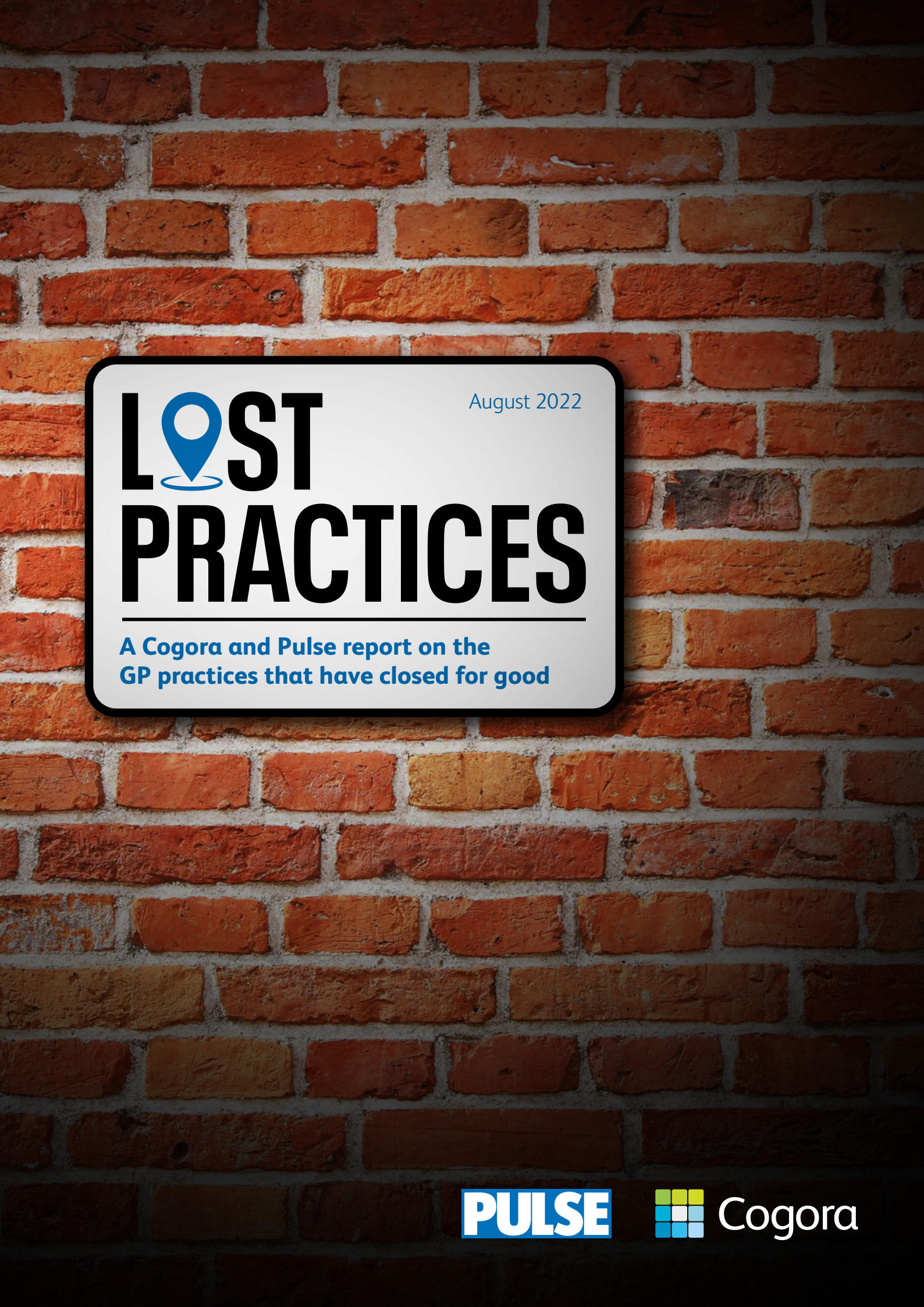
LOST
PRACTICES
August 2022
A Cogora and Pulse report on the
GP practices that have closed for good
PULSE
Cogora

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Introduction

In the early 2010s, GP practices shutting for good was almost unheard of. A Pulse front cover warning about 60 potential closures was seen by many as an exaggeration. But today, closures are disturbingly common, with more than 800 since 2013.

This might not be news to many, as Pulse reports on the situation annually. While each practice closure may be a tragedy – for GPs and for patients – there are different types of closure. In some cases, a closure is really a transition to new ownership, or a takeover by a neighbouring practice.

However, the most devastating instances are where a surgery closes permanently, with no practice taking its place. The report will examine these 'lost' practices. The results are shocking: at least 474 surgeries across the UK have folded with no replacement, with the impact felt by 1.5 million patients.

In some cases, these permanent closures have left patients traumatised as they say goodbye to a surgery that has served their community for decades. For others, access to GP services will have become significantly more challenging. And in all cases, neighbouring practices will have had to absorb the extra numbers.

We have used dozens of datasets to dig deep into the reasons behind these closures. We have looked at the individual cases, finding out what the triggers were. But we have also looked at the wider picture, analysing what factors link these closures, and the role of funding, recruitment, deprivation and size.

The results are fascinating, and we hope that the Government, the NHS, the BMA, the RCGP and anyone else with an interest in the future of general practice will take note.

How list size and staffing impact practice closures

The biggest factor in determining the permanent closure of a GP practice is size. The median list size of those that closed was 2,738. This compared to a median list size of 6,279 for all open practices in 2014-15.

The straightforward explanation for this is that smaller businesses are often at greater risk than larger ones, which is the case in most sectors, and it is true practice mergers have helped some practices to stay open. But some GPs say that smaller practices can and should be viable in their own right – not least because they so often provide continuity of care and greater patient satisfaction.

Yet the failure to replace small practices may be a de facto national policy. When Dr Arvind Madan resigned from his position as NHS England's director of primary care in 2018 over his comments that there were 'too many small practices' struggling to meet patient demand, NHS England was insistent that his comments were not a reflection of wider policy.

But federations, super practices and primary care networks all focus on GPs working at greater scale, with smaller organisations subsumed into larger ones.

This move to larger healthcare providers is happening in Shrewsbury. There are controversial plans to move six small practices with a combined 40,000 patients into a single location – while retaining their individual identities. The proposal has sparked two protests so far – with patients concerned about having to travel further, maintaining contact with their regular GP, and the loss of what they consider to be their local practice, according to reports in the Shropshire Star.

In August 2022, five retired GP partners also wrote to the clinical lead of the hub programme, Dr Charlotte Hart, with concerns around the new centre. They said: 'As regards the Hub, it is self-evident it is going to be huge to cope with 40,000+ patients. The waiting room alone will be airport lounge size, never mind the car park with on some days up to 2,000 visits... not everyone has access to a motor vehicle during the working day. Lack of transport links are obvious.'

Dr Hart replied: 'You seem to imply a large building is a bad thing but I'm not sure why. The architects propose a building that is light and spacious and easy to navigate.'

Gateshead and South Tyneside LMC chair Dr Paul Evans says: 'In a singlehanded practice, when one goes, that is it, the contract has to be handed back.' But he points out that smaller practices are not alone in struggling: 'In our patch, there's a practice of about 12.5k that is struggling to recruit and the partners are working extremely long hours, and one of about 7.5k that's gone from four partners to one in the space of five years.'

He adds: 'I think if small practices have a future, then they do need – in urban areas at least – to collaborate with neighbours on projects of mutual interest. But I don't think that should mean they can't be independent – I think there should be viability to smaller practices.

'There is evidence that small practices tend to offer better continuity and we know that continuity is associated with fewer admissions, better results on morbidity and mortality, and importantly patient satisfaction. A big theme of super practices is you never get to see the same doctor twice – if it's a single-hander then by definition a patient will see the same doctor every time...'

Chart 1: List sizes

Examples of small practice closures

- **A CCG statement on the closure in 2019 of Leicester Road surgery in Coventry, which had 2,635 patients, said: 'Leicester Road is one of our smallest contracts and we believe that the best use of our funding would be to support patients to find a different practice nearby.'**

- **Following the 2018 closure of 4,000-patient Woodrow Medical Centre in Redditch, the CCG reportedly said that 'to be viable, a GP practice needs at least 6,000'. The CCG was unable to find a new provider so patients were directed to other practices, the closest 1.7 miles away.**

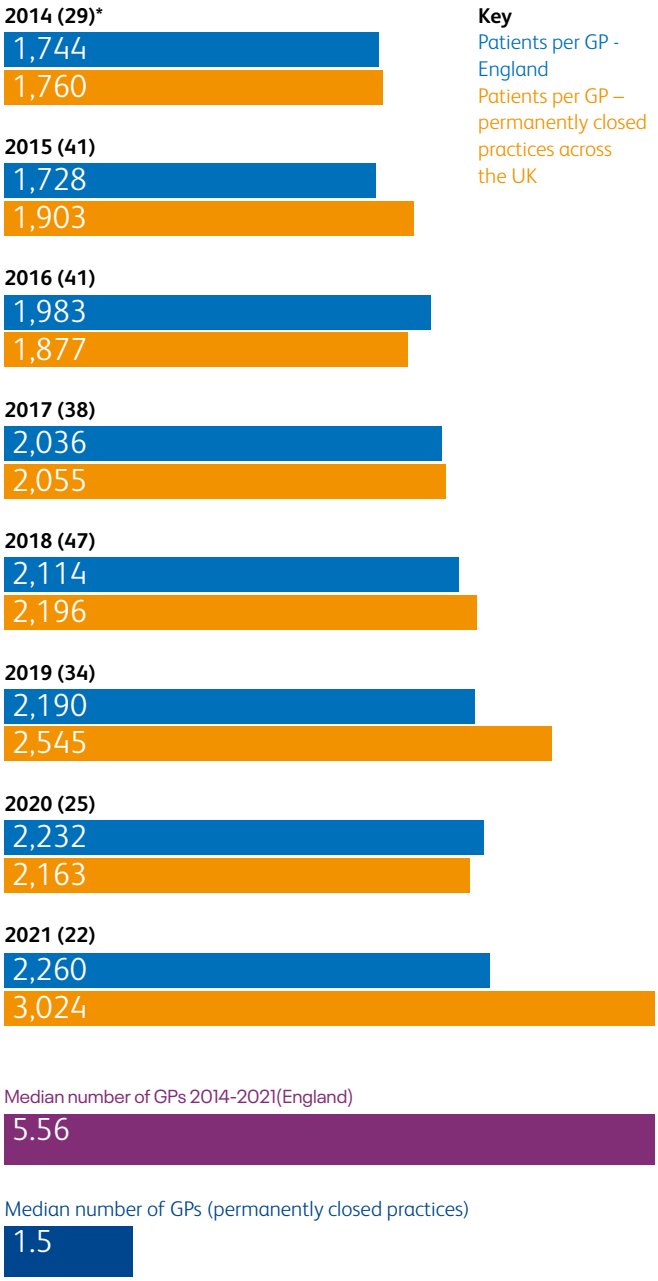
- **A CCG representative commenting on the 2020 closure of Brandon Estate practice in Southwark said its small list of around 3,000 made it 'less financially viable and unlikely a provider would be interested', adding that most practices have 'at least 6,000 patients now'.**

- **Dr Prabhakar Kusre – a singlehanded GP for 28 years in Milton Keynes – told the Milton Keynes Citizen local paper on his retirement in 2019: 'I wanted to retire, but I didn't want to see [the practice] close down. Unfortunately, things are different now, they don't want small practices.'**

Workload and staffing

It will come as no surprise that workforce and workload problems play a part in closures. The profession has lost 1,806 fully qualified FTE GPs since September 2015. There are fewer staff to do the job – and for those that remain, the pressures are increasing all the time, with closures themselves adding more workload where neighbouring practices must absorb the extra patients.

Chart 2: Workload and staffing



*The figure in brackets indicates the number of permanently closed surgeries we have patient and staffing data for in this year. There is a discrepancy with the total numbers of permanently closed practices because we only have data for whole practices that have closed, and not branches, and we only have full data for England.

This was highlighted in the closure of Victoria Medical Centre in Bridgewater, Somerset, in 2021, which was forced to shut due to ongoing clinical staffing shortages. Commissioners had spent 12 months trying to find a solution. Commenting on the closure local MP Ian Liddell-Grainger said transferring patients to other health centres would only 'add intolerably to the pressures their staff are currently working under' and that this could only be a 'stop-gap solution'.

Somewhat surprisingly we found that in practices that permanently closed the number of patients per GP was only slightly higher than the national average. But more important were the GP numbers – the median was 1.5 FTE GPs, which is also in keeping with smaller practices being at risk.

GPs leaders said all practices have intense workloads but those with fewer GPs are less likely to withstand the loss of a GP through burnout or any other reason.

Dr Richard Vautrey, former chair of the BMA GP Committee, says: 'Practices get to the point where they are not able to recruit, fewer GPs are left seeing more patients and that places them in an impossible situation, leaving them to look for alternatives which is often to merge with another practice or disperse a list altogether.

Dr Evans adds: 'There's a point when everyone has to ask the question can I keep doing what I'm doing...do I need to cut down my sessions if there is a concern that the job may actually literally kill me? We know that the hours and the stress are not necessarily conducive to good health.

'I know plenty of GP partners whose typical working day is 12-14 hours and many of these are people of my age or a little bit older or younger who can't retire now. But we would all be daft to not at least be taking a look at the alternatives for that day when we can't keep going.'

Examples of closures due to workload and recruitment challenges

A statement on the 2020 closure of Eagle Way surgery in Southend reads: 'The last five years have seen a huge increase in regulation and bureaucracy and huge increases in the workload involved in running two surgeries.

A singlehanded GP in Kent had decided to retire because they 'could no longer cope with the demand of 12-hour shifts'. The GP said they had spent three years trying to make arrangements for the future of the surgery.

In 2019, Eveswell Surgery in Newport – which had served its community for 70 years – closed after struggles recruiting. A local news article said the remaining two partners had been sharing the workload since 2017.

The link between practice funding and closures

Of the 232 practices in England where funding data was available, two-thirds (69%) were receiving below the average funding per patient in the year before they closed.

However, we found that the 'minimum practice income guarantee' (MPIG) was not a major factor in practices closing – contrary to previous expectations.

Dr Adam Janjua, a Fleetwood GP and former clinical chair of the NHS Fylde and Wyre CCG, says any cut in funding for practices can have 'serious detrimental effects'.

'Funding is a huge factor [in closures] because that is the formula by which we make our living and are able to pay our staff, even a £1 per patient reduction in funding is a job – that is a full-time receptionist in a practice of 12,000 patients.'

He explains that in 2014 his own practice merged with another nearby after both experienced a loss in historic funding of £25,000 and £50,000 respectively. This had previously been agreed under the Primary Care Trust, and so the CCG was unable to carry it forward.

'In order to be able to get some sort of safety of finances, we had to merge because then we could do a little bit of cost-cutting to make it work. But practices that don't have that option will have to close, because you need a minimum level of staff to have safe services as well.'

Former BMA GP Committee chair Dr Richard Vautrey adds that finances 'do play an important part' and if practices haven't had the necessary resources for a number of years, then it compounds their problems. But he says that even with adequate finances, practices can still be struggling, especially with recruitment.

MPIG

The impact of other funding changes – specifically the withdrawal of MPIG – are less clear. The MPIG was introduced in the 2004 contract to protect practices disadvantaged by the new funding formula. In 2014, the Government began phasing it out, claiming this would lead to fairer funding.

But we found the MPIG wasn't a major factor in permanent closures. We reviewed practices receiving MPIG in 2014/15, when phasing out began – 37% of practices received it that year. When we looked at the number of practices that permanently closed since 2014, 37% (of the 306 where data was available) had received MPIG funding in 2014/15. This only slightly changed for more recent closures, when the effect of the funding withdrawal is more likely to be felt.

Medical accountant Andy Pow says: 'A lot of the effect of MPIG withdrawal depended on solutions implemented locally.' However, he adds: 'The risk is how integrated care systems look at local funding... [if] they want to move it to PCN level, that will destabilise practice level funding.'

The proportion of closed practices in England that were GMS, APMS and PMS also broadly mirrored the national picture, although Pulse's analysis did identify 37 examples of closures where an expiring APMS contract had been the trigger.

Chart 3: Funding

Deprived practices are more likely to close – does funding need to change?

'We have much higher consultation rates than most parts of the country for activity we don't get paid for,' says Dr Farzana Hussain, a GP partner in Newham, an east London borough with a high level of deprivation. 'But when it comes to bringing patients in for proactive care, such as long-term conditions or screening, which brings in extra money through the QOF or enhanced services, this is an impossible task. As a result, we are struggling to pay the London Living Wage for our staff.'

This has an effect. We found that deprived practices face greater pressures that force them to close more than practices in affluent areas. On average, practices that close for good are in postcodes that have a ranking of around 3.81 on the Index of Multiple Deprivation, compared with a national average for practices of 4.41 (with 1 being most deprived, 10 being least deprived).

It is not only that practices in deprived areas are more likely to close – but when they do, it has worse effects. For example: Gorton Street Practice in Blackpool closed when its only GP left in 2017. It was in the 16th most deprived postcode of 33,000 in England. The town was badly affected by recruitment problems, with poverty cited as a key issue.

Two surgeries in Lowestoft, Oulton Medical Centre and its satellite branch of Marine Parade Surgery – which is in the 25th most deprived postcode in England – were closed in 2015 due to CQC concerns. Peter Byatt, a local councillor at the time, said 'not enough' was done to save them, adding: 'These practices are in areas of Lowestoft that are very deprived, with many disabled, elderly and vulnerable people making use of these services. These people are now left in the lurch.'

This research is timely as it comes when there is a growing call to look at the funding formula for practices in England.

The Carr-Hill formula rewards practices that have high numbers of elderly patients and young children on their lists. There are obvious reasons for this, of course; the very old and the very young generally require more healthcare than those in between.

But ever since the Carr-Hill formula was introduced in 2004, there has been controversy.

Chart 4: Deprivation

Factors in the funding formula

Age and sex
Patients of different ages and sexes attract different payments.

Additional needs
Using 1998-2000 England health survey data, Carr-Hill considers standardised limited longstanding illness and under-65s' standardised mortality ratio.

List turnover
New patients tend to need more consultations, so require extra funding.

Staff market forces
The geographical variation in staff costs.

Rurality and density
The impacts of rurality and of density and dispersion, were modelled using HMRC data on GP expenses aggregated to practice level.

Source: BMA

It quickly became apparent that practices in deprived areas with high numbers of young adults were facing the worst of all worlds: high levels of activity without the funding to match.

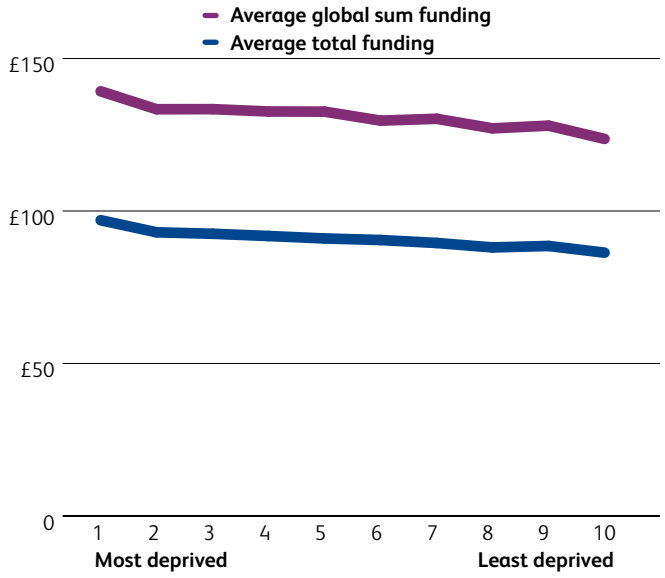
However, things might potentially be changing. Increasingly influential voices are calling for reform of the formula to take greater account of deprivation factors, ahead of major negotiations for the 2024/25 GP contract.

In mid-June 2022, then NHS England primary care medical director Dr Nikki Kanani told the NHS Expo conference the formula needed to change, adding that we need 'a shift in our contractual framework and our funding allocation formula... We've got a new contract coming in 2024/25. We've got an opportunity now'.

The following month, at a Policy Exchange think-tank event, RCGP chair Professor Martin Marshall weighed in, saying the formula 'very clearly needs reworking'. He added the Carr-Hill formula was 'largely based on workload, not on need – we need to be distributing resources on need'.

The BMA GP Committee policy is also in favour of overhauling

Chart 5: How deprivation scores affect practice funding



the funding formula, as a motion was passed at the LMCs Conference in 2021 stating 'the Carr-Hill formula is no longer fit for purpose' and it 'disadvantages practices serving the areas with the highest levels of deprivation'.

But there is a reason nothing has changed in the 18 years since the formula was introduced; any reform will create losers, as well as winners. So is this time going to be any different?

Uneven funding in deprived areas

The first thing to say is that deprivation does have an effect on a practice's funding. The Carr-Hill formula takes into account standardised limited longstanding illness and the standardised mortality ratio for patients under 65, using health survey for England 1998-2000 data. This is not the main factor – age and sex provide the heaviest weighting. Deprivation is not mentioned explicitly, but these 'additional needs of patients' naturally uplift funding for practices in deprived areas.

A Pulse analysis of 2020/21 payments to practices revealed that practices in the top 10% most deprived areas in England receive around £16 more per patient in total funding than those in the 10% least deprived areas.

However, this doesn't paint the whole picture. Away from these two extremes, the practices in the second decile of most deprived areas only receive around £4 per patient more than those in the second decile of least deprived areas.

Dr Hussain, whose practice is located in that second decile of deprivation, says the funding differentials within the global sum do not make up for the amount of extra work that comes from a deprived population.

'If we look at access, in our experience the ability to self-care is much less for people in deprived areas so consulting rates are much higher. And in my practice, only 3% of patients are over 65, yet our prevalence of diabetes is higher than anywhere in the country,' she says.

But it is in the extra work through the QOF and enhanced services where practices in deprived areas really suffer. A recent change to childhood vaccination payments has left some practices out of pocket by tens of thousands of pounds. The inclusion of vaccinations in the QOF has introduced thresholds that are proving impossible for some practices to meet and, as a result, their funding has been slashed.

Dr Hussain says: 'I'm scoring no points on any of the vaccines indicators. We know in those areas of deprivation, we will never get 95% of patients in. To get one person in for MMR, where there is still hesitancy from patients, we probably need to ring the parent or carer five times. We can't just text them, like in some areas.'

She adds: 'If this was a pure business model, we would not do immunisations as we are unable to make any income and lose money paying nursing and admin staff. We do it to protect our children – but how long can GP practices do charity work and remain sustainable?'

Dr Sam Everington, former chair of Tower Hamlets CCG, in east London, says there are additional pressures for practices in deprived areas. He says: 'One of the big issues for us is the number of consultations in which you are dealing with literacy and language issues and use of translators, which makes the consultation at least twice as long.'

Are things changing?

The mood music does seem to be changing, however. Dr Everington says the Government's 'levelling-up' policy could bring a new approach.

Yet even if the levelling-up policy continues, and with the apparent support of the BMA, the RCGP and NHS England, funding will not necessarily change. Dr Kanani's recent departure from her role as NHS England's primary care medical director will see her influence on the new contract dwindle – and it remains to be seen whether NHS England's appetite for change will dwindle with it. Professor Marshall will also step down from the RCGP chair in November. Meanwhile, there has been barely any noise from the BMA about pushing for a change.

The problem, everyone acknowledges, is that there will be losers if the funding formula changes within the current funding envelope, and no practice can afford this with the current work and staffing pressures.

As Londonwide LMCs chief executive Dr Michelle Drage puts it: 'Every practice is underfunded and the real issue with any formula is that, unless the size of the pot is increased to ensure everyone reaches the funding they actually need to run the service expected of them by the commissioners and politicians who tell them what to do, it will simply create a different bunch of have-nots. Redistributing a fixed cake funding formula is not the solution.'

Unfortunately, extra funding doesn't look likely. NHS England has ruled out an uplift in funding for practices to cover soaring inflation, despite the Government recommending a 4.5% uplift for practice staff.

There have been a number of false dawns for deprived practices. This could easily be another.

The final straw for practices: What is triggering closures?

Using official papers and local news reports, Pulse was able to identify the reasons or 'trigger' behind the closure of 162 practices.

Unsurprisingly, staffing was the most common by some distance – 42% of the 162. In a fifth of cases, this was retirement, in 8% resignation of a partner and in just over one in 10 an inability to recruit. We also identified 30 closures triggered by an 'inadequate' rating or enforcement action from the CQC, while 37 were due to non-renewal of an APMS contract.

While we found evidence that structural problems linked practice closures, the more unique circumstances of an individual practice can be the final straw. In the recent case of the Central Lakes Medical Group, for example, partners were forced to hand back their contract last month following the decision by commissioners to remove atypical funding worth £70,000.

'This funding helped keep us afloat,' says Dr Kaye Ward, a partner at the Central Lakes Medical Group in Cumbria. 'Its removal also made us more vulnerable if a GP left.'

She adds that Central Lakes is also not the only vulnerable practice in the area: 'Around us, GPs tend to be over 50. Locally, age, retirements, illness have all been triggers for closures.'

Northumberland LMC medical secretary Dr Jane Lothian says that GPs are 'clever businessmen' on the whole and so they learn to cope with what they've got, but she has seen practices tip over 'for completely different reasons' over the years.

'Personal issues, political things that go back many, many years – and one situation built up over around twenty years where the patient population became almost impossible to manage. That is all historical stuff, and it is far more transactionally complex than just pounds and pence.'

Retirement

Two of the most common reasons for closure in our snapshot of 162 were retirement and an APMS contract coming to an end.

It's no surprise that retirement can cause a closure – and there are already concerns that this is only going to get worse over the coming years, as more GPs opt to exit the profession early. A recent Pulse survey found almost half (47%) of more than 800 GPs surveyed intended to retire at or before 60, including one in 8 who said they intended to retire before reaching 55.

The issue with retirement is that if there are no succession plans in place for a partnership – and the commissioners can't or won't find anyone to take over – then a practice will have to close. Pulse's investigation found many examples where this was the case. These included:

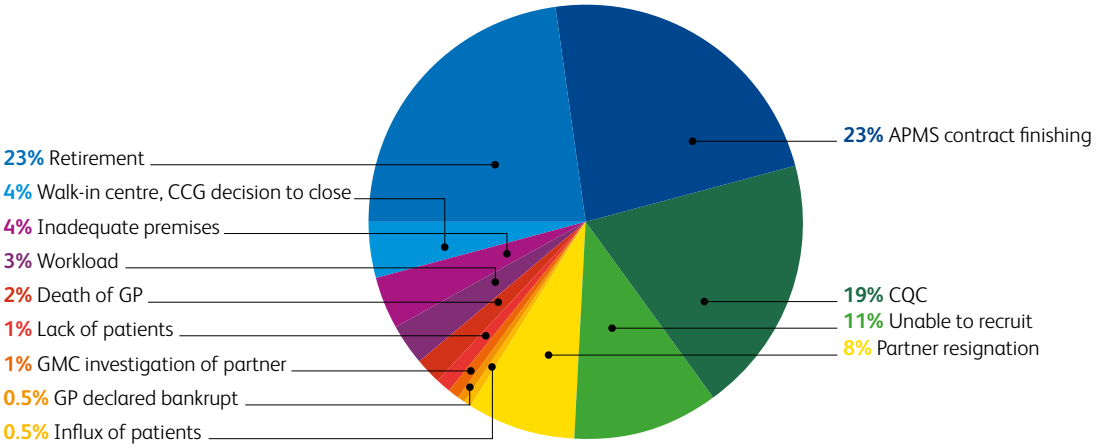
Dr Benedict Glover, who retired from the Antrim Coast Medical Practice in Glenarm, Northern Ireland on March 31 2017 after 51 years, told the local newspaper at the time: 'No one applied and no other practice wanted to take it over. It is a big loss for the area, now the nearest doctor will be 10-12 miles away.'

When Porth Farm Surgery in Rhondda closed in 2019 after the retirement of two GPs, a spokesperson for Cwm Taf Morgannwg University Health Board said it had considered 'every option' to keep the surgery open but 'due to the ongoing challenges of recruiting GPs' had concluded that the only sustainable solution was for patients to register elsewhere.

A local news article on the closure of the Lawns Surgery in Rustington, Sussex said that as there was no team to take over from the retiring GP Dr Charles Shlosberg, the CCG was 'looking at alternative options with the other GP practices in the town'.

A Healthwatch statement on the closure of Peppard Rd

Chart 6: The triggers of closure



Surgery in Caversham in 2019 said no surgery could be found to take on the 2,600 patients in 'one single transfer' after the husband-and-wife GP team retired and was therefore dispersed between several practices. A CCG statement in the local press said Peppard Road was 'considered too small these days to offer the full range of primary care health services and be viable in the long term'.

APMS contracts

Pulse found 37 examples of closures that were triggered by the ending of an APMS contract. In some cases, commissioners had tried unsuccessfully to find someone else to takeover.

The contract for Whitehall Medical Practice in Shrewsbury was put out to tender in 2019, but received no bids, according to a CCG representative. Local news reports on the closure said the practice's list of around 3,700 was dispersed to alternative local practices.

It was a similar picture in the case of two practices in Bristol – Northville and Bishopston – which closed in 2019. A health scrutiny committee report says a review of the APMS contracts 'identified that procurement would not be a viable option, as providers had not indicated an interest'. Over 15,000 patients were re-registered with surrounding practices.

There was also evidence that wider commissioning factors played a part in a practice's fate when the time was up on its APMS contract: The Ali Practice in Trafford was closed in 2015 after the CCG recommended list dispersal. Official papers on the closure said 'the procurement of a single-handed general practice with a registered population of 2,657 [was] not consistent' with the CCG's primary care strategy, which focused on a 'greater collaborative, federated, more robust model' delivered by larger practices.

CQC

Our analysis also found 30 cases where an 'inadequate' CQC rating or further enforcement action taken by the regulator had resulted in a practice closing its doors. These included:

Devon Live reported that Barton Surgery, in Plymstock, closed temporarily in October 2019 after a CQC inspection found it to be inadequate. Five weeks later the CQC announced that the surgery would not be reopening. Our data shows the practice had a list size of 2,700.

An article in the Liverpool Echo said Baycliff Health Centre was forced to shut in 2014 after NHS England terminated its contract with the practice following a 'damning' CQC inspection. An NHSE spokesperson commenting on the closure said: 'Due to circumstances within the practice and following many months of support from NHS England, Merseyside, it is with regret that we have now taken the decision to end the contract with Baycliff Family Health Centre.'

West End Surgery in Nottinghamshire closed in 2018 following an 'inadequate' CQC rating, according to local reports. The surgery had been rated as either 'inadequate' or 'requires improvement' since March 2015. An official FAQ document on the closure said the practice had faced 'increasing challenges over the past few years' and services had 'become unsustainable' as a result.

The BBC reported that Goodwood Court Medical Centre in Brighton was ordered to close by the regulator in 2015 over concerns that patients were at risk. The immediate closure left commissioners having to arrange alternative practices for around 9,500 patients. An NHSE statement included in the article said the decision to shut such a large practice overnight was 'unprecedented' but justified in the circumstances.

The areas where practice closures have left a gap in provision

There is no part of the UK that hasn't been affected by practice closures. But a number of those that have closed have left patients having to travel much further. We have highlighted some of the most problematic closures.

Gardenstown Surgery, Aberdeenshire, Scotland
Gardenstown Surgery in Aberdeenshire was originally closed on a temporary basis in 2015 after two doctors left – one to take up a new post and the other to recover from an accident, according to the Scotsman. It was later closed permanently in 2016 following a merger with Macduff Medical Practice, which is a 20-mile round trip from Gardenstown.

At the time, local MSP Peter Chapman was quoted in The Press and Journal saying that the staff shortages that had led to the closure of Gardenstown were 'disastrous for rural communities in particular, leaving them 'further cut off from the health services they need'.

NHS Grampian health board told Pulse that the population of Gardenstown is roughly 700 people and 'with a lack of GPs nationally' it had been 'unsustainable' to keep the practice open as a branch surgery.

Milverton Surgery, Somerset
Milverton Surgery, a branch of Lister House practice, closed in 2018.

Local news reports at the time said that the closure had been triggered after four doctors from Lister House announced their plans to leave. The Somerset Partnership NHS Foundation Trust, which took over the short-term management of the practice, later applied to close the branch surgery due to difficulties recruiting GPs.

According to the Somerset County Gazette, the village has an elderly population and the closure would have resulted in a six-mile round trip, with some having to 'struggle 900 metres for a bus to Wiveliscombe', where the main Lister House practice is based.

There had been a surgery in Milverton for 90 years.

Beech Grove Surgery, Isle of Wight
Beech Grove, a practice in Brading on the Isle of Wight, closed in 2020. The Isle of Wight County Press reported that the wife and husband team running the surgery had said they 'could no longer cope with rising demand and decreasing resources'.

A statement from the two doctors also said the decision was made 'in light of forthcoming retirements and additional loss of GP cover'. The list of around 4,500 patients was dispersed after the CCG was unsuccessful in finding anyone to take over the practice.

The nearest primary care services to Brading are in Ryde (a 12-mile round trip), St Helens (a six-mile round trip), or Sandown (a three-mile round trip).

In a letter to affected patients, seen by local news site Island Echo, the CCG said: 'We appreciate that this is not the outcome that everyone wanted, and that it presents some patients with difficulties, but the decision cannot be changed. The PPCCC (Partnership Primary Care Commissioning Committee) agree that, realistically, it was the only option open to us to ensure your continued safe access to GP primary medical services.'

Birch Surgery, Colchester
Birch Surgery, a branch of Winstree Medical Practice, closed in 2016. The practice manager quoted in the local press at the time said the surgery had reached 'crunch point' and the practice did not 'have the ownership structure' to be able to commit to the new lease arrangements that were on offer after the existing lease expired in November 2015.

The same article said that the nearest surgery was more than two miles away, and there was no direct bus route, meaning those that are elderly and who could not drive would be affected. The village had also already lost a shop and a post office, it said.

The Daily Gazette also later reported that there were plans to hold GP sessions two days a week in the village school after the closure, but these fell through after parents objected.

Pattingham Surgery, Wolverhampton

Pattingham surgery, a branch of Claverley Medical Practice, closed in 2018 after receiving formal notice to vacate its premises.

A CCG report from the time said 1,500 of Claverley's 4,250 patients had been using the Pattingham branch site, and of those approximately 850 lived in Pattingham. It added that the Pattingham surgery building belonged to a previous partner in the practice and they had been leasing it to the practice until notice was served on the lease.

The Express and Star reported that the closure would mean patients had to make a six-mile trip to Claverley for GP care and quoted a patient saying there was no public transport available to do this.

A spokesperson for Staffordshire and Stoke-on-Trent ICB told Pulse that the Pattingham building was an 'old house' that 'just wasn't fit for purpose', and that closing the branch meant that the practice would be 'more resilient and provide a better service to patients'. They added that there is plenty of choice of service provision for patients in the area. This ranges between practices that are a seven-minute drive to a 12-minute drive away from the village of Pattingham.

Broadmayne Surgery, Dorset

Broadmayne Surgery closed in 2015. The Dorset Echo reported at the time that the decision to close the surgery was taken after the GP based there announced he would be retiring.

According to the local news article, NHS England wrote to the surgery's patients telling them that Broadmayne has a very small patient list which made it 'difficult to sustain'.

It also said that NHS England had 'asked 15 local GP practices if they would be interested in providing services in Broadmayne but after three initially expressed interest they said that it would not be sustainable'. All patients were transferred to the Atrium Health Centre, which operates from two locations in Crossways and Dorchester, the article added. Both are an eight-mile round trip from the village.

A local councillor quoted in the story said the closure was 'another blow' for the village's rural community and it would impact 'a lot of older people'.

Scan the QR code to view an interactive version of the map

Conclusion

We have made clear that practice size – and the number of GPs – is the most important factor in determining permanent closure, while per- patient funding and deprivation scores are also relevant.

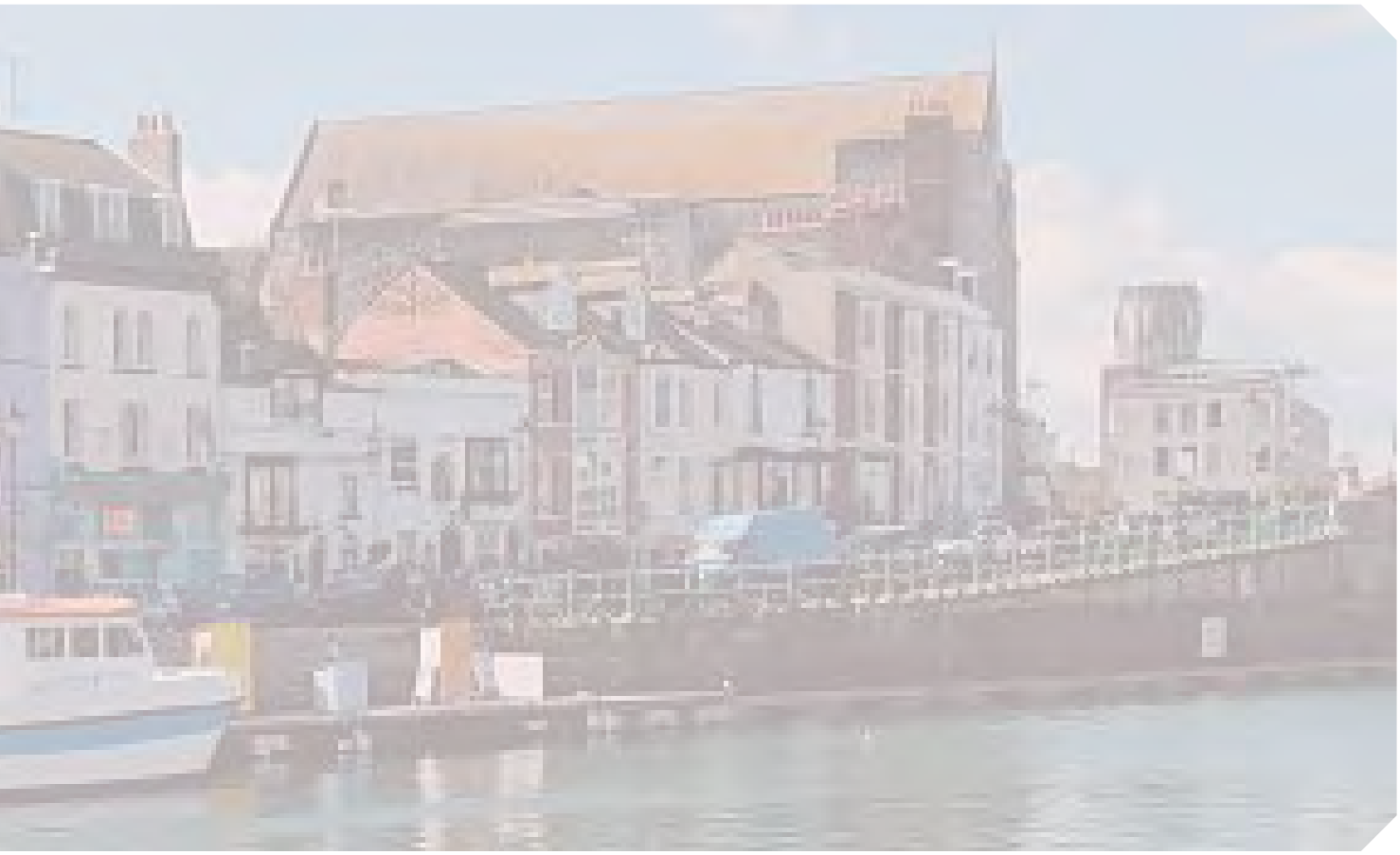
Other factors – including patients per GP and whether the practice received MPIG funding – had far less influence than would have been expected.

The likelihood is that there are a number of practices on the edge and in many cases, it only takes a trigger to tip them over. Often the retirement or resignation of a partner, burnout, poor decisions by commissioners or a perfect storm of factors is enough to create a community without a GP surgery.

In many areas, it is simply impossible to bring in new contract holders, however much effort commissioners and the outgoing GPs themselves put in.

Things don't seem to be improving. In August 2022, Pulse reported that 22 practices in Northern Ireland on the brink of handing back their contracts were being looked after by a 'crisis team'.

We hope our research will spur decision makers to tackle the causes of practice closure, and their effects on GPs, patients and the wider community. Otherwise, many more people – especially those in deprived areas – are going to find it even harder to access general practice.



Methodology

There were times when we didn't have the perfect data, and had to use the best available – for example, basing average list sizes on English practices, rather than UK wide.

Determining the 'lost practices'

Our aim in researching practice closures every year has been to look at the physical premises that had closed. This is not the same as comparing the number of practices in 2013 with the number of practices in 2022 – in many cases, a reduction in the total number is meaningless. They might be mergers where nothing materially changes.

To find out premises closures, since 2014 we had been submitting freedom of information requests to CCGs and health boards in the devolved nations, as well as NHS England. We asked about full practice closures (where they hand back their contract and close their only surgery), branch practices and surgeries that had closed as a result of a merger.

This year, we reviewed all the information we have collected over the past eight years. We realised there were examples of CCGs and NHS England sending us the same practice with different names and in different years, so we removed these.

To get the list of 'lost practices' we collected the data on active practices and branch surgeries from all four UK nations. We compared this list to our list of closed practices and removed instances of duplicate postcodes. This left us with 474 practices or branch surgeries that had closed, and there is no current surgery in the same postcode.

Funding

We only had data for England on this. We also only focused on actual practice closures either through partners handing their contracts back, or where a practice had closed due to merging with other practices.

We used the NHS Digital document NHS Payments to General Practice 2020-21. We used the practice codes we collected through our FOIs and matched them to the NHS Digital document.

To calculate total payments, we removed premises payments, dispensing fees, locum reimbursement and prescriptions reimbursement, as these either distorted the figures or were straight 'in and out' payments that represented no profit or loss to practices.

For the closed practices, we used the final full financial year before they closed to calculate their average funding per patient. We then measured them against the average funding for all practices in the same financial year.

We used NHS Payments to General Practice 2014-15 to calculate the average number of each contract type – ie, GMS, PMS and APMS. The reason we used this dataset was because we suspected there had been a relatively large proportion of APMS practice closures since them, so this would be best as a baseline.

We used NHS Payments to General Practice 2014-15 to determine whether a practice was an 'MPIG' practice, defining this as a practice that received minimum practice income guarantee funding in 2014-15, before the funding was reduced.

List size

In our FOI, we did ask for list size before closure. Where this wasn't provided – mainly for branch surgeries – we looked at other official data sources.

To calculate the number of patients displaced, we used the data whichever surgeries – including full practices and branch

surgeries – that had been permanently closed. However, when calculating the median list of the practices that had closed, we excluded branch surgeries.

We used the NHS Payments to General Practice 2020-21 data set to calculate the median list size of all practices, but this applied to England only as adequate data wasn't available for a UK wide figure.

Staffing levels

We used NHS Digital's annual reports on practice level staffing. We looked at the closed practices' – but not branch surgeries' – staffing levels from the year before they closed. We calculated the aggregate of patient numbers and the aggregate of full-time equivalent GPs and divided the total number of patients by the total number of FTE GPs for closed practices and practices in England overall. This data wasn't readily available for the other UK countries.

Deprivation levels

We checked each closed premises postcode against the 2019 deprivation indexes in England, Scotland, Wales and Northern Ireland. Using their rankings in the index of multideprivation to give them a decile score to two decimal points in their respective countries. We then worked out the median score of the closed practices across the UK. We used the same method to work out the median score of all practices in the UK, except for Northern Ireland due to logistical problems, but we don't believe this had any effect.

For the funding element of deprived practices in England, we used the deciles assigned in the English indices of deprivation 2019 and worked out average fundings using the NHS Digital Payments to General Practice removing premises payments, dispensing fees, locum reimbursement and prescriptions reimbursement (see funding section).

Geographical hotspots

We input the postcodes of current active practices and permanently close practices into Google Maps using different colours. We reviewed the areas where there was no active practice close to a closed practice, researching the reasons behind this.

Triggers

We used official papers and contemporary local newspaper reports to determine the trigger for the closure. We only used reasons that had been given directly by the practice's partners or commissioners. For those we could find reasons, we sorted them into the following categories:

- Retirement
- APMS contract finishing
- CQC decision
- Unable to recruit
- Partner resignation
- Retirement
- CCG decision to close walk-in centre
- Inadequate premises
- Workload
- Death of GP
- Lack of patients
- GMC investigation of partner
- GP declared bankrupt
- Influx of patients

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