing number of GPs who hold more than one contract to provide medical services. Table 6.3 also shows significant movement in the numbers of GMPs in higher income brackets following the introduction of the new GMS contract, followed by some year-on-year reductions since 2005-06.

6.46 Table 6.4 below sets out actual GMP average net income for 2002-03 to 2009-10 and current Departmental estimates for GMP earnings in 2010-11 and 2011-12.

Table 6.4

England GPMS GMPs				
Year	**Average Net Earnings £**	**Year on Year Cash Change**	**Cumulative Cash Change**	**Cumulative Real Terms Change**
2002/03	75,106	-	-	-
2003/04	84,795	12.9%	12.9%	9.8%
2004/05	103,564	22.1%	37.9%	30.5%
2005/06	113,614	9.7%	51.3%	40.6%
2006/07	111,566	-1.8%	48.5%	33.6%
2007/08	110,139	-1.3%	46.6%	28.2%
2008/09	109,600	-0.5%	45.9%	24.1%
2009/10	109,400	-0.1%	45.7%	23.9%
Estimates:				
2010/11	109,400	0.0%	45.7%	21.9%
2011/12	109,947	0.5%	46.4%	19.0%

6.47 Table 6.5 below shows trends in the ratio of gross earnings to practice expenses. The expenses to earnings ratio has traditionally been around 60:40. In 2005-06, when average GP earnings peaked at £113,614, the ratio was 56:44. Since then, the ratio has gradually returned to its historic level.

Table 6.5

England GPMS GMPs			
Financial year	**Gross Earnings**	**Expenses**	**Expenses as a % of Earnings**
	£	**£**	**%**
2002/03	191,777	116,671	61%
2003/04	212,467	127,672	60%
2004/05	241,885	138,321	57%
2005/06	257,564	143,950	56%
2006/07	260,764	149,198	57%
2007/08	266,110	155,971	59%
2008/09	274,100	164,500	60%
2009/10	278,100	168,700	61%

Additional Earning Potential

6.48 Unlike many other staff groups, GMP contractors have scope to increase their net income from sources other than their main contract payments. These include:

- additional income from a variety of professional activities outside their NHS work. The latest GP earnings and expenses report by the NHS Information Centre states that it is not possible to provide an NHS/private split using HMRC earnings data. However, as a guide, NHS earnings for GPMS contractor GPs were 90.7% of total earnings, suggesting 9.3% was private income**.**

- additional investment in local enhanced services. Over the last two years, investment by PCTs in local enhanced services has grown by 14%, from £323 million in 2008-09 to £367 million in 2010-11.