KENT Local Medical Committee
Supporting GPs since 1912

Supporting list based personalised care, the partnership model and meaningful collaboration

Health Overview and Scrutiny Committee 15th July 2025
General Practice Funding – the Carr-Hill Formula

This paper is intended to support HOSC to understand the complexity of funding in General Practice, specifically the Carr-Hill Formula. The Global Sum is one of the main sources of income for the majority of General Practices, the Carr-Hill Formula directly influences how this is calculated for practices delivering NHS General Medical Services. The Carr-Hill Formula was implemented in 2004, at the time this represented a major shift in how funding was allocated to practices as the new formula calculated an amount of funding per practice. The introduction resulted in some practices receiving less funding than under the previous contract and to mitigate this a Minimum Practice Income Guarantee (MPIG) was negotiated to ensure no practice was left with less funding. Over time, as the core GP contract increased, the correction factor reduced from 2014 and since 2021 has been completely phased out. Practices have had to make internal adjustments to offset the loss in funding as in the same time period core funding has not kept up with inflationary cost pressures.

How the global sum allocation (Carr-Hill) formula is calculated:

The global sum includes various components. The main payment is based on the GP registered patient list size (the headcount) and adjusted, using the Carr-Hill Formula, to reflect differences in the age and sex composition of the practice population, together with a range of factors which take into account the additional pressures generated by differential rates of patient turnover, morbidity, mortality and the impact of geographical location. These elements are outlined in the table below:

Drivers of workload accounted for in the formula	Description
Patient age and sex	Patients of different ages and sexes attract a different level of payment under the Carr-Hill formula based on a cost curve
Additional needs of patients	Using health survey for England 1998-2000 data, the formula takes into account standardised limited long standing illness and the standardised mortality ratio for patients under 65
List turnover	Patients in their first year of registration in a practice tend to have more consultations than others, so require extra funding

Unavoidable costs	Description
Staff market forces factor	The geographical variation in staff costs
Rurality	The impact of rurality was modelled using HMRC information on GP expenses aggregated to practice level. The impact of population density and dispersion was modelled against GP expenses, controlling for other factors

Each adjustment within the formula generates a separate practice index comparing the practice score on the adjustment to the national average. The indices are then applied to the practice list to produce a **practice weighted population.** The payment mechanism means that where patients are registered, seen and then leave the patient list within a financial quarter the practice does not receive any funding for these episodes of care. It also means that practices are not reimbursed according the actual number of patients registered, they are reimbursed according to the practice weighted population. The payment

is calculated quarterly based on the 'Capitation statement' which reflects the number of patients registered at that point in time. The current England average global sum payment is £121.79 per patient for delivery of all GP services for 12 months[1].

At the point of inception there were limited ways of measuring workload for individual practices and so the formula was derived from a sample of practice data taken from the General Practice Research Database (GPRD) between 1999 and 2002. Since this time GP records have been digitalised, we have robust coding of conditions, the ability to audit consultation numbers, durations, staff skill mix, mode of consultation and conditions being managed. We also have a greater understanding of population health and the impact of deprivation. It is widely acknowledged that the formula does not account for this and so practices in the most deprived areas receive on average 9.8% less funding per needs adjusted patient across all income streams than those in the most affluent quintile [2]. It is now widely acknowledged that the funding formula is in need of revision and reform.

What does the Global Sum Payment (Carr-Hill formula) fund practices to do?

It provides funding for practices operational costs and the costs of delivering essential GP services within core hours (0800-1830) – providing services for registered and temporary residents living within the practice area who are ill, or believe themselves to be ill, delivered in the manner determined by the practice. This includes identification and management of illnesses, providing health advice and referral to other services as required.

The number of consultations a patient can have is not limited and is determined by the patients assessed need. Some patients will need more appointments in a year and some may need less. As inflationary pressures have increased it is worth noting that the reality for practices is that the Global Sum Payment now predominantly only funds overheads such energy and staffing costs.

Other sources of funding:

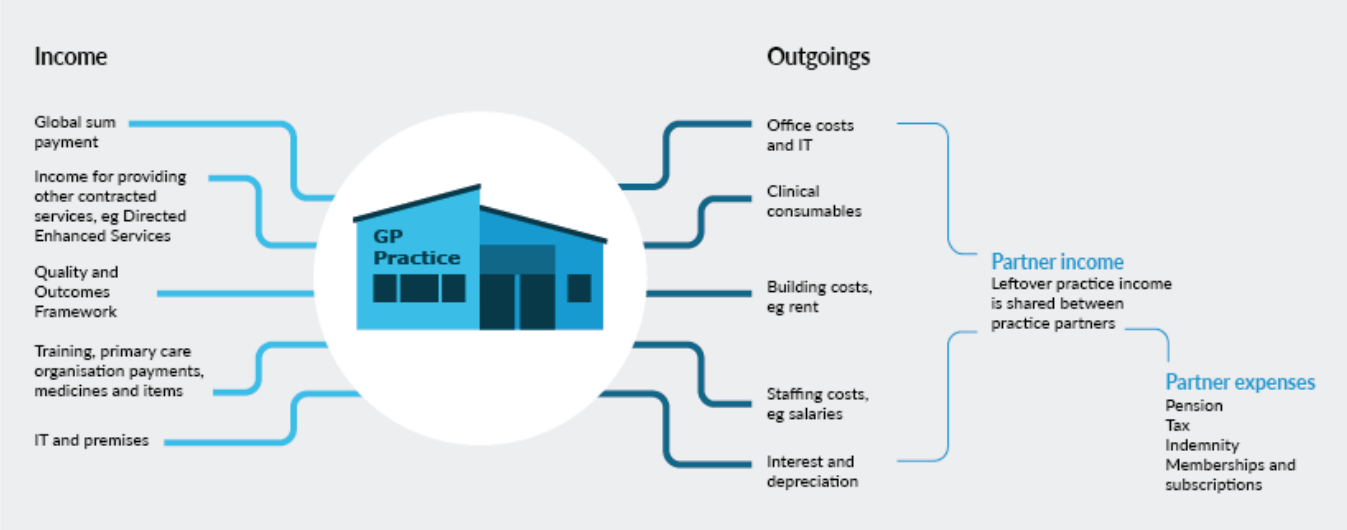
Practices claim funding for additional services, this includes:

1. **Quality Outcome Framework** (QOF) – provides an opportunity for practices to meet specific quality targets and funding is paid to practices monthly based the previous years achievement with a balancing payment the following year calculated according to actual achievement. The QOF year runs April to March. Components are renegotiated annually nationally. This year has seen many indicators moved into the Global Sum payment and a focus in the contract for 2025/26 on Cardiovascular Disease prevention.

2. **Enhanced Services** – local enhanced services are defined and commissioned by individual ICBs to meet the needs of our local population – including delivery of wound dressings, medication injections, phlebotomy, ECG, ambulatory BP monitoring, minor surgery. Directed Enhanced Services are nationally defined and includes the Primary Care Network Directed Enhanced Service (PCN DES).

3. **Primary Care Network funding** – where practices have signed up to the PCN DES they receive funding for the delivery of the services defined by the DES, responsibility is shared between the practices in the PCN and co-ordinated by the PCN Clinical Director. The Additional Roles Reimbursement Scheme (ARRS) provides funding for additional roles as determined nationally (such as PCN pharmacists, and as of this year nurses and newly qualified GPs) to deliver services.

4. As you can see in the diagram[2] below there are other sources of reimbursement such as premises, and funding for training GP registrars and medical students.

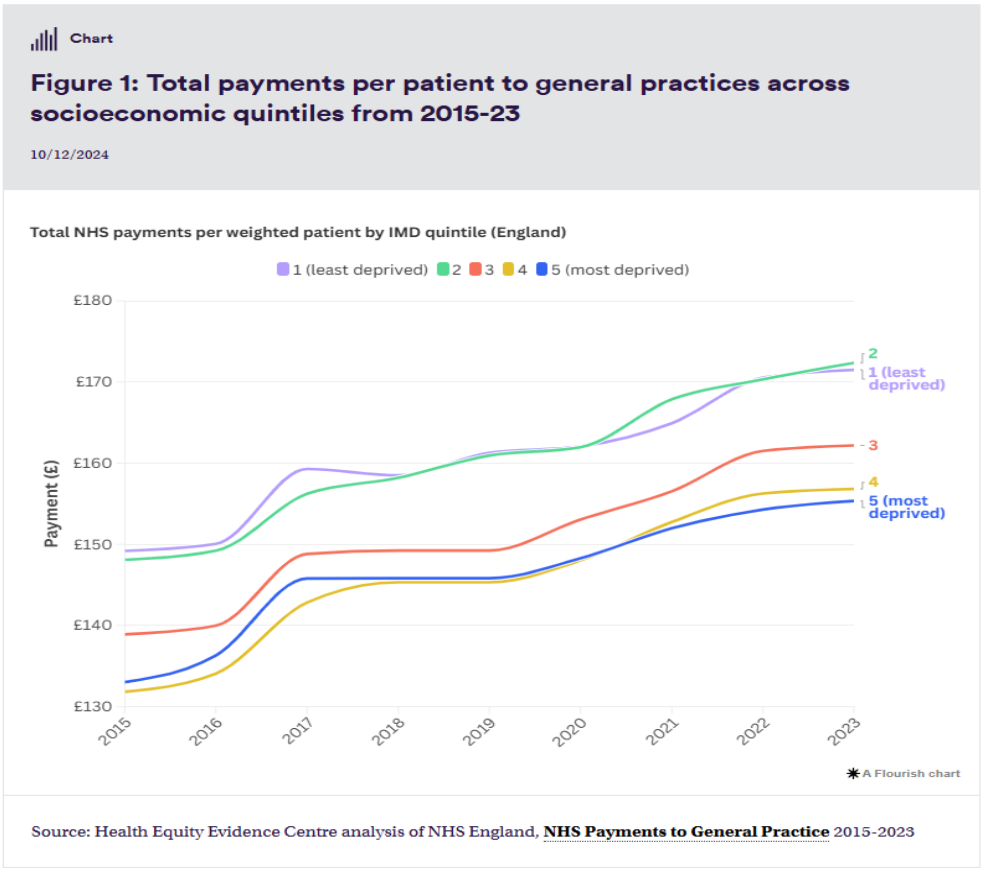


Why are GP practices struggling?

The current pressures on general practice reflect increasing population health needs and the funding provided by successive governments not keeping up with inflation, the expansion in ARRS has also added pressure to the General Practice estates.

As the demographics and population health needs of our society have changed, the weaknesses in the funding formula have been increasingly exposed and funding is inequitable and insufficient. Other limited funding streams have been added over successive years to address local needs and this has created a complex patchwork of funding streams which practices claim for monthly or quarterly. Despite greater health and social needs in poorer areas, general practices in the most deprived areas of England receive less funding than more affluent areas.

As seen in the graph below from the briefing undertaken by Nuffield Health[3]. Practices in more deprived areas have less funding to employ staff and consequently have fewer GPs.



GP partners are not just clinicians they are also small business owners and employers the majority of whom operate in a partnership model. This comes with a number of challenges such as managing complicated income streams and holding personal liability for financial risks. Most recently GP practices have been included in the governments National Insurance increases, this will cost the average practice in Kent and Medway over £38,000. The advantages of the partnership model are partners have a strong vested interest in maintaining and developing their practice, representing the most financially efficient part of the NHS, a lot of additional work is undertaken by GP partners to maintain practice services and regulatory compliance.

The BMAs General Practitioners Committee England released their vision for General Practice in the future, 'Patients First – Why general practice is broken and how we can fix it[4].' This sets out the national context and the desire of the profession to bring back the family doctor. There is strong evidence that patients who have continuity of care have better health outcomes, reduced need for frequent visits, reduced admissions to hospital and improved patient satisfaction. Guidance to practices from the BMA aims to support safe working and increase continuity of care by reducing the number of patient contacts GPs undertake in a day, this recognises the increased burden of disease and complexity that patients now present with.

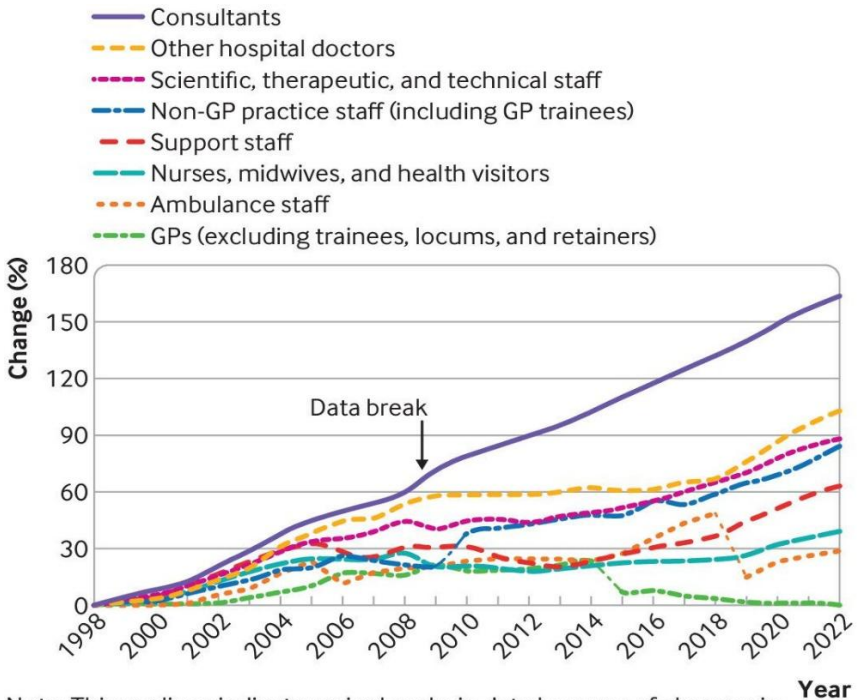
Many practices are being forced to freeze recruitment due to increasing cost pressures and financial uncertainty, without sustained guaranteed increases in practice funding continuity of care will continue to be compromised. For the first time we are now seeing underutilised or unemployed GPs in some areas while at the same time other areas have found it hard to recruit. Our current government hope to improve this situation by including GPs within 2 years of qualification in the PCN ARRS. In practice many PCNs have already recruited other roles using this budget and so have been unable to utilise the offer. GPs employed in this scheme work across a number of practices and so these posts can be less attractive and have the potential to further stifle continuity of care for patients.

Locally the Primary Care Training Hub have developed GP Fellowship Schemes which have been popular and enable GPs to continue to develop their skills while working in practices, recent funding cuts have reduced the opportunities available. The LMC continue our support offer for practices and recently have added a regular Mid Career Peer Network and Coaching offers to GPs across Kent and Medway.

Due to the national lack of investment into the Global Sum one in five independent NHS GP practices across England has been lost since 2013. Practices are closing and their patients are being either taken over by neighbouring practices or an incumbent provider takes over the service from the existing practice.

As the body of evidence increases to support investment in primary and community care in terms of improved health outcomes the newly elected government have worked with GPC England and this led to agreement of the 2025/26 contract and a commitment from the Rt Hon Wes Streeting, Secretary of State for Health and Social Care, to work with GPC England to secure a new substantive GP contract within this parliament. It is widely agreed that a transfer of resources from acute services to enable an NHS focus towards proactive and preventative care in the community should occur and following the NHS public consultation and the more recent dissolution of NHS England, at the time of writing we await the publication of the NHS Ten Year Plan.

Locally our Full Time Equivalent (FTE) GP numbers remain approximately 142 below the national average, currently each FTE GP cares for 2702 patients (this number varies across our region, in Medway and Swale 1 FTE GP has 3833 patients). Our GP numbers continue to struggle which reflects national trends. The table below from the British Medical Journal[5] indicates the change in staff mix between 1998 and 2022 and demonstrates the decline in GP numbers which continues today in 2025. The paper identified that trends in health staff numbers more or less match Department of Health spending trends.



Note: Thinner lines indicate major breaks in data because of changes in definition or data collection

Sources: NHS Digital[2345]

Local projections based on population size increase and demographics estimate that an increase in 1.7 million appointments per year will be needed by 2030 to meet the needs of our population. General practices in Kent and Medway deliver on average 910 777 appointments per month, 69% are delivered as in person appointments. The total population of Kent and Medway is, according to NHS digital data May 2025, 2,038,583. The data demonstrates practices are seeing more patients than ever before. Despite this the challenge of access reflected from feedback from our patients remains as demand frequently exceeds practice capacity, ability to triage and assess need, and increasing needs and demand due to increased disease burden caused by our aging population. The situation is compounded by the pressures of other parts of the NHS system leading to patients with increasingly complex conditions being managed in General Practice while waiting to be seen by specialists. The LMC have been working closely with Kent and Medway ICB to identify and address local enhanced services to support patient care closer to home, this includes introduction of the Primary Care Quality Standard and other initiatives already presented to the HOSC.

In 2024 Lord Darzi's independent investigation into NHS Performance[6] illustrated the current challenges faced by the NHS. The report made clear the value of General Practice to our Health Care System, indeed for every £1 spent on primary and community care in the NHS there is a return of up to £14 to the local economy[7]. We hope this paper illustrates to the HOSC the essential role General Practice plays in supporting our patients and explains the complex funding arrangements. General Practice and GPs can truly be valued and invested in, with this investment practices will be able to spend more time with patients, focus on preventative care, chronic disease management and increasing continuity of care.

Report Author: Dr Caroline Rickard, Medical Director, Kent Local Medical Committee

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8 Roebuck Business Park, Ashford Road
Harrietsham, Kent ME17 1AB

Tel: 01622 851197
Email: info@kentlmc.org