Indicator 8.1 - Primary care professionals

Rationale

The number of primary care professionals (PCPs) per 100,000 population is a measure of the relative access to primary care across the country. Although it does not measure quality of care, it does indicate areas where access to health care may be a problem. The population is weighted for need to allow direct comparison between areas and allow for differences in need between areas. This indicator enables us to track change in the number of primary care professionals according to need. This indicator is a national headline inequalities indicator.

In March 2008 the National GP Access Programme was established in response to recommendations in the report Primary Care Access and Responsiveness, with the aim of supporting the NHS in driving continuous improvements in the accessibility and responsiveness of GP services.\(^1\)

As set out in World class commissioning for GP services\(^2\), improving access to GP services can also help improve the quality of care, by:

- improving the patient experience
- reducing health inequalities. International studies have shown that increasing access to primary care professionals is one of the most effective ways to improve the health of that population, for example by improving smoking cessation and screening rates, and by improving quality for specific vulnerable groups
- providing a starting point for practices and commissioning organisations to undertake far-reaching improvements to other aspects of care quality
- making practices better places of work for staff
- reducing inappropriate (and often more expensive) time spent in secondary care, for example the circa 50% of minor attendances in accident & emergency that could be dealt with in primary care.

Further, the PSA Delivery Agreement 18, and more broadly the Department of Health’s (DH) ‘Better Health and Well-being for all’ strategic objective sits alongside the DH’s other two strategic objectives of better care for all and better value for all. This reflects the ambitions set out in ‘Our health, our care, our say’\(^3\) to create a health and adult social care service that genuinely focuses on prevention and promotion of health and well-being informed by what people have said they want.
**Existing indicator sets**

This indicator is a national headline inequalities indicator.

**Definition**

For years 2003-2006, the indicator is for the number of full-time equivalent (FTE) primary care professionals per 100,000 population (weighted for age and need).

For years 2007-, the indicator is for the number of full-time equivalent (FTE) primary care professionals per 100,000 population.

**Numerator definition**

Primary care professionals include GPs, primary care nurses and other healthcare professionals. A clear and robust definition of ‘primary care professional’ is currently being developed. The current data for this indicator includes information on GPs only, however, we will be looking to expand this indicator to include other primary care professionals in the future once a clear, measurable definition has been developed.

The term GP includes Unrestricted Principals and Equivalents (that is, General Medical Services (GMS) Unrestricted Principals, Personal Medical Services (PMS) contracted and PMS salaried GPs); Restricted Principals; Assistants; GP Registrars; other PMS GPs; salaried doctors and GP Retainers.

However, GPs included in this indicator are ‘NHS Plan’ GPs only. NHS Plan GPs include GMS Unrestricted Principals, PMS Contracted GPs, PMS Salaried GPs, Restricted Principals, Assistants, Salaried Doctors and PMS Others (i.e. it excludes retainers and registrars).

Full Time Equivalent (FTE) data up to and including 2005 were estimated using the results from the 1992-93 GMP Workload Survey. For 2003, FTE weightings were; contracted GPs: full time = 1.0 FTE, three quarter time = 0.69 FTE, job share = 0.65, half time = 0.60 FTE. Other GP types: full time = 1.0 FTE and part time = 0.6 FTE. For example if a PCT has one full time GP and one three quarter time GP that equals a total of 1.69 FTE. For 2004-2005, FTE weightings were; all GPs: full time = 1.0 FTE, part time = 0.6 FTE. In 2006, FTE data were collected based on the number of sessions or hours each GP works. Therefore FTE data may not be comparable across all years.
Source of numerator

The NHS Information Centre's Census of General and Personal Medical Services. (The HSCIC conducts three annual workforce censuses of NHS hospital and community health services (HCHS) medical & dental staff, HCHS non-medical staff and General and Personal Medical Services).

Denominator definition

For the years 2003-2006, the population is the GP-relevant population (i.e. based on patients registered with a GP), weighted for age and need, and constrained to the ONS mid-year population estimate for England (to reduce list inflation).

Populations are weighted to reflect age according to the distribution of GP consultations with age. Older people are more likely to consult their GP and therefore PCTs with older populations would experience increased demand for GP consultations than those with younger populations.

Populations are weighted to reflect need for GP consultations using a formula developed by the Centre for Health Economics at the University of York (*A GMS needs measure based on the General Household Survey*). The formula adjusts the population according to the Jarman underprivileged area score and an age-standardised limiting long term illness ratio.

The Jarman underprivileged area score is a measure of general practice workload. It is a composite measure of eight individually weighted variables, weighted by a sample of General Practitioners according to their subjective assessment of their workload. The eight variables are: unemployment, overcrowding, lone parenthood, children under five, elderly living alone, ethnicity, low social class, and population mobility.

A standardised limiting long term illness (LLTI) ratio is a measure of how more or less likely a person living in that area is to report an LLTI compared to the standard population. It is a ratio of the actual number reporting an LLTI in the area to the number expected if the ward had the same age specific percentages as England, multiplied by 100.

From 2007 onwards the data rate is calculated using the standard mid-year estimates from the ONS. For example, if the data is for 2007, the 2006 Mid-year estimate is used.

Source of denominator

Weighted GP-relevant populations are produced by The HSCIC using the Exeter Attribution Data Set, weighted for age and need, and constrained to the ONS mid-year population estimate for England.

Standard mid-year estimates are from the ONS.
Geographic coverage
Data on number of GPs are available for England by Clinical Commissioning Group (CCG), or Primary Care Trust (PCT) prior to 2013, based on the organisation to which a primary care professional belongs, not geographical location. Weighted GP-relevant population is also available by CCG, or PCT prior to 2013, in England.

Other dimensions of inequality
Information is not collected on other dimensions of inequality.

Timeliness
The GP Census takes place twice a year in September and March. Data from the surveys are released approximately 6 months later. However, information at commissioning organisation level is not routinely published.

Accuracy and completeness
The population registered with a GP is constantly changing and people who have died or have moved house and registered with another GP are often not removed from a GP’s list. This leads to ‘list inflation’ where the GP list has more people registered than there should be. Although these populations are constrained to the ONS population estimate for England some residual list inflation may remain in some areas.

The GP Census is only a point survey and therefore does not take account of changes between surveys. However, there is no known cyclical change in the number of GPs by commissioning organisation.

In October 2006, a reorganisation of PCTs in England resulted in a decrease in the number of Trusts from 303 to 152. Ten new PCTs were not coterminous with old ones and the weighted populations of these are unknown. Therefore the number of GPs per 100,000 weighted population could not be estimated and the sum of the weighted populations from 2003/04 to 2013 does not equal the England total.

FTE data may not be comparable across all years (see note under Numerator Definition).
Disclosure
No disclosure control has been applied to this dataset.

Further information

Health and Social Care Information Centre
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1 Professor David Colin-Thomé, Report of the National Improvement Team for Primary Care Access and Responsiveness, May 2008
2 World class commissioning for GP services: Improving GP Access and Responsiveness,
3 *Our health, our care, our say White Paper*: a new direction for community services, DH, 2006