Developing General Practice today

Providing healthcare solutions for the future

BMA

Foreword

General practice has been the cornerstone of the NHS since it was formed over 65 years ago. The UK family doctor service is admired around the world – for its equitable, cost effective and leading edge provision of locally accessible, high quality care. Every year in England more than 300 million patient consultations take place in general practice[1]. GPs are generalists who are experts in providing holistic care. They are used to managing complex medical problems and dealing with uncertainty. For most patients, their GP is the first, and sometimes only, point of contact in the NHS.

General practice has never stood still. It has been constantly evolving. Today's GP practices are providers of an expanding and more specialist array of care once only done in hospitals. This means that more patients are able to be treated close to home at their local surgery. Many GPs are also clinical leaders in their communities, helping to shape and develop local services through local commissioning arrangements.

NHS general practice delivers outstanding value for money. The quality and standards of care provided by UK GPs are well recognised internationally, as well as by patients who consistently report high satisfaction levels with the services proved by general practice[2]. The success of NHS general practice has contributed to more of our patients living longer and being able to live with more complex long-term conditions.

In this paper, we bring together our case for general practice, the ways in which it can help provide solutions to some of the most difficult challenges the NHS faces, and how general practice needs to be supported and developed to achieve its full potential. Our vision is that with adequate support and development, general practice can be enabled to be at the forefront of the transformation that the NHS needs, and with a compelling economic argument that investment in general practice will be key to delivering the cost efficiencies required for a sustainable future NHS.

This document draws on existing policy as well as the experiences and views of the BMA General Practitioners Committee and our wider membership. We hope it will be useful for GPs, policy makers and other NHS stakeholders. We will explore the key ideas further in a series of discussion papers and events over the coming months.

We would welcome your views about the important issues we have raised; together we can make the greatness of general practice even greater.

Dr Chaand Nagpaul
Chairman, General Practitioners Committee

1 https://www.gov.uk/government/speeches/primary-care-and-the-modern-family-doctor
2 https://www.gov.uk/government/publications/results-of-gp-patient-survey

General Practice – Building on a Solid Foundation

In spite of the many challenges ahead, general practice remains one of the UK's most important and valued public services.[3] It manages a huge and increasing workload with more than 300 million people being seen and treated by GPs and practice nurses every year. UK general practice is recognised throughout the world as one of the most cost-effective, high quality means to deliver care.[4]

The model of general practice in the UK has remained remarkably stable since the inception of the NHS in 1948, despite the very many ways in which GPs have adapted to the huge changes that have happened to society and technology during that time.

GPs have successfully developed and changed but based on a solid foundation of core values: to consider patients as people, to help them manage their health through life and their interactions with the NHS and provide high-quality generalist medical care.

Although general practice always needs to evolve it has five clear strengths that underpin its success and which should be built upon for the future.

Continuity and co-ordination of care

Everyone living in the UK is encouraged to register with a local GP practice. GP practices have long term contracts to provide a broad range of primary care for patients living in their community who are on their registered list. As such, many individuals and families remain registered with and have continuity of care provided by the same GP practice over generations – and those individuals may often see the same GP over many years. GPs get to know children as they grow up and adults as they grow into old age. They not only know their patients' medical histories, but also their social context, personalities and preferences – and the greater the knowledge of the individual they have, the more tailored their advice and care can be. General practices are also a central part of the local community. In the UK, 99 per cent of the population is registered with a GP practice. In the United States, it is just 17 per cent. As part of the GP contract, general practices are also responsible for overseeing the long term care of their patients, co-coordinating care and acting as the lynchpin for patients with long term conditions or multiple health problems who may have to see multiple health and social care professionals.[5]

Patient advocacy

GPs are usually members of the communities they serve and are often the first and only port of call for patients seeking health and social care advice. They have a freedom and a responsibility to advocate for their patients across occupational, medical and social care sectors. GPs are an integral part of the NHS family, but the fact that practices operate as independent contractors enables GPs to advocate strongly on behalf of their individual patients as well as for the health needs of their local communities as a whole. It is why patients trust their GP so highly, because they know that they are on their side.

3 https://www.gov.uk/government/publications/results-of-gp-patient-survey
4 A survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs and Experiences. Schoen, Osborn,Doty,Squires,Peugh,Applebaum, The Commonwealth Fund 2009
5 Macinko J, Starfield B, Shi L. Is primary care effective? Quantifying the health benefits of primary care physician supply in the United States. International Journal of Health Services 2007

Flexibility and innovation

GPs as independent contractors also retain a degree of flexibility within the system that allows practices to implement imaginative solutions quickly to meet the needs of their patients. GPs have led generalist care advances in many areas including commissioning and delivering community services, innovating IT solutions and leading collaborative care for their patients.

Holistic and preventative care

As GPs are responsible for the ongoing care of all patients on their list, they deliver a whole person approach. GPs are expert generalists, taking into account their patients' physical, psychological and social needs, helping patients to reduce risk and manage uncertainty, and connecting patients with more specialist support when necessary. This model in particular optimises the management of long-term conditions and co-morbidities. GPs also successfully deliver national public health preventive programmes such as annual influenza immunisations, cervical cytology and child health surveillance. Everyone living in the UK is encouraged to register so that GPs have sight of whole populations, not just individuals who need active care.

Coordinating efficient use of NHS resources

GPs are generally the first point of contact for NHS patients. An individual usually needs to see his or her GP to secure a referral to specialist hospital care or community health services, if required. In this way, GPs ensure patients are referred to the most appropriate specialist care, making responsible use of NHS resources and having a crucial role in the sustainability of the future NHS. GPs play a vital role in helping patients understand their care options – whether self-care, low-level support or more specialist care – and so match the needs of patients to the most appropriate service. In making these decisions repeatedly every day, GPs are experts in managing risk and are skilled at identifying the serious and rare from the many more common clinical presentations that can be safely managed in primary care.

General Practice – challenges now and in the future

An immediate crisis – workload, morale and workforce pressures

More than ever before, general practice is under severe pressure. The latest national GP worklife survey funded by the Department of Health[6] revealed the lowest levels of job satisfaction amongst GPs since before the introduction of the new GP contract in 2004, the highest levels of stress since the start of the survey series in 1998, and a substantial increase over the last two years in the proportion of GPs intending to quit direct patient care within the next five years.

The single biggest issue is the increase in demand and workload without a comparable increase in resources. In England, over 300 million consultations took place in general practice in 2009, over 80 million more than in 1995.[7] The average member of the public now sees a GP almost six times every year – twice as much as a decade ago. The average time a GP spends with each patient is now just under 12 minutes compared with just over eight minutes in 1993, highlighting the increasing complexity of managing more long-term conditions that patients are living with.[8]

6 Seventh national GP worklife survey: http://www.population-health.manchester.ac.uk/healtheconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf
7 Health and Social Care Information Centre, Trends in consultation rates in general practice, 2 September 2009
8 Health and Social Care Information Centre, Trends in consultation rates in general practice, 2 September 2009

A rising workload without an expansion in the workforce to be able to respond appropriately impacts directly on access, quality and the ability to innovate. An analysis by the Centre for Workforce Intelligence[9] concluded that the increased demand for GP services points to a workforce under considerable strain and with insufficient capacity to meet expected patient needs. There is a clear need to substantially lift workforce numbers to more sustainable levels. However junior doctors are not choosing general practice as a career choice in anything like enough numbers to meet the expected workforce needs[10].

The Government's imposed changes to the GP contract in April 2013 have only added to workload and further undermined morale. The largest survey of GP opinion since changes to the contract were imposed, published by the BMA in September 2013, found that 97 per cent have seen bureaucracy and box ticking increase in the past year[11]. The use of targets within the GP contract has expanded to create clinically dubious, one-size-fits-all incentives and a huge volume of box-ticking, with nine out of 10 GPs stating this had taken them away from spending time on attending to patients needs, and 82% of GPs reporting that such target chasing had reduced routine available appointments to patients. It is not surprising therefore that 86% of GPs report their morale worse this year than last.

Austerity and efficiency savings

The economic crisis is putting all parts of the UK, both public and private sectors, under unprecedented financial pressure, and the NHS is no exception. Between now and 2020, it is estimated that the NHS in England alone must make efficiencies of £30 billion. However general practice has to face this future challenge following years of under-investment which has led to the current crisis we face.

Spending on GP services increased by 10.2% between 2006/07 and 2010/11 – compared to a 41.9% increase in spending on hospital services – but practice expenses have been rising faster. The proportion of NHS funding supporting general practice in England has fallen from 10.4% in 2005/6 to 7.47% in 2012/13.[13]

A growing and ageing population with more complex health needs

The UK population is increasing and at 63.7 million is at its highest ever. Not only does this mean that there are more people in absolute terms for general practice to care for this increase is likely to continue as last year, over 813,000 babies were born, which was the highest number for 40 years.

The UK is also growing older. Over the last 50 years, the average life span has increased by 10 years for a man and eight years for a woman. Older people are more likely to live with a health condition and often more than one. By 2021, more than one million people are predicted to be living with dementia and by 2030 three million people will be living with or beyond cancer. By 2035 there are expected to be an additional 550,000 cases of diabetes and 400,000 additional cases of heart disease in England. The number of people with multiple long-term conditions is set to grow from 1.9 to 2.9 million from 2008 to 2018.

As the number of people with long-term conditions increases, so too will demand on GPs: although patients with long-term conditions account for around 29% of the population, they make up 50% of all GP appointments.

9 http://www.cfwi.org.uk/publications/how-could-the-community-workforce-alleviate-some-of-the-pressure-on-general-practitioners-and-improve-joint-working-across-primary-and-community-care
10 http://www.bma.org.uk/cohortstudy
11 http://bma.org.uk/working-for-change/negotiating-for-the-profession/general-practitioners-committee/gp-work-load-survey-chaand-letter
12 Source: HM Treasury Public Expenditure Statistical Analysis 2013, 2012, 2011, 2010: total DEL (resource + capital)

Changing patterns of care – moving care closer to home

Changing population demographics mean that current models of healthcare are rapidly becoming outdated. Health reform is focused on moving care closer to home, delivering more services in community settings and encouraging closer collaboration between providers. The movement of care "out of hospital" is a policy driver in all devolved nations in the UK, augmented by an economic argument of reducing the greater expense of hospitalisation.

This shift of care from secondary to primary and community settings must logically be accompanied by a commensurate investment in General Practice. Yet, as highlighted earlier, the reality has been a reduction in the proportion of overall NHS funding spent on general practice. This trend is unsustainable and is at the root of the current workload and workforce pressures experienced by GPs and their staff.

In many areas, commissioners are undertaking wide ranging reviews of current acute providers with a view to reconfiguring services; a particularly challenging task in the context of enormous financial pressures on health service budgets and the requirement for commissioners to find year on year efficiency savings.

Unless there is increased capacity in general practice, primary care and community settings to absorb this transfer of care out of hospitals, the quality of care for patients will suffer, and with adverse effects.

Health system reform

The Health and Social Care Act (2012) radically reformed health structures in England. The new commissioning structures pose challenges to general practices both as providers and to GPs in their new role as commissioners. The reforms were extensive and the transition timescales far too hurried. Area Teams have far fewer staff and resources than their predecessor PCTs. As a result, the support practices may need to help with development is often absent. With many more organisations to work with practices are struggling to build productive relationships in a more complex and at times fragmented new system.

Practices are also the constituent members of CCGs, which have responsibility for commissioning secondary care services. This new role in commissioning places extra demands on already work saturated general practices and many are struggling to find the time to get involved with their CCG.[13]

The Act also promotes competition and plurality of provision as a lever to improve quality of services. The evidence for the effectiveness of competition in health is limited, yet in the meantime, commissioners are now required to move services out to competitive tender. General practices find themselves in competition with large scale, corporate entities and many lack the commercial expertise to bid in complex and costly procurement processes. These procurement and tendering processes risk destabilising existing services by salami slicing elements of care currently delivered by local practices, so reducing the comprehensive, cost effective, high quality care a single practice can provide to a population.

The huge upheaval of constant NHS reform and regulatory change has left GPs and practices anxious and uncertain about the future. Time is needed for the new structures and procedures to bed in without more top down management and imposition, or there is a risk of stifling innovation and further demoralizing the profession, both of which will have a negative effect on patient care.

13 BMA GPC Survey of GP Workload September 2013, available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/general-practitioners-committee/gp-work-load-survey

Changing patient and public expectations

Public satisfaction with the NHS and with general practice, in particular, remains very high. However, there is much variation in what patients want in terms of access, for example in terms of the trade-off between immediate access and the desire to see a named GP, as well as that between austerity in the NHS and affordability for extended access and services.

Patients and public also want more information about health and about their care. Many wish more involvement and engagement, from determining individual care plans through to shaping local services. The report of the Francis Inquiry stressed the importance of public and patient engagement and highlighted what can go wrong when this is not achieved.

General Practice – providing solutions for the future

We believe that a properly developed and supported general practice will be fundamental to providing real solutions to the significant challenges facing the NHS. In particular the cost effectiveness of general practice and its ability in turn to release cost efficiencies in the whole system will be key to enabling the NHS to be sustainable within an increasingly challenging financial environment.

Four important areas include:

1. More integrated care, closer to home, delivered by a team built around the GP practice

GPs as expert generalists build longstanding relationships with their patients and local communities. They are key to developing services that support the growing number of patients with multiple, complex, long-term health problems and helping them manage their conditions at home and in the community with support from the right specialists at the right times.

To develop this further there is a need to:

a) Expand the infrastructure of general practice and primary care within an integrated approach

Enablers to achieve this include:

- Increasing the numbers of GPs, practice and community nurses, to provide an accessible, high quality, comprehensive service across all communities.
- Community health care teams built around GP practices. Collaborative working across localities with practices either singly or collectively employing or directly managing community nurses who, working together with practice nurses, will provide a seamless and more flexible nursing service for patients in the community.
- Secondary care clinicians and GPs working collaboratively to design and provide care pathways for local health economies, bringing more diagnostics and specialist care out of hospital and into community settings, including hospital-based specialists visiting nursing and residential homes and working alongside GPs in practices when appropriate.
- Patients with long-term and complex needs should be jointly managed through an integrated team in line with a single care plan led by the most appropriate named clinician. This would require a much greater alignment of incentives and funding streams between general practices and hospital and community service providers.
- Specialists given the opportunity to collaborate with and to support primary care, such as in general medicine, elderly care, mental health and paediatrics, acting as a specialist resource across localities to optimise patients' complex health needs and help to prevent unnecessary hospital attendances and admissions.
- A shift to community based care with more doctors and nurses in the NHS working in general practices and community settings or having had experience of working in such settings.
- Joint training and education for GPs and secondary care clinicians.
- Greater collaboration between community pharmacists and practices with a practice-aligned pharmacist undertaking medicines management and other elements of chronic disease management.
- Greater collaboration between practices and social care services, with named social workers or team leaders aligned to every practice and regularly attending multidisciplinary meetings.
- Citizens Advice Bureau and other advice and social support services to be sited in or linked to specific practices to ensure a comprehensive service is available across a community.
- Expand and develop practice premises to allow for delivering increased care in the community, including space for teaching, training and research.

b) Enhance proactive and personalised care for vulnerable patients and those with complex or multiple long-term conditions.

Enablers to achieve this include:

- Proactive case management with GPs leading the coordination of care, within a multidisciplinary and multiagency approach. Whilst GPs should lead this process, day-to-day coordination and delivery of care would often be by other members of the extended practice-based team.

- Longer consultation times so GPs can fully meet the needs of their patients who are living with many and increasingly complex long-term conditions, so providing increased personalised care for each and every patient who needs it.

- Empowering patients and their carers to develop their knowledge, skills and confidence to become active partners in their health care.

- Using one clinical electronic record by all members of the extended practice team.

- Sharing electronic care records (with requisite consent and information governance standards) with other providers of care to optimise personalised care in the community

c) Reduce the need for hospital admission and attendance

Enablers to achieve this include:

- CCGs commissioning with the intention of achieving a "whole system" approach with aligned incentives between different providers, reforming the current divisive tariff payment system and removing counter-productive targets such as crude A&E waiting times.

- A more effective, responsive integrated urgent care system (see below) that avoids the need for patients to be admitted to hospital.

- Practices providing timely access e.g. via a dedicated telephone number or line to enable services managing patients in emergency situations to be able to promptly seek advice that may avoid a transfer to hospital

- For those patients who would benefit, having one single, simple, short and clear care plan so that all those who might provide care in emergency situations are aware of the patient's condition, needs and wishes

- Expand the availability of short-term nursing or residential home beds that can be immediately available for patients who would otherwise require admission to hospital

2. Improving urgent and out of hours care services

Urgent care day and night on every day of the year is provided by GPs, either through their practices or via GP out-of-hours (OOH) organisations covering their practice area. Just as practices have been coping with an increased workload with reduced resources, similarly GP OOH organisations have had similar pressures. Improvements can be made so optimising access to appropriate urgent care in and out-of-hours and enhancing self-management.

Enablers to achieve this include:

- Clinical commissioning groups commissioning integrated models of out-of-hours care, bringing together community nursing, social care, walk-in-centres, pharmacy, OOH

general practice organisations, NHS 111 services, minor injury units, ambulance services and hospital emergency services so providing a joined up and consistent approach to urgent care.

- High quality first point of contact urgent care telephone triage, led by clinicians rather than relying solely on computer algorithms allowing a presenting problem to be managed in the most efficient and cost effective way.

- Removing the compulsion for competitive tendering from the provision of urgent and unscheduled care, thus enabling commissioners to select the best option in the interest of patient safety and the efficient use of NHS resource.

- Awarding contracts based on a provider's existing experience and expertise in successfully delivering safe, high quality OOH care.

- Lift A&E minor attendances out of PbR and tariff arrangements and give CCGs the responsiblility and the budget for commissioning an integrated community and hospital service for unscheduled care.

- Ensuring consistent health and wellbeing messages to patients through better co-ordination of information materials provided by different parts of the NHS to ensure appropriate use of urgent care services.

- Setting a minimum clinical staff/population ratio for OOH organisations.

- Enabling patients to access to their Summary Care Record and providing better access of clinical information for OOH providers to improve standards and continuity of care.

- Improving the quality of clinical information and reducing the length of primary post event messages passed on to general practice providers by NHS 111 and after each and every attendance at A&E.

- GP practices to be more closely involved in monitoring the quality of care provided by OOH providers and CCGs to act on the concerns raised by practices

3. Improved accessibility and local accountability

Workload and workforce pressures have made it more difficult to maintain the levels of accessibility and quality of care GPs want to be able to deliver and know their patients need.

Enablers to achieve this include:

- GPs working in larger practices and/or across groups of practices in collaborative alliances or federations. Practices should be supported to maintain their unique identity and relationship with their patients whilst working together with others to share "back office" functions, organisational learning and standards as appropriate.

- Collaborating with other practices to provide extended hours surgeries at a range of

different times across a community.

- Offering more alternatives to a face-to-face consultation when clinically appropriate, such as dedicated telephone and/or Skype-like surgeries

- Clinicians meeting in larger groups for peer-group learning, sharing ideas and reviewing the clinical care offered to patients in their community to improve performance and consistency.

- GP practices providing more meaningful information about their services and the quality of care they provide, than is currently provided on the NHS Choices website, taking in to account the context of the community they serve.

- Encouraging GPs to build on their role as patient advocates by challenging and reporting on poor care provided by local health or social care providers.

4. Empowering patients as partners

Too often in recent years policies have been introduced that have disempowered patients rather than empowering them. Patients have a key role to play as partners in both supporting the development of general practice and in ensuring the sustainability of the NHS as a whole

Enablers to achieve this include:

- Strengthening patients' input to the organisation and delivery of their general practice services though the development of practice-based patient participation groups.

- Increasing the local patient voice within clinical commissioning group decision making.

- Investing in public education campaigns and better health education, particularly as part of the school curriculum

- Empowering patients to self-care where appropriate, avoiding the inconvenience of unnecessarily accessing healthcare services. This could be via consistent information that is easily available through, for example electronic kiosks in public places, including in health care settings, and via accredited websites.

- Greater involvement of patients as partners, providing longer consultation times where appropriate, in order to share in decisions and management of their care including the co-creation of care plans when appropriate.

General Practice – Turning Solutions into Reality

Government, policy makers and commissioners must now commit to long-term investment in general practice if it is to be in a position to deliver these much needed solutions. This investment will enable the essential building blocks to be put in place that will underpin the successful delivery of change and development in general practice and for the NHS as a whole.

General practice can be supported and enabled by:

1. Sustained and increased funding

Unfortunately, general practice has seen a progressive reduction in its proportion of NHS spend in recent years. We propose that Government sets a target for NHS England to invest in a year on year increase in the proportion of funding in to general practice.

The table below shows the year on year decrease in the proportion of NHS funding invested in general practice in England.

Year	% total investment	% investment excluding dispensed drugs
2004/5	10.00%	N/A
2005/6	10.41%	N/A
2006/7	9.83%	N/A
2007/8	9.17%	N/A
2008/9	8.74%	8.04%
2009/10	8.45%	7.81%
2010/11	8.31%	7.68%
2011/12	8.16%	7.56%
2012/13	8.04%	7.47%

Patient care should be built around their needs for integrated pathways that break down the current barriers between acute care, general practice and community services. Where this involves service reconfiguration then the accepted good principles governing reconfiguration must always apply, principally the need to be based on evidence and supported by a clinical consensus.

2. Expand recruitment and better retention

A greater public commitment towards general practice from the Government downwards, alongside promoting it as a rewarding career choice and dealing with issues that undermine the morale of the existing workforce, would go some way to addressing the impending GP recruitment and retention crisis.

Enablers to achieve this include:

- Expansion of the general practice workforce through increased long-term core funding.
- Greater contract stability to enable practices to invest in an expanded workforce
- Creating long-term incentives to expand partnerships.
- Investing in initiatives to support GP returners back to work.
- Removing barriers and providing support for fully qualified GPs who wish to return to working in the UK.
- Funding innovative schemes such as the Flexible Career Scheme to encourage practices to expand substantive GP posts.
- Providing long-term support for practices in under doctored areas to take on additional staff, so working to reduce health inequalities.
- Providing an NHS occupational health service to support all practice staff.
- Ensuring GP involvement in management and leadership roles is fully resourced to enable full clinical back-fill arrangements in practices.
- Supporting career development with a clearly defined post-graduate training allowance.
- Lengthening GP training to a fully-funded five years with a much greater proportion of time training based in general practice.
- Recognising general practice as a specialty in European law to enhance its credibility as a specialty and to ensure that training meets required standards.
- Enhancing the GP trainer grant and providing a supplement to encourage more trainers in under-doctored areas.
- Supporting GPs to enhance their skills or develop additional special clinical interests.
- Providing a training grant to support practice nurse training.
- Developing a practice nurse training curriculum to promote general practice nursing as an attractive career choice.
- Providing protected learning time for peer review and joint learning.

- Supporting practice manager development and training.
- Greater practice management and financial training as a core component in GP training, to help produce enough GPs with the skills necessary to take on the role of being a GP partner.

3. Premises fit for the future

Investment must be made in better community-based premises if we are to deliver the necessary changes described above. Many premises are sub-standard and not fit for purpose, making the possibility of providing more services in the community extremely difficult.

Enablers to achieve this include:

- A 10 year rolling programme to ensure all practices that require it have a purpose-built surgery, working with NHS bodies, Local Authorities and third-party developers where necessary.
- Creating a general practice premises development fund to support new developments such as primary care hubs providing expanded diagnostics and services in the community for networks of practices, and the expansion of existing premises.
- Practices working together in collaborative alliances, federations or larger practices to make the best use of their available premises to enable a wider range of high quality out-of-hospital services to be located in a complimentary way within a defined community, whilst also ensuring patients retain local access close to their homes.
- Guaranteeing the reimbursement of premises running costs, as specified under the Premises Costs Directions 2013, to give GPs the confidence to move to new developments or significantly refurbish existing premises.

General Practice – Providing healthcare solutions for the future

The increasing financial problems facing the NHS means the pressure to make radical changes in order to deliver effective quality care in the future can no longer be delayed. The crisis of capacity versus demand is not new and neither can it be solved quickly or easily. Investment in workforce and premises will take time to deliver. However a commitment to developing general practice must be made **now** so that these longer term issues can start to be addressed.

General practice should be supported and enabled to evolve in order to meet our patients' needs and that of the NHS. It does not need a central one-size-fits-all destabilising approach nor being forced into change for the sake of changes sake. Instead we must see a new strategic focus towards supporting general practice, encouraging and allowing it to develop based around the needs of their patients and communities.

General practice has always been a sure foundation on which the NHS has been built. With more GPs, spending more time with their patients, working in bigger and more comprehensive teams built around the practice, based in better quality premises and underpinned by a fairer share of NHS resources, general practice can deliver the healthcare solutions for the future. Now more than ever, general practice is offering solutions which will enable the whole NHS to remain sustainable and successful.

Appendix

A few facts about general practice

There are almost 43,000 GPs in the UK – 35,415 in England, 4,287 in Scotland, 2,022 in Wales, and 1,163 in Northern Ireland.[1]

They work mainly from over 10,000 GP practices – 8,316 in England, 1,002 in Scotland, 483 in Wales and 353 in Northern Ireland.[2]

In England, over 300 million consultations take place in general practice every year – almost ten every second – and over 80 million more each year than took place in 1995.[3]

The average time a GP spends with each patient is almost 12 minutes – up from just over eight minutes twenty years ago.[4]

Each GP practice takes between 30 and 50 calls from patients every day.[5]

The average member of the public sees a GP almost six times every year. – twice as much as a decade ago. On average an older person sees their GP over once every month.[6]

Almost 87% of patients rate their experience of GP services as good or very good.[7]

In England in 2012-13, expenditure on GP services accounted for £7.8 billion. Expenditure on secondary care – largely hospitals – was over £70 billion.[8]

Spending on GP services increased by 10.2% between 2006-07 and 2010-11 – compared to a 41.9% increase in spending on hospital services.[9]

19 out of every 20 consultations taking place in general practice are dealt within primary care alone – rather than in hospital or elsewhere in the NHS.[10]

Studies from the US suggest that an increase of just one GP per 10,000 population is associated with a reduction in deaths rates of over 5 per cent.[11]

1 Health and Social Care Information Centre, General practice trends in the UK, 23 January 2013

2 Health and Social Care Information Centre, General practice trends in the UK, 23 January 2013

3 Health and Social Care Information Centre, Trends in consultation rates in general practice, 2 September 2009

4 Health and Social Care Information Centre, Trends in consultation rates in general practice, 2 September 2009

5 Royal College of General Practitioners, The 2022 GP, Compendium of evidence, 17 September 2012

6 Royal College of General Practitioners, The 2022 GP, Compendium of evidence, 17 September 2012

7 Department of Health, Annual report and accounts 2012-13, 15 August 2013

8 Department of Health, Annual report and accounts 2012-13, 15 August 2013

9 Deloitte, Primary care: today and tomorrow – improving general practice by working differently, 2012

10 The King's Fund, Improving the quality of care in general practice: report of an independent inquiry commissioned by The King's Fund, 2011.

11 Macinko J, Starfield B, Shi L. Is primary care effective? Quantifying the health benefits of primary care physician supply in the United States. International Journal of Health Services 2007

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