Opposition policy costing – Bringing back the family doctor – Labour

Description of policy
Labour would 'bring back the family doctor'. 'Labour will bring back the family doctor by providing incentives for GP practices to improve their continuity of care offer for people who want and need this' (National Policy Forum, *Final Policy Documents*, 15 September 2023, p.71, archived). **Labour said they would 'bring back the family doctor'.** 'Bring back the family doctor: For those who would benefit from seeing the same clinician regularly (for example those living with chronic illness), Labour will improve continuity of care, which is associated with better health outcomes and fewer hospital admissions' (The Labour Party, *Build an NHS fit for the future*, 22 May 2023, archived).
Additional policy assumptions
• That this applies to every patient, based on current GP patient lists. • That this costings accounts for population growth over the next 5 years, as set out in ONS forecasts • That any GP workforce expansion (costs of training, pay, pension liabilities) required to deliver this is funded, and incorporated into this costing. • That other costs associated with expansion of the GP workforce – expansion of QOF, IIF to keep incentives at the same level per practice – are included. • That the cost of providing the required number of wider support staff, equipment and physical infrastructure to accommodate that workforce increase is incorporated too.
Additional technical modelling assumptions or judgements required
• That not all appointments will be with a patient's named GP (as that might not be practicable). Instead, an ambition will be set that a given percentage of appointments will be with the patient's named GP (if the patient should so wish). Some appointments will be excluded (e.g. same day appointments). • Patients' stated experience of being able to see their preferred GP is used as good proxy for their likelihood of seeing the individual who would be their named GP. • No assumptions have been made about potential additional, preventative benefits of better continuity of care.
Cost/Revenue to the Exchequer over five years

We estimate the cost of delivering the family doctor model in England only could be around £800m per annum ('central' estimate, with a potential range of £0 - £1.5bn, explained below). Barnett consequentials are shown in the table below.

The level and scope of the ambition to 'improve continuity of care' are not defined, therefore this estimate is highly uncertain and subject to caveats and assumptions, with limited available supporting evidence. Most notably, the costings assume that:

- Patients would see their named GP for 80% of their non-urgent appointments - including those without a preference for a particular GP.
- Urgent appointments – ie. same and next day appointments – are excluded for the calculation of the central estimate.
- GP practices could not readily re-allocate appointments, but instead would need to increase the overall supply of appointments and therefore their workforce capacity to be able to ensure patients are seen by their named GP.
- Over time, practices would be able to change their staffing structure to be able to re-allocate appointments towards named GPs, and this will reduce the costs of the policy.
- Waiting times would not be allowed to increase to ensure continuity.

Changes to these assumptions could considerably change the cost of implementation with likely costs ranging from:

- A lower bound of £0 per annum if practices were able to reallocate appointments across existing staff, waiting times were allowed to increase, or fewer patients were expected to see their named GP.
- An upper bound of £1.5bn per annum if next day appointments were considered in scope.

The modelling assumptions used are discussed in more detail below. There are also several policy decisions needed that would affect implementation, and therefore the cost of delivery. Examples of these policy decisions are also provided below.

All costs included in the central estimate require new funding, as they are for the additional activity that might result from the new requirement for practices to ensure patients are seen by a named GP rather than flexibly using available resources.

The costs are estimated using 2022/23 costs and volumes (given data availability) and would incur at the time of policy commencement. It is assumed that costs will stay flat over the 5 year period, as practices adapting their processes and workforce to be better able to re-allocate appointments towards a named GP would be likely to cancel out any inflationary pressures.

Table 1: Total cost by year, £bn

Year	2024-25	2025-26	2026-27	2027-28	2028-29
Resource (England only) Central estimate	0.8	0.8	0.8	0.8	0.8
Total Barnett	0.15	0.15	0.15	0.15	0.15
Total Cost	0.95	0.95	0.95	0.95	0.95

Impact of the named GP approach to continuity of care

Using the GP Patient Survey (GPPS) 2023 results[i], we estimate that **around half of all appointments** (**between 44% - 58%)** are not delivered by a patients' named GP.

The GPPS is a useful data source for this modelling, with around 760,000 patients completing and returning the questionnaire, resulting in a national response rate of 28.6%.

However, the impact of introducing a patient-list approach on these appointments is highly uncertain. This is partially due to data limitations: as there is no routine data on continuity of care, we had to estimate the potential scope for change using survey data.

Several key assumptions required to translate this evidence into cost estimates are set out in the sections below:

- Section a) the derivation of current levels of continuity from GPPS survey data
- Section d) assumptions underpinning our estimate of how much additional activity is required to improve levels of continuity and what the cost of that activity would be.

In addition, the impact will depend on policy design and implementation, notably:

- the level of ambition for continuity of care – i.e., what proportion of appointments will be expected to be with patients' named GPs. Different levels of ambition are modelled and explained in section b) below.
- the scope of the ambition – i.e., whether some appointments are excluded, e.g., urgent same day appointments. Different scenarios have been modelled and are explained in section c) below.
- the extent to which practices will be able to reallocate appointments between GPs. Depending on their staff and case-mix some practices will find it easier than others to increase continuity within their current appointment numbers. This is discussed in section e), but further complex modelling would be required to estimate practices' ability to reallocate appointments. Such modelling would need to take into account policy choices that have not been made at this point (discussed in section d), as well potential changes in practice organisation and patient behaviour over time (section f).

a) Modelling assumptions and limitations

Our estimates are based on:

- GP Patient Survey data on the proportion of patients by age/ sex/ Long Term Condition (LTC) status who say that they have a preferred GP and see them "always", "a lot of the time", "some of the time", "never" or have not tried. We had to make assumptions to translate these categories into proportions of appointments that are currently with the patients' preferred GP. The table below summarises the three, indicative scenarios we have modelled.

Note that, where a patient is currently not seeing their preferred GP, they may be seeing either a different GP or another healthcare professional.

	Proportion of appointments assumed to be with the patient's preferred GP by response to the question 8 in the GP Patient Survey ("How often do you see or speak to your preferred GP when you would like to?")				
Scenario	**Always or almost always**	**A lot of the time**	**Some of the time**	**Never or almost never**	**I have not tried**
Low	90%	66%	33%	0%	0%
Medium	95%	75%	40%	0%	0%
High	100%	80%	50%	10%	0%

- Internal modelling on the number of appointments per age/sex/ LTC cohort

We assume that:

- Patients who do not have a preference for a particular GP are as likely to experience continuity as those who do (potentially overstating the current level of continuity of care if those who do have a preference for one GP are more likely to be seen by the same GP).
- The likelihood of seeing one's preferred GP is a good proxy for the likelihood of seeing one's named GP under a patient-list approach to continuity.
- Within each age/sex/LTC cohort, continuity of care is the same patients regardless of whether they have few or many appointments.

b) Setting target levels for continuity of care and scope of the ambition

It is not realistic to assume that 100% of all appointments will be with patients' named GPs. There may be instances where patients have a genuine preference for seeing another GP or other clinician, situations in which it is unavoidable to see somebody else, e.g. if the patient's named GP is absent and situations where seeing another healthcare professional is the most appropriate choice for the type of appointment patients require. Even under the family doctor system, some of these appointments are likely to stay with GPs other than the 'preferred clinician', and other healthcare practitioners in the practice.

Similarly, it might not be realistic to extend the patient list-approach to all appointment types, e.g., when patients need to be seen urgently (on the same day). Therefore, we have assumed that an allowance is made for 20% of appointments to be with GPs other than patients' named GPs or other primary care professionals. In addition, as a lower bound, we have assumed that urgent same and next day appointments are excluded from the ambition, while the upper bound estimate would include next day, but not same day appointments.

c) **Findings: the scale of ambition**

Based on the above, we have estimated that between 12.6% and 24.1% of all appointments taking place in general practice would need to be reallocated to a different GP if a patient-list approach was introduced. Some of these will currently be with other GPs, or a different healthcare professional.

Proportion of all appointments that need to be reallocated when introducing a patient-list approach (scenarios)

	Scope of ambition	
Scenario	**Excluding Same and Next Day Appointment**	**Including Next Day, But Not Same Day Appointments**
High	17.7%	24.1%
Medium	15.6%	21.2%
Low	12.6%	17.1%

d) **Resulting costs**

The costs of reallocating between 12.6% - 24.1% of all appointments are highly uncertain and will depend on the conditions under which the policy is implemented. We estimated them to lie between £0bn - £1.5bn per annum (2022/23).

At the lower end, it is possible for the policy to cost £0 to implement if it was possible to reallocate workloads across the same numbers of GPs, in line with the growth committed to in the NHS Long-Term Workforce Plan. Similarly, the policy could be achieved at zero cost if waiting times were allowed to increase from current levels, i.e. patients would be guaranteed to see their named GP but might have to wait longer for their appointment.

On the other end of the scale, we can assume that it would be possible to re-allocate the required number of appointments by simply increasing the number of appointments available in line with the number of appointments to be re-allocated. The upper bound also assumes more GP capacity is needed, and that any appointments freed up by moving them to a named GP will still be utilised. As such, at the upper bound all existing staff remain in place.

The cost of doing so is highly uncertain: in 2022/23, GP practices were paid £6.02bn under the core contract for delivering essential services. If, to be able to re-allocate 12.6% - 24.1% of all appointments, capacity would need to increase in line with the number of appointments to be reallocated, this would amount to an increase in funding of £0.8bn - £1.5bn.

Given the full range of costs (£0 - £1.5bn), we consider £0.8bn a reasonable mid-point estimate.

This includes on-costs and overhead costs of running a practice, but excludes expenditure on upgrading premises, which might be necessary in some cases to accommodate more appointments.

(An alternative costing methodology based on the unit cost of GP appointments could result in much larger costs of £1.7bn - £3.3bn per year, but this would include costs that are unlikely to be relevant such as costs of premises, training of additional staff, and imply a fixed ratio of GP to other staff, even as more appointments are being allocated to GPs.)

Recognising the range of cost options available, several policy decisions would need to be made to determine where within this range delivery and implementation falls. Key considerations for Ministers would be:

- The level of ambition – i.e., the proportion of appointments that are expected to be with the 'family doctor'.

- The degree to which waiting times are allowed to increase to facilitate appointments with the family doctor.
- Whether the 'family doctor' is the default for all appointments or whether patients need to request an appointment with their 'family doctor' specifically.
- Whether certain types of appointments will be excluded – e.g. are certain check-ups still completed by nurses.

e) Limitations to the cost estimates

As noted, the above figures are highly uncertain. Much will depend on local circumstances and how practices would be able to implement the policy.

The above estimates may overestimate the true cost if:

- There is scope for efficiencies and flexibility within practices: re-allocating appointments, in itself, does not need to result in increased costs (or waiting times) if practices can simply re-assign appointments from one GP to another.
- Similarly, appointment slots freed up with practitioners other than the named GP might not be re-used. Instead, staffing numbers, e.g. of locum GPs, nurses and other staff, might fall.

The estimates may, however, also underestimate the true cost if:

- Demand for appointments has peaks and troughs - under a named GP approach, practices would be less able to spread appointments across multiple clinicians in periods of high demand. They will need to reduce the number of patients each GP has on their list to ensure GPs have enough spare capacity to deal with peaks in demand on their personal patient list.
- Part-time staff: the above problem is further aggravated for practices relying on multiple GPs providing limited hours each. While practices can currently make use of staff providing few hours, this won't be the case if appointments are meant to be with a named GP. At one extreme, GPs who provide too small a fraction of a FTE will not be able to meaningfully serve as the named GP for any patients.
- Variation across practices: the above figures are national averages. Some practices might find it easy to simply re-allocate appointments between their GPs – but other practices might find that they need to change the composition of their workforce to deliver the patient-list approach.
- Premises: some practices might not have any scope to increase the number of appointments offered overall, or even by individual GPs, due to the physical limitations of their premises, e.g. no spare consultation rooms. These practices might face much higher costs if they were to accommodate the additional appointment slots required.

Further complex modelling would be required in the longer-term to understand the extent to which a patient-list approach would affect individual practices and, therefore, the extent to which more capacity would be required to deliver it.

f) Evolution of costs over time

The above costs are based on the latest available data. We assume that the costs will stay broadly flat over time, as countervailing pressures and efficiencies cancel each other out.

Over time, costs might increase in line with overall expenditure on primary care, GP pay, number of appointments delivered and complexity of case-mix. Equally, however, given time, practices might find it easier to adjust their activity in such a way that it allows for increased continuity (e.g. by changing the number of GPs and hours worked by individual GPs) thereby moving closer to the zero-cost option set out above. Finally, patient preferences over seeing the same GP might change over time, especially as patients get more used to appointments with staff other than GPs.

Quality Outcomes Framework

The Quality and Outcomes Framework was established in 2004 and is a voluntary pay-for-performance scheme in Primary Medical Care for the NHS in England. In 2022/23, the Quality Outcomes Framework paid out £780 million, with each point having a value of £207.56. This represents 7% of the overall Primary Medical Care budget.

A policy decision could be made to reallocate a proportion of this funding, or include an additional funded indicator, to incentivise delivery of improved continuity of care. This is a scenario in which practices are incentivised to prioritise continuity of care by reallocating workload across the same number of GPs rather than funding for additional GP appointments. The financial cost of this would vary dependant on the relevant measure(s) and the number of points attributed to them. Points for current indicators that are comparable to a continuity of care indicator (i.e. quality improvement indicators) range from 10-20, and vary based on the time and resources taken to deliver the indicator as well as the potential impact of the intervention. The extent to which an indicator would improve continuity of care would likely depend on the value of the indicator, the target/s set, and the workforce arrangements of each practice.

GP Workforce Expansion

As set out in the above analysis, increasing continuity might require substantial increases in the number of appointments delivered by GPs. This could result in a need to recruit additional GPs, or improve retention of the existing GP workforce, over and beyond the ambitions set out in the Long-Term Workforce Plan, which plans to increase the number of GP training places by 50%, alongside other commitments to expand the primary care workforce. While achieving the commitments outlined in the Plan would go some way to improving practices' ability to deliver continuity of care, it is not possible to estimate the precise cost implications of this, as no estimate is made of the conversion rate of trainees to fully qualified GPs.

Another consideration is whether increasing GP pay would increase the pipeline of trainees choosing to specialise in general practice or improve staff retention. We do not have reliable analysis on what level of funding is likely to increase numbers entering general practice rather than other specialities, and the resulting impact that this may have on other parts of the health system. Similarly, there is not necessarily correlation between increasing workforce pay and improving staff retention. Other factors would also be a consideration here, such as: workload and staff morale.

Similarly, achieving continuity of care will require changes to the structure of the GP workforce in individual practices, e.g. ensuring that named GPs are available for a sufficient number or hours per week, and throughout the year. The impact of this on the supply of GPs willing to fill these roles, or any need to adjust GP pay to ensure sufficient supply, has not been modelled.

Comparison with current system (if applicable):
N/A
Other comments (including other Departments consulted):

This note sets out the costs of the delivery of the policy, it does not include estimates of any benefits or potential cost savings that may flow from it. This costing has been produced by DHSC. No other Departments have been consulted.	
To be completed by Permanent Secretary's Office Date costing signed off:	02/02/2024
[If applicable] Date revised costing signed off:	

[i] NHS England. *GP Patient Survey 2023*. Available from: https://www.england.nhs.uk/statistics/2023/07/13/gp-patient-survey-2023/