GP Partnership Review

Interim report

2nd October 2018

Chaired by Dr Nigel Watson MBE MBBS FRCGP

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Foreword by Dr Nigel Watson, Chair of the Review

General practice is recognised as the foundation of and the front door to the NHS. Over 85% of doctor-patient contact occurs in general practice,[1] ensuring the health and wellbeing of our communities.

The Partnership Review was established because general practice and GP partners are facing major challenges. I accepted the role as independent chair of the review because I strongly believe that, despite the headline challenges of a rising workload and changing workforce, the partnership model is not dead. I have worked closely with and been supported by the General Practitioners Committee of the BMA, the Royal College of General Practice, the Department of Health and Social Care and NHS England.

Over the last four months, I have travelled to many different parts of the country and met a wide variety of people and organisations. I have visited a large number of practices: some who are performing really well despite the challenges, and others who are really struggling. It is essential that we fully understand these challenges and develop solutions that will make a significant difference to frontline general practice.

General practice must retain its core and unique strengths: providing high quality care, with the continuity of care that patients value and that results in better outcomes for patients. Practices must offer good access to a range of services, that are appropriate to their populations, and must engage effectively with other local providers. As the front door of the NHS, general practice also has a responsibility to use resources appropriately and wisely.

These strengths can be a feature of small practices as well as larger ones. What is clear is that practices cannot thrive if they work in isolation, and that there is an increasing role and potential benefits for practices and providers who can work together to support natural communities of care.

The first stage of our review has provided us with consistent messages about the challenges that GP partnerships face. This stage is near completion, and we now move to address the challenges and develop a number of recommendations that could make a real difference to general practice, our patients and communities, and the wider NHS.

While I have been asked to make recommendations to revitalise the partnership model of General Practice, it is difficult to separate this from issues that more broadly relate to the future of general practice. For example, addressing the issues of workload, workforce and

risk would give confidence to newly qualified GPs, who might then become partners in a practice. This could also reduce the rate at which experienced GPs and GP partners are leaving general practice.

This report details much of what we have heard and has allowed us to distil the most important factors that we need to develop in our final report, which will detail our recommendations.

Over the next three months, we will move to the next stage of our work, which will include wide consultation; we would welcome your contributions to the review. Details are available at the end of this document.

I would personally like to thank all those who have contributed to the review so far, whether that is by giving up their valuable time, sharing their views, inviting us to their practices to discuss the challenges they face, or emailing us with their concerns, ideas and expectations. It has been a real privilege to meet with so many people and see so much fantastic care and commitment to patients and communities. This can be seen in the most challenged places, as well as in those that are doing better.

While it is clear to me that general practice and the partnership model are fragile at the present time, and doing nothing is not an option, I retain the optimism that I set out in our Key Lines of Enquiry earlier this year: this is our future, and it is up to us to shape it.

Dr Nigel Watson

Independent Chair GP Partnership Review

GP and Managing Partner, the Arnewood Practice, New Milton, Hants

Chief Executive, Wessex Local Medical Committee

Member of the General Practitioners Committee of the BMA

Executive summary

The partnership model of general practice has been the foundation of the NHS for over 70 years. The evidence from around the world shows that healthcare systems that have invested in primary care have better outcomes, with greater patient satisfaction delivered at a lower cost.

General practice is at the very heart of primary care and, therefore, the NHS. It is essential, when we look at the challenges that NHS faces, with an ageing population, more people with long term conditions, and the inevitable rise in demand, that we look to support and invest in general practice and the wider primary care team, and not just hospitals.

General practice is facing some major challenges, with declining numbers of GPs (excluding locums and trainees), with low morale, increased levels of stress, mental health problems and burnout, working days getting longer and the complexity and intensity of work increasing.

The traditional services that have, in the past, formed part of the primary care team are no longer part of the practice team in most areas, and the fragmentation has led to inefficiencies, duplication and less effective care delivered to our patients.

During our visits and engagements with a large number of GPs, Practice Managers, Practice Nurses and others we have heard consistent messages:

- The workload is a major factor in the current problems with recruitment and retention
- The workforce is inadequate to deliver the care that is needed
- The risks of being a partner outweigh the benefits and the reasons for this are premises, the cost of medical indemnity and unlimited liability held by partners.
- There is uncertainty about the future of general practice which contributes to the recruitment and retention issues
- General practice reports that it is adversely affected by underprovision of community nursing services, and community mental health services, which has an impact on workload. These services are less integrated with general practice than they were a generation ago, leading to inefficiencies and fragmented care
- The resources that are invested in general practice or primary care, all too often are not seen to support the frontline delivery of care and are bundled up in small packages which are often seen as too difficult to bid for. The bidding process is

over-burdensome and the delivery is so tied up with bureaucracy it is deemed to be not worth it

During our visits around the country, we were privileged to see a wide range of practices, and saw areas that are really struggling such as Plymouth, Folkstone and Bridlington, in addition to other practices who are delivering high quality care and are truly inspirational in how they are doing this.

This report starts to explore the potential solutions that will revitalise the partnership model of general practice. These include for example:

- Workload – address the workforce issues. With a larger and more diversified workforce, we could start to turn the tide. There needs to be an increased focus on preventing disease, investment in prevention of complications of existing long-term conditions (for example, from diabetes and cardiovascular disease), and more self-care and self-management, with the use of technology to support patients

- Workforce – increase GP numbers by making general practice a better place to work, making partnership more attractive than being a locum, expanding the multi-professional team working with and supporting GPs. Also embedding existing community staff within general practice and creating the opportunities for working as a single team. Creating primary care networks that will support practices, and use more of the existing resources to deliver frontline care, will support the workforce

- Risk – address the risk of lease holding and property ownership, introducing a comprehensive state backed indemnity scheme and addressing the issue of unlimited liability

- Status – GPs need to feel valued by more than just their patients - by politicians and the wider NHS. The GMC needs to recognise general practice as a speciality and legislation is required to deliver this. Medical students need to spend more time in general practice, and placements need to be funded at the same rate as hospital placements. There should be more placements created in the community for GPs in training, ensure more hospital trainees spend time in general practice, and that all foundation trainees have a period of their training in general practice

- System leadership – general practice must be part of any system's senior leadership voice. To continue to ignore this will mean existing barriers continue, and the hope of ending the fragmentation and organisational barriers will not be realised

The potential that sits within the partnership model needs to be unleashed, as this will benefit our patients and the wider NHS. To achieve this, we need support from the NHS and partnerships to engage and lead the transformation to a better future.

Places the review visited are doing some amazing things, and could do so much more with even greater support. There is the potential, in a future system, for primary care, if properly supported, to achieve its full potential.

In summary, general practice needs to be valued; it is vital to the future of the NHS and rests on the partnerhsip model.

Introduction

The previous publication 'The Key Lines of Enquiry' stated:

> "International evidence has repeatedly shown that, in countries who have well developed primary care, the population generally live longer, experience better health, and see lower overall healthcare costs with a lower level of medication usage. General practice has been described as 'the Jewel in the Crown' of the NHS, and it has been said that 'if general practice fails the NHS will fail'. Demand for services is increasing across the NHS, and I believe that general practice and primary and community care are absolutely vital in ensuring the stability and sustainability of the health service.
>
> The evidence could not be clearer that if we want a cost-effective NHS that provides the best possible outcomes for our patients and the population, this must be based on high quality, stable and sustainable general practice built on the registered list of patients."

In the UK, the partnership model has underpinned general practice since before the establishment of the NHS. This model is a major component of the success of English general practice. In recent years, partnerships have become less popular with GPs and there is a risk that, if the model is lost, general practice and the patients and communities it serves will suffer. Therefore, it is important to consider the strengths of the partnership model of general practice, and what value the model offers above and beyond a salaried alternative. From our engagement work, we have been told that some of the strengths of partnerships are:

- Freedom to innovate
- Ability to implement change at pace
- Relative autonomy in decisions relating to patient care (or the ability to act relatively independently as a powerful advocate for patients)
- Being part of a community and being accountable and responsible to that community
- Desire to succeed as a business owners
- Value for money

General practice is diverse in terms of practice size, the type of contracts practices hold (General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS)) and in the populations they serve. The partnership

model has developed in an equally diverse way. The flexibility of the model enables partners to develop their interests. For example, in larger practices, some partners may focus on clinical care, and some may focus more on the business side. Regardless of the area the partner focuses on, they will have an interest in setting and delivering strategy, creating a conducive culture in the practice, and in being part of the community.

Terms of reference for the review

As previously announced[2], the GP Partnership Review will consider and, where appropriate, make recommendations, in the following areas:

> 1) The challenges currently facing partnerships within the context of general practice and the wider NHS, and how the current model of service delivery meets or exacerbates these;
>
> 2) The benefits and challenges of the partnership model for patients, partners, salaried GPs, locum GPs, broader practice staff (practice nurses etc) and the wider NHS;
>
> 3) Drawing on 1) and 2), consider how best to reinvigorate the partnership model to equip it to support the transformation of general practice, benefiting patients and staff including GPs.

The recommendations should be focused, affordable and practical.

Key lines of enquiry

In July 2018, the review published Key Lines of Enquiry[3]. Alongside a clear message of support for the strengths of the partnership model in general practice, and its role in the current and future health and care systems, the Key Lines of Enquiry identified four themes. These were workforce, workload, the role of general practice in local healthcare systems and business models. The document set a number of key questions for each theme.

It was intended that these questions would develop over the course of the review, as the Chair engaged with both the partner organisations to the review process (including the Department of Health and Social Care (DHSC), NHS England, Royal College of General Practitioners (RCGP) and General Practitioners Committee of the BMA (GPC), and those with an interest at the frontline. The diagram below depicts the chain of processes involved in the production of this interim report.

Working timeline

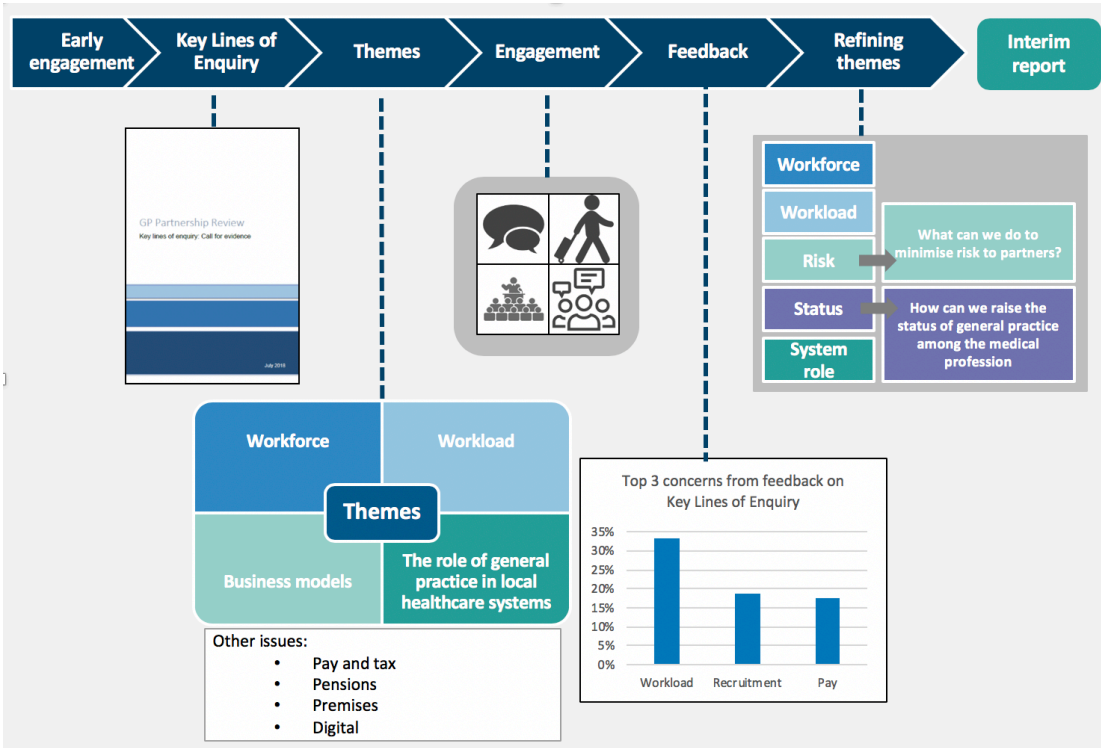


Figure 1: Timeline showing the working processes involved in producing this interim report

Interim report

This interim report sets out a summary of engagement activity to date, and the wide range of evidence and experiences which have been shared with the review. It then describes the developing thinking in relation to each theme in light of the evidence received and ongoing policy developments in these areas. The report also highlights some further overarching issues of relevance to the review, which were identified as important additional considerations: for example, digital and technology, and status and morale.

Related developments

The Partnership Review is not taking place in isolation. As highlighted in the Key Lines of Enquiry, a number of linked but independent pieces of work are currently underway, including: the Long Term Plan for the NHS, the GMS Contract negotations; the introduction of state-backed indemnity; a review of GP premises; and the ongoing implementation of the Next Steps on the NHS Five Year Forward View and the General Practice Forward View.

Long Term Plan

Following the Government's announcement of an additional £20bn for the NHS, NHS England is developing a Long Term Plan.[4] The support and development of general practice and primary care is critical in the development of the plan.

GMS Contract

Negotiations on the 2019/20 GMS contract are ongoing. NHS England has indicated that it wants to work with the GPC to reform the GMS Contract. The specific areas that have been identified for negotiations are the state-backed indemnity scheme, reform of the Quality and Outcome Framework (QoF) and the development of Primary Care Networks.

State-backed indemnity

The rising cost of medical indemnity has been cited to the review as a major reason for GPs leaving the profession prematurely, reducing the number of sessions they work, and not being prepared to undertake additional work. The Government is committed to introducing a state-backed indemnity scheme by April 2019.

GP premises review

The review heard that the burden of premises, both real and perceived, is not only putting potential partners off joining a practice, but can also be a reason for existing partners to leave partnership or even the profession.

In response to concerns about premises and estates, NHS England announced a review into General Practices Premises Policy. A Call for Solutions has recently concluded, and recommendations are due early 2019 at the latest.

NHS England's Five Year Forward View and General Practice Forward View

The General Practice Forward View and the Next Steps on the NHS Five Year Forward View described new models of care based around communities with general practice at the heart of them, focused on population health. The General Practice Forward View committed to investing a further £2.4 billion a year by 2020/21 in general practice services. NHS England have recently reported that they have achieved that level of funding to support general practice. While there has been progress on implementing policies set out in both documents, the review has heard about difficulties in accessing funding, and a need to have more of this invested recurrently to expand the workforce and support the delivery of care.

Our engagement process

The review team would like to thank all those who hosted the Chair and the team on visits, all those who have sent their thoughts and evidence to the review so far, the numerous Local Medical Committees (LMCs) for their support in spreading the word about the review, and who have hosted discussion sessions on behalf of the review.

Overview of our engagement process

Since June, the team has been travelling across the country to meet with partnerships and practices of all shapes and sizes, to hear from practice staff on the ground about the challenges, the solutions they have developed and their proposals for change. The team has seen over 20 practices, in a range of urban and rural settings, with practice list sizes from 7,000 to 360,000. Alongside this, the Chair has hosted a number of roundtable discussions facilitated by LMCs.

The review has received written evidence in response to the Key Lines of Enquiry from a range of parties (including GPs, partners, trainees and medical students, practice managers) and organisations from other industries, including accountancy, legal services and banking. The review has also established a stakeholder reference group who have met in person and virtually, to support the development of recommendations.

Areas visited

Areas visited
Birmingham
Devon
Kent
London
Nottingham
Sunderland
Humberside
Harrogate
Cheshire
Bristol
Taunton
Hampshire
Worksop

Figure 2: Areas visited through engagement on Key Lines of Enquiry

Evidence received

As of 7 September 2018, the review had received a total of 300 written responses to the Key Lines of Enquiry from a range of stakeholders (Figure 3). The feedback has ranged from moving personal accounts of the challenges faced by individual GPs, to detailed technical responses to questions posed in the Key Lines of Enquiry. The majority of responses were from individuals but responses were also received from practices, LMCs, the National Social Prescribing Student Champion Scheme and clinical commissioning groups (CCGs).

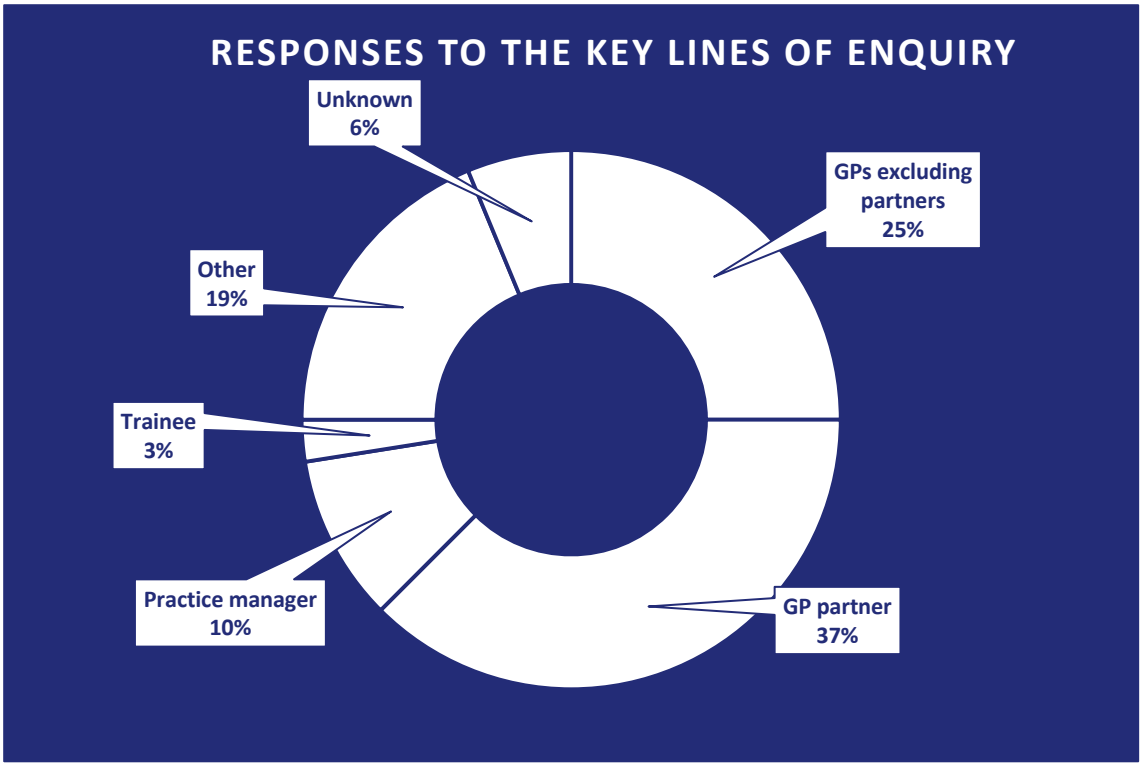


Figure 3: Chart showing responses to the Key Lines of Enquiry by role

Analysis of responses

A thematic analysis was conducted on the responses received, which included a qualitative review of the correspondence. These were also divided into two strands: concerns and proposed ideas for solutions. Following this, the key words were grouped into themes. Once key themes were identified and agreed for each strand, the relative weight and importance of themes in the responses could be quantified. The figures below describe the most common concerns and the top suggested solutions from all responses (Figure 4 and Figure 5).

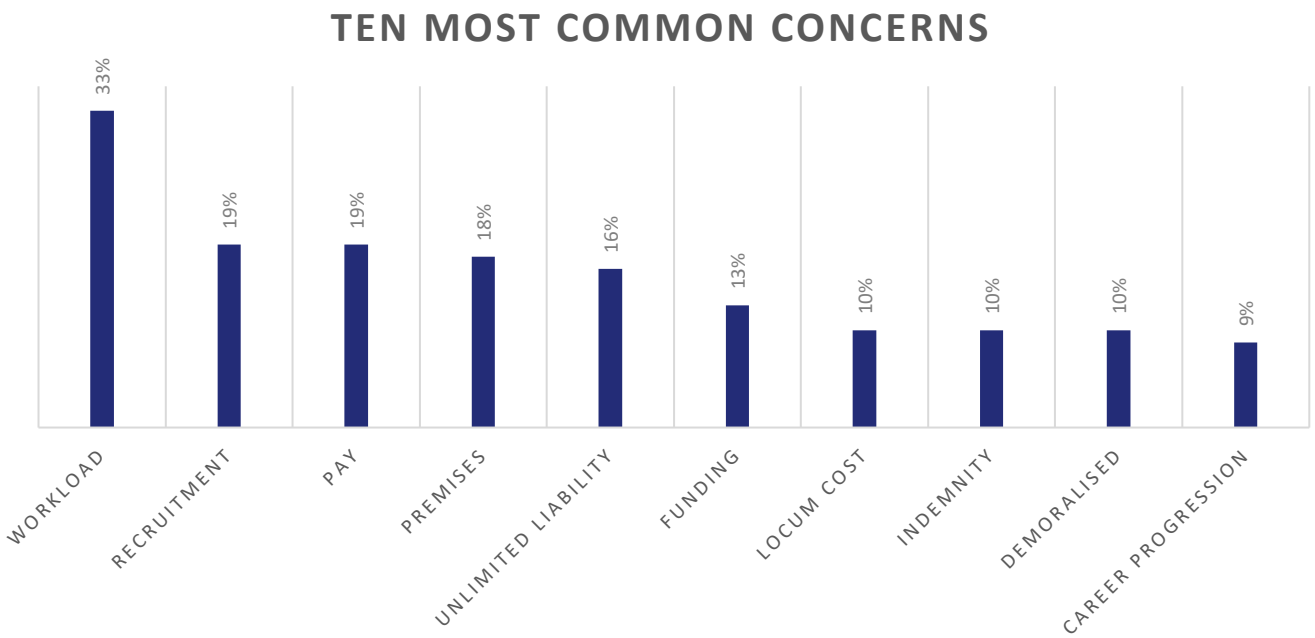


Figure 4: Graph showing ten most common concerns raised by respondents to the Key Lines of Enquiry

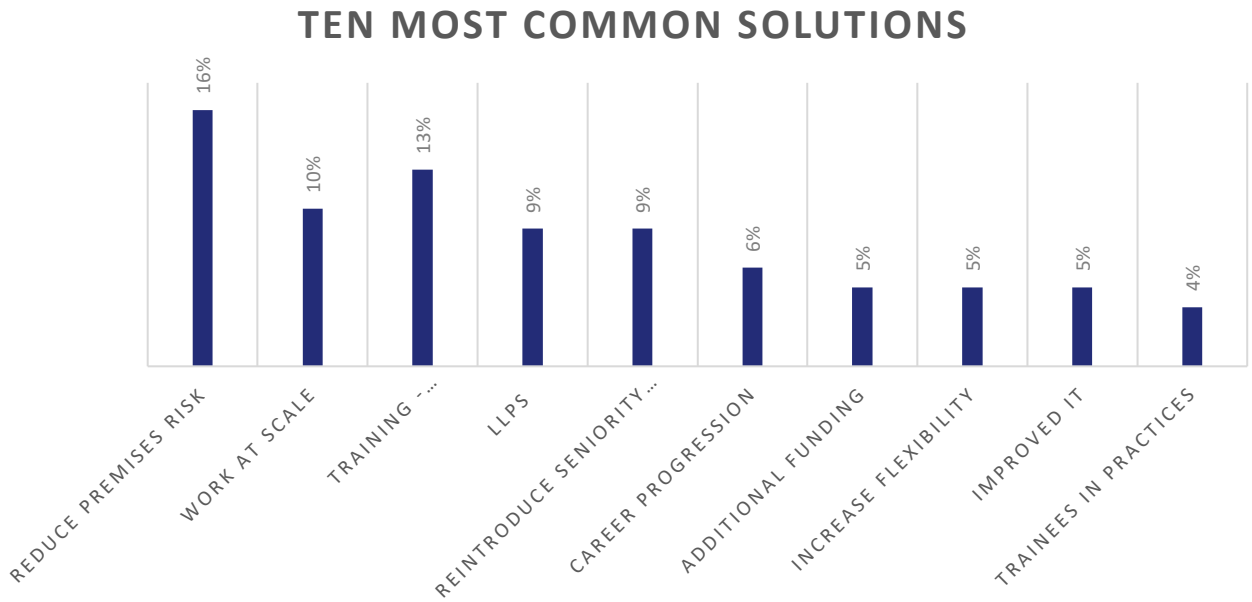


Figure 5: Graph showing ten most suggested solutions raised by respondents to the Key Lines of Enquiry

Next steps

The review will continue a programme of face-to-face engagement across the country following the publication of this interim report, as the Chair develops his final recommendations. Details of these events will be publicised in due course.

The review continues to welcome written evidence, particularly in light of the content of this report, and the emerging areas for further consideration and potential solutions.

The review also intends to focus particularly on engaging further with patient groups, professionals in social care and locum GPs.

The role of general practice in the local healthcare system

Background and key lines of enquiry

The Key Lines of Enquiry acknowledged the unique place that general practice has within the community, and asked how partnerships could play a more significant role within the local health system.

During our engagement, the review has witnessed increasing collaboration both between practices and also between practices and other parts of the system. Ways of working collaboratively and at scale are maturing across England and have many benefits for both patients and partnerships.

A recent progress update on the General Practice Forward View from NHS England states that 5000 practices are part of Primary Care Networks (PCNs)[5] but there is ongoing discussion to determine how these and similar structures can best be operationalised to address the needs of their local populations and support the partnership model as it exists in both larger and smaller practices.

‘It is our experience that encouraging groups of practices to work together across an area where they are all challenged, such as workforce, has helped enormously’

Respondent to Key Lines of Enquiry

Developing our thinking

Responses to the Key Lines of Enquiry suggested some level of fatigue with change in general practice and the health system architecture. One respondent wrote of having seen ‘several false dawns’, and there is undoubtedly a history of policy initiatives both promoting, and sometimes preventing, collaboration within local healthcare systems.

A number of areas have emerged from the engagement for further consideration at this stage in the review process.

- Partners as system leaders
- Working at scale
- Barriers to working closely with the local health system

Partners as system leaders

It is the view of the chair, drawing on responses to the Key Lines of Enquiry, that there is a clear case for partnerships working collaboratively to be the building blocks and leaders of the local healthcare system.

Practices are responsible for the vast majority of daily contacts with patients, providing a wide range of services and utilising and connecting with many more. The relationships GPs form with patients, and often with generations of patients, and the local insight that lodges in a practice's institutional memory are unrivalled by secondary care and community services.

Despite this, general practice, as a provider, does not routinely have a 'seat at the table' for system leadership discussions. For example, despite being members of CCGs, many practices feel that they do not have much influence over these organisations' strategic decisions. Additionally, many GPs told the review that they did not feel any sense of involvement or inclusion in their Sustainability and Transformation Partnerships (STPs), and felt that their STPs were too focused on hospital based care: that the majority of senior leaders were from acute trusts with little or no representation from general practice taking place.

The difficulty of synthesising the disparate viewpoints of numerous practices is a cause of the lack of GP perspective in these conversations. Working together, general practice could develop a shared view and with joint working across a network, which would be easier for organisations to engage with. LMCs and practices working at scale is a way to give a united voice for general practice. Further consideration needs to be given to exploring the potential for GPs, working in partnership, to take a system leadership role here.

Working at scale

Working at scale: the context[6]

Practices have been working together since the 1980s. Following the 1989 White Paper, Working for Patients[7] (Department of Health 1989), Medical Audit Advisory Groups were created, designed to bring practices together and facilitate district-wide care. During the 1990s, various initiatives developed out of the Fundholding Scheme, which involved practices purchasing and providing services across a given geographical area. Around the same time, Out of Hours Co-operatives came about as the result of increasing demand for out-of-hours services.

A change in government in 1997 resulted in the institution of Primary Care Groups that commissioned primary care and served more than one practice, with many covering a population between 50, 000 to 100, 000 people. These were GP-led commissioning bodies that later evolved into Primary Care Trusts, and, most recently, following the 2012 Health and Social Care Act, CCGs. Practice-Based Commissioning, the creation of Federations, and Primary Care Home have been recent attempts to encourage network-like agents. In 2014, the responsibility to commission primary care was delegated from NHS England to many CCGs.

Many practices are already working either as part of a network or closely with neighbouring practices. How they do this varies across sites.

It is clear from responses to the Key Lines of Enquiry for the review that practices are predominantly motivated by providing quality care to their patients and improving health outcomes. Working at scale will be able to support delivery of this ambition through providing:

- Care closer to home
- Joined-up knowledge between services through improved use and sharing of data, with the potential for reducing hospital referrals
- Increased access and patient choice

The General Practice Forward View and the Next Steps on the NHS Five Year Forward View described working at scale via new models of care focused on communities and population health, with general practice at the heart of these. There are many evolving models around the country which are supporting practices, providing new opportunities for GPs, and also providing more care closer to patients' homes using an expanded multi-disciplinary team. These groupings are typically geographically based, consisting of one or more practices working in partnership with community services and social care to work in a more integrated and sustainable way. They have a variety of names including

neighbourhoods, clusters, natural communities of care, primary care homes, and Primary Care Networks (PCNs).

The successes achieved by existing collaborations are perceived to be the result of following behaviours –

- sharing of skills and resource, both between practices and between general practice and other providers within the healthcare system
- working across larger geographical areas and larger patient lists
- innovation, and willingness for general practice settings to provide care traditionally provided in hospitals

Primary Care Networks

Primary Care Networks (PCN) are not merely GP Networks; they will involve health and social care professionals working together as a locally based, multi-disciplinary teams. PCNs have the potential to improve quality and improve efficiency. The PCN must support general practice in terms of workload, and expanding the workforce. It will then help with recruitment and retention, making general practices more resilient and a better place to work. PCNs also have the potential to be vehicles for the implementation of change at a scale, not only supporting general practice but also addressing much of the demand for hospital-based care. This blog explores the potential of a PCN to support general practice and primary care.

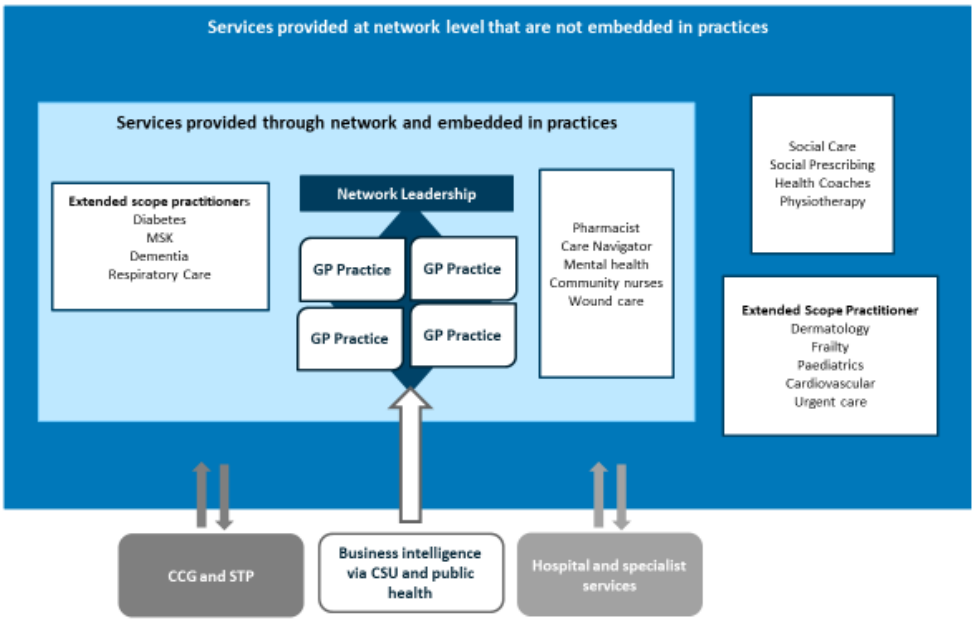


Figure 6: One possible model for a PCN and the services it could work with, based on examples and feedback shared with the review

The menu of service offers made by a PCN might be divided into:

- Services best offered at practice level. For example, a pharmacy team – working with GPs, community and hospital pharmacy to reduce polypharmacy, managing medication queries and supporting the management of long term conditions

- Extended scope practitioners, based either in or out of the practice, working in close partnership with the general practice team and network. For example, diabetes care consisting of extended scope GPs, trainees, specialist nurses and led by a specialist; creating and managing care plans using the patient's GP record, without the need for separate referrals

- Shared services and resources based outside of practices which can be accessed across the network. For example, health coaches or voluntary sector services. For staff this could improve access to training and support

Case study: Integrated Clinical Pharmacy teams – West Hampshire CCG

These teams were established in 2016 as part of the collaboration between the CCG and the Vanguard Pilot. The service was embedded in GP practices, with a focus on pharmacist-led clinical medication reviews for high risk patients, e.g. frail elderly, patients with multiple long-term conditions, care home residents, patients on multiple medications (starting with those on nine or more drugs), and those at high risk of admission. Key to this initiative is that the pharmacists are employed by the CCG and not the practice. They work for the practice, but not in isolation as the pharmacists work with their colleagues in other local practices and form a strong link with the community and hospital pharmacists. The aims of the initiative were to:

1. Support primary care workload

2. Improve patient experience and outcomes with medicines.

3. Deliver financial sustainability and reduce wasted medication.

Outcome measures have demonstrated these objectives have been met and have also demonstrated a return on investment of £2 for every £1 invested for all practices and £4 for every £1 in some larger practices. There has been a demonstrable saving of both GP and nurse time, many examples of improved quality and safety (especially with the focus on discharge medication) and patient benefits have been realised.

Case study: Citizens Advice in practices – Derbyshire

Advice is available in 98 practices acorss Derbyshire. This is a long-standing programme, originally commisioned by the NHSE and now by Derbyshire County Council. This is delivered by 4 Citizens Advice in partnership.

People are signposted or referred by GPs or health professionals in the practice. In some locations, the appointments are managed by reception staff within the GP practice, integrating this into the services offered by the GP practice. Popel who attend the GP surgery can also book appointments directly.

Perceived barriers to working closely with the local health system

Administrative and financial burdens

The key perceived barriers to the implementation of collaborative local healthcare systems for most practices, as shared with the review, seem to be related to finances and workload. Many respondents to the Key Lines of Enquiry were concerned by the prospect of coordinating scant resources across a wider patch.

> They often lump together things for convenience of CCGs/PH that […] are set in a way that is detrimental financially as the money doesn't follow the patient. The Practices/locality are also being left with the admin
>
> Respondent to Key Lines of Inquiry

However, the review has also heard and seen that there can be solutions to these challenges. Functions such as HR, and some administrative staff, could be employed centrally by a network, with a single point of access, staffed by shared receptionists. Support with legal and financial intelligence could also come from existing organisations, such as CCGs and Commissioning Support Units.

Continuity of care

Continuity of care is a priority for many patients and practices. Responses to the Key Lines of Enquiry revealed some concern around the potential anonymity of larger systems and the loss of continuity of care.

'The area of Bristol that I am a partner in a practice at has 4 small/medium sized practices and patient satisfaction is significantly higher in these small partnership models than the merged mega practices and those with 15K+ patients.'

Respondent to Key Lines of Enquiry

It is well-recognised that continuity of care not only improves outcomes but it also improves patient satisfaction and is valued by GPs and other members of the clinical team. One of the many perceived strengths of the partnership model is its local insight, and the relationships this allows with communities.

Some larger practices are creating ‘micro teams’ within their practices to address the issue of continuity of care. These teams would typically be responsible for 5-6,000 patients, consist of three to four GPs, practice nurses, and have administrative support. They would know their patients well, particularly those with most need, and deliver the continuity needed. This does not mean other members of the practice could not support the micro team; input could come from, for instance, a specialist in diabetes or chronic obstructive pulmonary disease (COPD) or through access to practice screening.

Next steps

The Chair will continue to input into the development of primary care networks, working alongside NHS England.

Workforce

Background and key lines of enquiry

In December 2016, the BMA published the results of a survey[8] which found that three in ten GP partners (31%) have been unable to fill GP vacancies in their practices (excluding locum cover) in the last 12 months. The number of practice nurses has remained fairly stable for a number of years - however, around a third of these staff are now over 55 years old.[9]

The latest data on the GP workforce shows that the number of GPs (excluding locums, FTE) has fallen by over 1,300 GPs in two years (between March 2016 and March 2018). This is also reflected in the number of GP partners (FTE), which has fallen by 1,796 (8%) over the same period - a reduction of 1,563 partners (headcount). In addition to this, a large proportion of the GP workforce is nearing retirement age. 19 CCGs currently have more than a third of their GPs over aged 55,[10] and the average age a GP first accesses their pension is 59,[11] - although, anecdotally, we know some GPs will take their pension and return to the workforce.

However, research from the Kings Fund[12] shows how the career intentions of trainees change over time, with a larger proportion looking to become partners 10 years after finishing training (37.15%) compared to 5 years and 1 year after finishing training (20.44% and 3.70% respectively). This aligns with feedback the review heard from trainees: that they were not ruling out partnership, but did not feel ready immediately after qualifying.

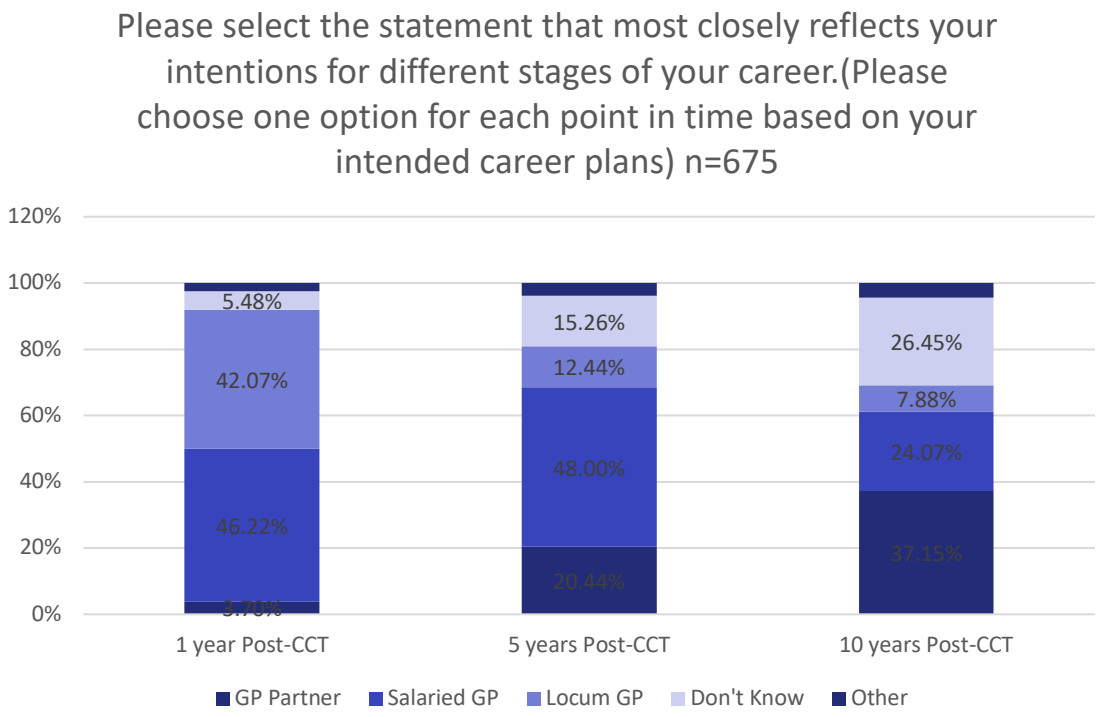


Figure 7: Graph showing data from research by the King's Fund pertaining to career intentions for GPs at different stages of their careers

The make-up of the workforce is also changing. The number of partners is falling as the number of locum GPs increases. This may be for a number of reasons. For example, the review has heard that some GPs believe the only way they can have a flexible role to fit around childcare commitments and maintain clearly defined working hours is as a locum GP.

General practice is, therefore, experiencing a growing workload whilst seeing a fall in the overall workforce numbers, and practices are struggling to encourage GPs into partnerships.

These issues are not new. In 2016, the General Practice Forward View[13] committed to an increase of 5,000 GPs, an increase in GP training places, support for GPs returning to practice, and an increase to the number of other health professionals working in general practice by at least 5,000 (including 1,500 more pharmacists, 3,000 more mental health therapists, 1,000 more physician associates). While it is taking time for these ambitions on GP recruitment to be realised, the wider workforce has expanded. At the end of March 2018 there had been an increase of 4,484 FTE working in general practice (excluding GPs) since September 2015 - within this, there was a 31% increase in FTE staff directly caring for patients, a 3% increase in FTE nurses and a 2% increase in admin/non clinical staff FTE.[14]

We are now seeing record number of doctors entering GP training, and the proportion of training places that are filled is also increasing.[15]

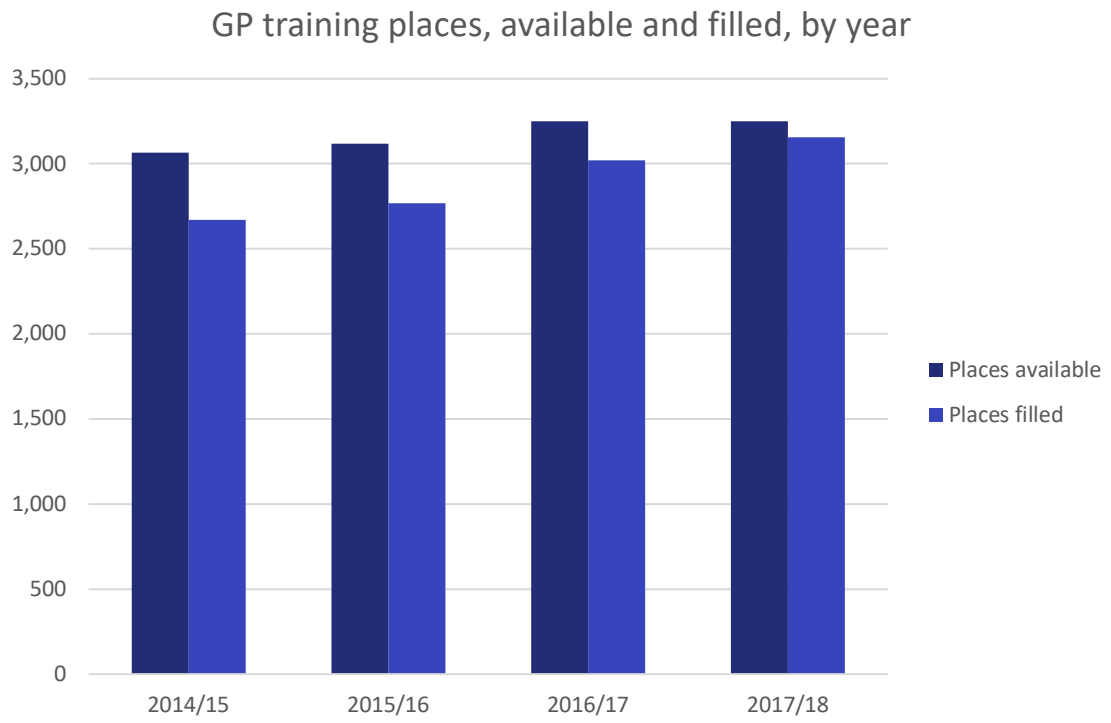


Figure 8: Graph showing number of GPs entering training by year

Developing our thinking

The Key Lines of Enquiry identified an interest in exploring the barriers and motivations for GPs considering partnership, and how introducing greater flexibility, improved work-life balance and portfolio working opportunities for partners could improve recruitment. The review also sought to look at opportunities to better recognise and support career progression throughout general practice and through partnerships.

Feedback received on supporting and developing the workforce has been grouped into four different areas.

- Expanding the workforce
- Training and development
- Working in different ways
- Incentivising entry into the substantive workforce

Expanding the workforce

For general practice to meet the increase in demand and demographic changes, the workforce must change and expand.

We know that one of the ways to expand the substantive GP workforce is to make general practice a better place to work, with the working day feeling manageable, unnecessary bureaucracy reduced, and GPs feeling valued. During the next stage of the review it will be important to consider how these challenges can be addressed.

Training and development

The review has received much feedback about training and development for GPs at all stages of their medical career. The interim report focusses on:

- Building confidence and skills
- Raising awareness of partnership among trainees and newly qualified GPs
- Training to prepare for partnership
- Training leaders for the future
- Career progression for partners
- Retaining expertise and experience

Building confidence and skills

Newly qualified GPs have told the review that they lack confidence in the future of general practice and do not have a clear vision of what the future might look like for general practice. They also see negative coverage in the media about general practice, which can make general practice seem daunting and unattractive, and they may have experienced first-hand the issues of rising workload and difficulties in recruitment and retention.

The review has heard that there is a perception from newly qualified GPs that a locum role provides more flexibility, a better work life balance and less risk than taking on a salaried role or partnership. However, working in this way can leave newly qualified GPs unsupported and vulnerable, and without the peer support that exists in GP practices or GP Locum Chambers.

It is at this career stage that newly qualified GPs might be looking to develop special interests, improve their knowledge and understanding of the wider health and care system,

and begin to consider taking on partnerships. It is also a time when GPs may have young families and so need particular flexibility and a good work-life balance.

We have heard that GPs are more likely to have a GMC referral in the first 5 years and the last 5 years of clinical practice. Newly qualified GPs are also more likely to access the NHS Practitioner Health Programme and NHS GP Health Service, where trainees make up 29% of the caseload, with GPs under 40 making up over 50% of the caseload.[16] Newly qualified GPs need to be better supported and should be offered roles that will encourage them to become part of the substantive workforce.

- The review is exploring the potential for creating new posts for newly qualified GPs. These would not be an extension of training, but would be a developmental role based in general practice. These roles should last for more than a year and offer a mixture of general practice, a chance to develop an interest in clinically relevant specialties and leadership and exposure to partnerships. There should also be the potential for some protected time for personal development, including mentorship. The roles could offer the opportunity to work in more than one practice not only providing an expansion of the existing workforce but also potentially allowing some cover to allow existing GPs to have some personal development time.

Raising awareness of partnership among trainees and newly qualified GPs

The review has heard that trainees have insufficent awareness and knowledge of the benefits of GP partnership and in some cases are basing decisions about whether to join a partnership on misinformation.

- The Chair has worked with Dr Nish Manek (Founder of Next Generation GP), to produce a "Myth Buster" addressing common issues raised by trainees, members of the RCGP First Five Committee and the GPC. The document covers subjects such as risk, tax implications, earnings, as well as the future of the partnership model.

Training to prepare for partnership

'General Practitioners have not always been given the right training or opportunities to complement their clinical skills'

Respondent to Key Lines of Enquiry

Feedback received from the Key Lines of Enquiry, practice visits and LMC discussions highlighted a current gap in GP training in relation to partnership. A GP partner has a dual role: that of an expert generalist clinician combined with that of a small business owner. Training is currently focused on the clinical aspects, which can leave newly qualified GPs without suitable training or knowledge about running a business. Any training in this area is often planned and arranged by the GP and in some cases undertaken in their own time. There is no central support for partnership training.

- The review recognises that the RCGP and BMA offer advice to doctors, but believe this needs to be complemented by more robust training. The review has received a number of suggestions as to how this could be achieved: for example a specific training module on running a business available to all GPs, or a targeted/shortened version of an MBA. Given the important role which non-GP partners can play in supporting the business of the partnership, this training should not be limited to GPs.

- The Chair of the review will be working with the RCGP, the BMA, NHS England and Higher Education England to develop this recommendation further.

Training leaders for the future

The unique role of the GP within the local community places GPs in a central role to lead and develop local health economies. The Chair has previously described his view of the potential for GPs to take on leadership roles across natural communities of care[17]. This could include GPs taking on leadership roles in wider community health based services.

Future GP leaders need to be equipped to take on a leadership role. The review has been impressed by the training offer from Next Generation GP.[18] As an organisation, Next Generation GP offers six-month programmes bringing together a supportive network of like-minded trainees and newly qualified GPs, providing a series of leadership and networking workshops. These programmes are being rolled out across the country and have been well attended and well-received; by August this year 500 GPs will have taken part.

'One of the absolute strengths of the programme is the access gained to really influential, wise, experienced leaders who haven't been shy about talking about weaknesses and downsides to pursuing such positions.'

Newly qualified GP, LMC discussions

Career progression for partners

The review received feedback from existing partners about the need for recognition, progression and development once GPs become partners.

- The Chair will be continue to work with the RCGP and GPC to consider how roles such as associate partners or non-equity partners, common in other professions who work in a partnership structure, could work in general practice.

Retaining talent and expertise

Repeated surveys show that the number of GPs leaving direct patient care is significant. The largest group of leavers is those over 50. Some of these will be at retirement age, but others will be taking early retirement. The review has heard a number of reasons for this, including workload and pension issues. As a result, general practice is losing expertise and experience from the workforce at a time when the profession is struggling.

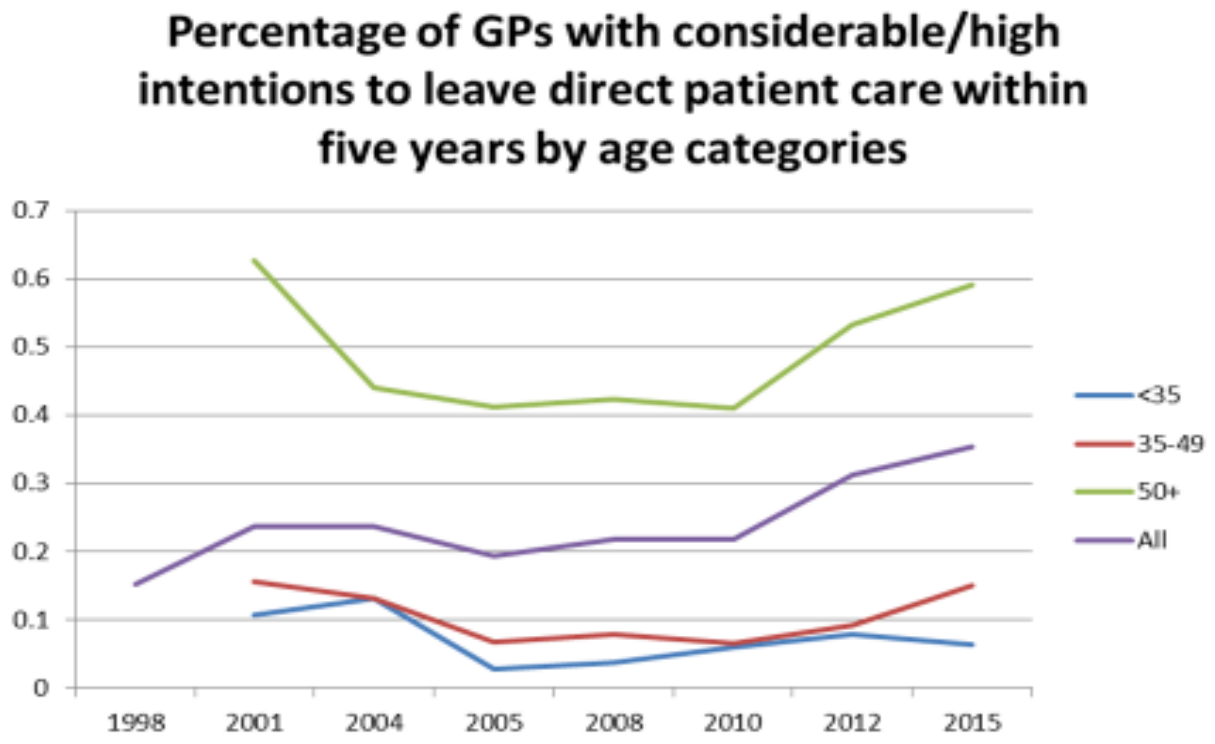


Figure 9: GPs intentions to leave direct patient care. [19] To note, this is a survey of a small proportion of GPs

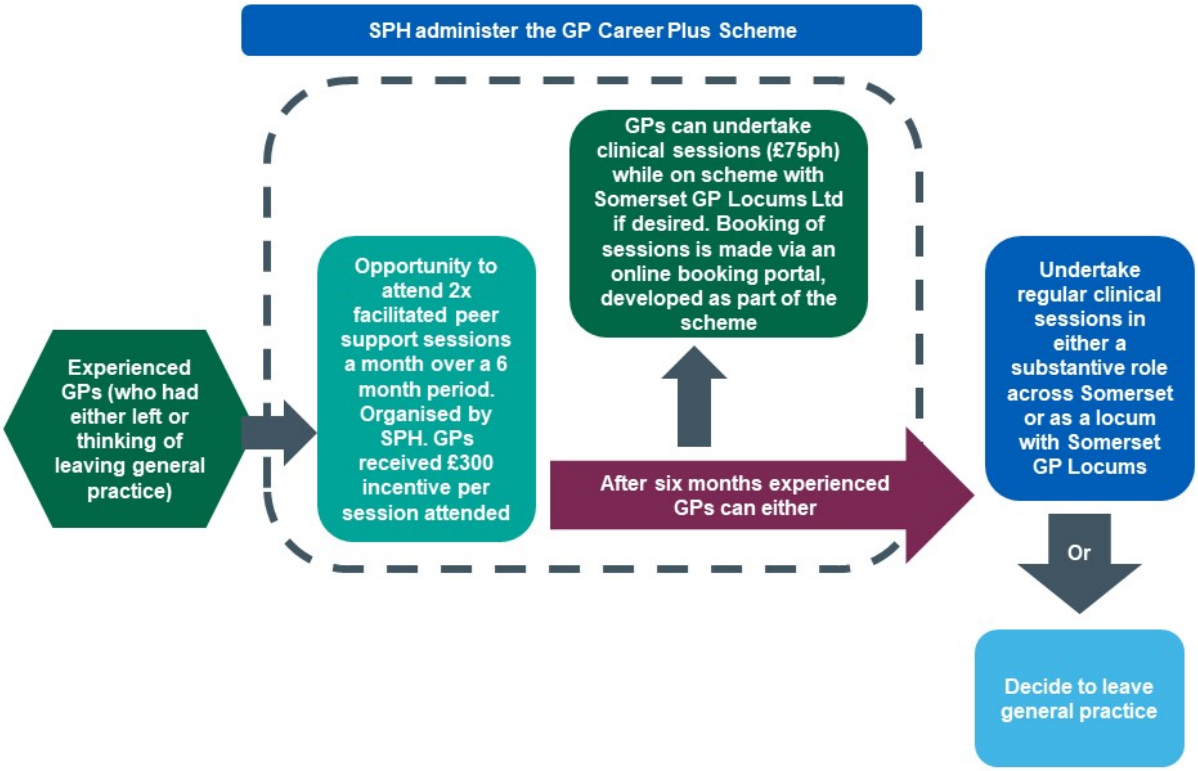
The review has heard that, as GPs reach the later part of their career, they often find they are seeing fewer people with simple, straight forward problems and see more of the older patients with complex multiple morbidities. They take on more clinical risk and develop skills to manage the intensity of working with this patient group.

- It is important to ensure that these skills are recognised, and that they are not lost as this group of GPs move towards retirement. One way of doing this may be through resourcing protected time whereby experienced GPs towards the end of their career undertake roles such as mentoring other GPs. There are also roles potentially linking with community-based services and organisations, including schools, local authorities, or primary care networks, which could all be beneficial to the community.

Case study: Facilitated peer support programme improves GP retention by reducing isolation and revitalising morale

GP Career Plus Scheme – Somerset Primary Healthcare Ltd. (SPH)

SPH, Somerset CCG and Somerset LMC have developed a scheme that provides six months of paid, facilitated peer support sessions (£300 for each session attended) to experienced GPs who are seriously thinking of leaving or who have recently left direct patient care. The result has been that nine GPs have been recruited onto the first cohort, with participants reporting how it has revitalised their enjoyment of and participation in general practice. Collectively these GPs now work 15 additional clinical sessions per week, compared to before the scheme.[20]



There are two GPs in the first cohort who had decided to leave general practice but who are now working happily as GP locums again and two have indicated they may want to become GP Partners again in due course.

The key to success has been inviting skilled and experienced GPs to share their experiences and contribute to discussion about all sorts of matters relating to general practice. The group has become an expert resource for ideas and proposals to be considered and developed, and this productivity is likely to be far more valuable in the long term than the modest service commitment members might otherwise have provided.

Working in different ways

GP workload is increasing and, over the last 20 years, the working day has got longer and more intense. GPs reported to the review that they were regularly working 12 to 14 hour days, with many rapid clinical decisions and complex assessments. This is not sustainable, and is contributing to the rising level of stress, burn out and wider mental health problems in general practice.

GPs that the review has spoken to talked about how ways of working are changing. They are looking for more variety in their careers, as well as having a better work-life balance, and wanting to be more in control of their day-to-day work. The review heard concerns that a more flexible way of working is not always supported by the partnership model and some partners. Working part time is more common than ten years ago, but the sessions worked are now often perceived to be insufficient to meet the work required. During visits, the review heard from GPs who reduced their working hours to protect themselves from burn out and stress, and so they could cope with the workload.

Feedback from stakeholders has shown a rise in GPs working more flexibly across a portfolio of career options, or looking to do so. Research from the Kings Fund[21] found that although trainees did not want to work full time in general practice, they are looking for portfolio careers taking on roles within the NHS providing direct patient care.

- The review is considering how to address these issues. To be able to achieve change, it is necessary to have sufficient workforce to meet the workload demands. The use of multi-diciplinary teams will be critical in freeing up GP time.

Incentivising entry into the substantive workforce

Locum doctors form an important part of the general practice workforce providing cover for sickness, parental leave and other absences. But demand has grown and locums now cover vacancies in the workforce. Latest workforce figures show the numbers of locums are increasing.[22] This could be for many reasons; the review has heard from GPs who view locuming as their only option for a manageable workload and to provide flexibility when working around family and other commitments. Some GPs have told the review they do not want to be a locum, but practices are not offering roles that are flexible and meet their needs. Individual needs will change over time and the course of a career, and therefore partnerships may need to think more long term to recruit and retain their workforce.

Case study: locuming

Dr Jane

Driven by my passion for GP education, over the last ten years I have also developed a career as a Portfolio GP with roles in GP education and mentoring: as Lead GP for our North Cumbria Sessional GP /First5 Group* (just reached 80 members this week), on my local RCGP Cumbria Faculty and Education Subcommittee, as a GP Mentor, and with Cumbria LMC. (First two are voluntary and unpaid roles). At the moment I am working as a freelance Locum GP again.

Although this is a positive choice, because this way of working so easily provides the flexibility I need right now, I would actually be keen to take on a Partnership role as the next stage in my GP career. Just not full time - and with enough flexibility in working patterns (ideally for me right now would be term time working) - so that I can balance work with my family responsibilities and continue to develop my Portfolio GP roles in GP education - both to sustain me and my enthusiasm for General Practice!

I feel it is very difficult right now for Partnerships to offer the flexibility GPs like me need - for example term time working, part-time working of 4 sessions a week or less, flexible job shares, or flexible working days, with variability in start and finish times.

In the view of the Chair, the important role that locums play in supporting general practice must be recognised. However if the number of partners continues to decrease and the number of locums continues to increase, the workforce will be unbalanced. The key to the future is to make general practice a better place to work by addressing these issues that we have identified throughout the review. There is no certainty that a salaried model would address all the issues.

Being valued is viewed as an important part of job satisfaction. The review has repeatedly heard from GPs that they no longer feel valued by the NHS or the Government. This needs to change.

- The review needs to consider further how we can support locums into permanent jobs, where this is appropriate. While some responses to the review suggested more punitive options, in the view of the Chair the way to do this is not by taking rights or benefits away from locums. Current and future models of general practice should address the barriers which currently exist to joining the salaried or partner workforce.

Next steps

The review has heard wide ranging views on how to ensure general practice is a workplace fit for the future. While increasing GP numbers is key, there also needs to be a focus on working in a way that better suits the workforce themselves and the new models of care and future structures that are emerging.

There needs to be an increase in substantive GP workforce in practices, alongside an expansion of the wider practice team, including pharmacists, MSK specialists, Mental Health Nurses, and Paramedics. The important role of the Practice Nurses needs to evolve for its potential to be realised. This should be considered as part of the development of the NHS's Long Term Plan.

In addition, the existing workforce can work more efficiently by recreating practice and locality-based teams, working together under a common leadership with shared caseloads and using the same clinical records. Community nursing teams need to become part of the expanded primary care team embedded in practices.

The review will continue to focus on the training and development offer, as well as how to incentivise entry into the permanent workforce.

Workload

Background and key lines of enquiry

Clinical and administrative workload has been rising for all staff across general practice. In the most recent GP Worklife Survey[23], GPs cited increasing workloads as the highest source of job related stress. This is also reflected in the 2018 RCGP survey, where less workload/reduced working hours was the top stated option that would make GPs who were unlikely to consider becoming a GP partner in the future change their minds.[24]

The rising workload can be partly attributed to an ageing population with increasingly complex conditions and multi-morbidities. We know that the demographic trends will continue: by 2035 over half the 65+ population will have 2 or more long term conditions.[25] However, alongside the changing population demographics, workforce issues and increasing bureaucracy are also compounding the issues.

The need to recruit and retain more GPs is clear, but there are also opportunities to embed a wider workforce in general practice. Innovative ways of working, including making best use of digital enablers, could support general practices to increase capacity and resilience in managing the needs of the population.[26]

The Key Lines of Enquiry for the review was particularly interested to explore the views of partners, salaried GPs and other practice staff on the areas of greatest burden (both clinical and administrative); to investigate any innovative solutions which partnerships and practices have deployed to reduce workload pressures and stress, and to consider how to best share learning from what has worked well. The work that has been undertaken by the GPC and the RCGP on reducing workload has informed the review.

Developing our thinking

Almost all of the GPs and practice staff who the review has spoken to were clear that workload has been rising. For some, this workload is verging on unmanageable, and some even felt it may be putting patients at risk. While there are existing strategies in place that aim to help with managing workload, as set out in NHS England's 10 High Impact Actions and Time for Care programme[27], there is more that can be done to support partnerships.

Part of the increase in workload is a direct result of an ageing population who have more long term conditions. GPs have consistently told us that they are managing more people with more complex health and social care needs. As a result, consultations are longer with greater intensity, and the administrative work associated with consultations of this type is far greater.

Based on the evidence and feedback received from stakeholder engagement, this section of the report focusses on six areas:

- Developing a better understanding of workload and the impact of regulatory change
- Simplifying access to funding and support services
- Identifying administrative tasks that do not need to be completed by a GP
- Sharing learning from different models of practice
- Managing the interface with secondary care
- Rectifying issues with national support services

Developing a better understanding of workload and the impact of regulatory change

Through the review's engagement with practices, it became clear that there is not a good overall understanding of the administrative burden faced by practices and how it is changing. The impact of changes to regulation are often not evaluated and, apart from the evaluation of NHS England's 10 High Impact Actions[28] and the GP Worklife Survey[29], there is little evaluation of the administrative burden on practices.

The RCGP Research Surveillance Centre is currently building a national NHS general practice 'workload observatory', aiming to provide a picture of the workload and complexity of cases increasingly seen in general practice. The ambition is that data will start to become available later this year.

- The review recognises the potential benefits of this data collection and would encourage all practices to contribute to the data set. This data should also be used to monitor and evaluate changes in regulation and other initiatives, such as the implementation of compulsory electronic referrals.
- As part of the review there will be consideration of how a strategy for the effective use of workload data and feedback should be developed, to help practices plan workload in the short and long-term.

Simplifying access to funding and support services

The General Practice Forward View set out different systems to support GPs, including support for staff training and development, and sustainability and transformation. This was

supported by the profession. However, the review has received feedback on the difficulties some practices have had in gaining access to different funding streams and support services already available.

This is reflected in the latest wave of the RCGP tracking survey[30] which showed that 18% of GPs stated that they did not apply for funding to improve or expand their practices despite requiring it, and that 5% stopped the application process due to complexity. This is not acceptable. Processes should not deter applicants and should not prevent funding reaching front line organisations, where it is most needed.

- The Chair has asked for an NHS England commitment to ensure that how GPs and practices access future funding is kept as simple as possible.

Identifying administrative tasks that do not need to be completed by a GP

Whilst this issue is not specific to the Partnership Review, the review received feedback on tasks that GPs are required currently to do, that need not be limited to GPs. GPs are faced with an increasing number of requests to provide evidence, advice and information to support a variety of situations, including applications for benefits and legal aid, wellbeing, lifestyle and travel advice, and discussions around decisions about plans at the end of life.

One area that has been drawn to the attention of the review is signing fit notes. Hospital nurses can sign fit notes as well as consultants, but only for the time a person spends in hospital. In general practice, only a GP can sign a fit note. With the development of multi-professional teams, increasingly patients may not be seen by a GP. If, for example, a nurse practitioner or physiotherapist is directly managing the patient, healthcare professionals still need to arrange for a GP to issue the fit note. DHSC is currently working with the Department of Work and Pensions to introduce provisions which will allow signing of fit notes by other healthcare professionals.

There may be other areas where a similar approach could be taken. The review is working to assess whether qualified and appropriate, staff may be able to provide the information required in other circumstances and whether there are digital solutions that could be employed.

Sharing learning from different models of practice

GPs are innovators and, through the engagement process, the review has heard examples of different models and ways of working that are making a real difference for GPs, helping to reduce and better manage their workload. However, there is a need to get better at sharing experiences and learning from our successes and failures.

Managing the interface with secondary care

The interface between primary and secondary care has long been an area at risk of high levels of bureaucracy and miscommunication. Throughout the engagement process, the review heard about unnecessary re-referrals between secondary and primary care. The introduction of the NHS Standard Contract changes in 2016/17 and 2017/18 were expected to help the workload in general practice. However, some practices have reported that they have seen some change, but not to the extent expected.

Rectifying issues with national support services

NHS Property Services

The review has received numerous comments about NHS Property Services (NHSPS) as lease holders, and the administration of service charges for properties.

- The review will continue to work closely with the DHSC, NHS England and NHSPS to address these issues.

As noted in the introduction to this report, NHS England is currently conducting a review of GP Premises, with the Partnership Review feeding into this work.

- The Chair of the review has written to NHS England setting out concerns shared by GPs and others with the review, and views on possible solutions.

Administration of NHS pensions

The review heard from partners and practice managers about frustrations with errors in the collection of pension payments for GPs. This is either the wrong amount for individuals, or practices have money deducted for months after a GP has left the practice or come out of the pension scheme. In addition, GPs and Practice Managers report they are no longer able to speak to an individual and communication can only be made via email. The review has heard from some Practice Managers who have thought they had resolved the problems, only to find in subsequent months that the correction had not addressed the problem and there were still errors.

- The Chair has written to NHS England setting out these concerns.

Appointment length

The review received feedback about appointment length. Whilst it is clear that this is not an issue specific to partnership, flexibility in appointment length can have an impact on workload. A ten-minute appointment is not a contractual requirement, however the reality

is that longer appointments will result in a reduced number of available appointments offered or the individual has to work longer hours.

- The Chair will work with DHSC, NHS England, the RCGP and the GPC to consider how we can best support practices in bringing in changes to appointment length, where this is appropriate, to support different ways of working.

Next steps

The review heard much about workload and the pressure that GPs and partners are facing, however there were also example of practices that had successfully reduced workload to manageable levels. Sharing learning is important and that needs to improve - general practice is a place of innovation.

- An expansion of the primary care workforce, ensuring they are working with or for practices to ensure the sustainability and development of general practice
- Increase the number of GPs working in general practice by developing the GP workforce, and expand the General Practice Forward View's 250 GP Fellows to 1,000 newly qualified GPs working in a GP Preceptorship role
- Identify technologies that can save clinical time, empower and improve care for patients
- All hospitals should have a single point of contact for hospital related patient queries
- There needs to be a commitment to reduce the unnecessary administrative burden faced by practices, with evidence of progess made
- The ongoing issues that relate to the errors in payment to practices, and amounts taken from practices for pensions, need to be resolved in an agreed timeframe
- The issues with NHSPS and leases and service charges need to be resolved as soon as possible

Business models in general practice

Background and key lines of enquiry

Partnerships balance autonomy and the freedom to innovate with the need for accountability for the needs of the local population. As partners, GPs have a direct role in running their business, and are able to adapt services quickly to meet the needs of their local population and community.

The partnership model is inherently flexible. Partnerships in general practice can range from a small practice with two partners; to a large partnership; to a super partnership serving a population of 50,000 with over 30 partners; to a large number of practices joining together to form a single partnership with over 400,000 patients (such as Our Health Partnership, based in Birmingham). Traditionally, partners in practices have been GPs, but more recently Practice Managers, Practice Nurses and Pharmacists have been taking on these roles. Partnerships can also mean partnering with another organisation, from a wider set of system partners, to deliver innovative business models. Specialist university practices, large integrated practices in hubs, and single-handed traditional practices are all partnerships.

During our visits to different parts of the country we looked at different models of partnership and the vast majority were the traditional model of general practice.

We looked at models in which a practice had gone into partnership with a hospital; for example in Tiverton in Devon, where Castle Place Practice has gone into partnership with the Royal Devon and Exeter Hospital. The practice has 15,000 patients which is about half the population of Tiverton. The GPs leading the practice believe this will not only allow them to develop services for their patients but will provide stability for the practice and opportunities for the future. This type of partnership can work well where a hospital truly understands the strengths of general practice, and seeks to develop services and invest in the community. The culture and strategy of the practice and the hospital are aligned, although this is not typical from what we have witnessed travelling to various parts of the country.

There are risks associated with the current partnership model, some of which are similar to those faced by other small to medium enterprises, and others specific to general practice. There is a concern that, on balance, the risks of becoming a partner may now be perceived to outweigh the benefits which, combined with uncertainty about the overall future of general practice, has led to fewer newly qualified GPs wanting to become partners. For example, 53% respondents to an RCGP survey of GPs said they thought it was not currently financially viable to run a general practice.[31]

The Key Lines of Enquiry for the review also identified that newly qualified GPs may not feel equipped with the business and management skills required to run a modern partnership. This has been considered as part of the Workforce chapter earlier in this report.

Pay and pensions

Pay was identified by GPs as an issue both during the enagement, by respondents to the Key Lines of Enquiry and in a recent RCGP survey[32]. The survey found that, for GPs who responded to say they were unlikely to consider becoming a GP partner in the future, 'better pay' was the second most cited reason (after 'a reduction in workload') that could lead them to change their mind.

The review also heard that the pay differential between a partner and a salaried GP is falling in some practices, and the differential does not compensate for the additional responsibility, risk and workload carried by partners.

The level of income that GP partners receive varies considerably from practice to practice and those practices where the level of partner income is close to salaried GP earnings find it difficult to recruit. However, in some areas even higher earning practices are facing exactly the same issues with recruitment and retention as the lower earning practices.

The review also heard from GPs that pensions are an issue for older GPs, with the changes to the annual and lifetime allowances making it less attractive to remain as a GP at a time of excessive workload. As a result, many GPs are opting to retire at an earlier age than would be expected.

Developing our thinking

Based on emerging findings, the review is exploring:

- Limiting personal risk
- The potential for general practice to operate via other business models
- The involvement of different professions in partnerships.

One important distinction between GP Partners and most other partnerships is that partnerships who hold a GMS or PMS contract are restricted in terms of the sale of goodwill. The review has not considered the sale of goodwill at this stage. Further information about this issue is available in the 'Myth Busters' document.

Limiting personal risk

Respondents to the Key Lines of Enquiry highlighted real concern about the personal financial risks of being a partner in an unlimited liability partnership. However, there was ambiguity about the best way to address these risks, with some perceiving the risks to grow as the size of partnerships grow, and others seeing larger partnerships as 'sharing' the risk between more partners and reducing the likelihood that one person becomes 'the last partner standing'.

Where working with another organisation does reduce risk, the trade-off may be with ensuring total autonomy, and the extent to which this is attractive will vary between partnerships.

The review has also heard that unlimited liability can act as a barrier to practices merging. Through an unlimited liability partnership, all partners are equally responsible for the entire debts of the business.

There are three main areas of risk which respondents identified:

- Premises
- Medical indemnity and vicarious liability
- Staffing

Premises

Issues concerning premises and estates were frequently raised by the GPs engaging with the review. GPs and other practice staff set out a range of issues relating to premises, for example:

- Partners being liable for the remaining years of a lease if a practice has to hand back its contract
- New partners being less willing to commit to a 20 to 25 year lease without adequate protection. For some, buying into a mortgage is a disincentive to joining the partnership
- Lack of transparency about the apportionment of costs where premises are owned and managed by NHS Property Services and Community Health Partnerships.

Running separately but concurrently to this review, NHS England and DHSC, with input from GPC and RCGP as key stakeholders, are currently undertaking a review of General Practice Premises Policy, which is looking at whether or not the system is fit

for purpose, both now and in the future. NHS England has recently undertaken an open Call for Solutions, which was the process through which all interested parties had the opportunity to submit proposals for how general practice estate could be best supported in future. A number of issues about how current policy is impacting on GPs and the system were raised during the Call for Solutions process, many of which align with those heard as part of the GP Partnership review. These include:

- Actual and perceived risk associated with each ownership model, including those issues raised above such as 'last partner standing' scenarios for both owned and leased practices
- How to address sub-optimal utilisation of estate, including through better enabling of mixed use of estate and shared ownership
- How barriers and administrative burden presented by the Premises Costs Directions could be reduced
- How primary care can be supported in strategic estates planning, transformation and the bids process for capital allocations

The General Practice Premises Policy Review is exploring a scope of emerging solutions, to understand how these could address the issues currently impacting on GPs and the system. These may range from where solutions already exist in the system but need standardising or expanding, such as assignment clauses in leases, to considering how pressures on GP partners could be reduced through promoting the separation of the partnership model and premises ownership as two distinct entities. The General Practice Premises Policy Review will produce a set of recommendations, but what is clear from the range of issues raised is that there will not be a one-size fits all model, and that general practice estate is likely to continue to consist of a plurality of ownership models.

- The Chair has written to NHS England setting out the concerns shared with him and the partnership review in relation to GP premises, and possible solutions. The review will continue to work closely with the GP Premises Policy Review team at NHS England.

Medical indemnity and vicarious liability

Issues around indemnity and liability were also highlighted to the review as significant concerns about risk.

Vicarious liability refers to a situation where someone (in this case a partner) is held responsible for the actions or omissions of another person; this may be a member of

practice staff. Where partners are part of an unlimited liability partnership, they may be personally liable for costs.

As noted in the introduction to this report, the Secretary of State for Health and Social Care has previously announced a state-backed indemnity scheme for general practice, to come into force in April 2019. Full details of the scheme have yet to be published.

- The review will continue to work closely with DHSC to provide input to support this important commitment, and to ensure the feedback we have received through the Partnership Review is reflected.

Staffing

The third area of risk that was raised was in relation to employment tribunals, staff redundancy costs, and other HR-related issues in situations in which practices hand back contracts and staff cannot be transferred to other practices. These costs may be significant and form another dissuasion for otherwise-potential partners.

Alternative business models

One way of limiting personal risk could be through the use of a different business model that limits liability. The review surveyed the reference group set up to provide support to the review, asking what other business models should be considered. A number of different business models were suggested, most commonly including:

- Limited Liability Partnerships (LLPs)
- Employee-ownership
- Community interest companies, social enterprises and cooperatives

Under current legislation, the group of people able to hold a GMS contract is limited to individual general medical practitioners or partnerships where at least one partner is a GP. Other partners may be, for example, NHS employees, healthcare professionals, or primary medical services employees. A company limited by shares may also hold a GMS contract, as long as at least one share in the company is legally and beneficially owned by a GP. Therefore, any change to who can hold a GMS contract is subject to changing primary legislation.

The review has preliminarily engaged with the legal and financial services sectors, to better understand their experiences of partnership. While LLPs have some merits, it is unclear if they would reduce the risk for GPs without adding additional burdens. For example, while LLPs could remove some individual risk, the review has heard that

personal guarantees may still be required by lenders for mortgages. Similarly, where practices are leasing property, a landlord may be reluctant to directly move the lease across to an LLP as it may be seen as higher risk.

However, this does not mean that GPs cannot operate as LLPs or via other business models, as an LLP can already hold an Alternative Provider Medical Services Contract (APMS). Based on responses to the review, the majority of GPs would not appear to wish to move from a GMS contract to an APMS contract.

- The review will continue to consider the potential benefits and continued risks of different models.

Different professions as partners

The review has heard from a number of practices in which one of the partners is the practice manager, a practice nurse or a pharmacist. These different ways of working can offer stability for partnerships, and can bring a different and valuable skill set to a partnership.

- The review will further consider the support that can be provided to practices considering working in this way, and how learning can be shared.

Next steps

The risks associated with the partnership model can be reduced and this will make the partnership model more attractive, not only encouraging the younger GPs to join but also retaining some of the older experienced GPs.

The identified risks could be reduced by:

- Premises

Where premises are fit for purpose, negotiate an 'assignment clause' which would mean that practices are not left in the position of potentially being liable for the full term of the lease if the practice contract ceases.

More information needs to be made available about the ways practice mortgages could be held to mitigate the risk of the last person standing.

These issues and more will be addressed in the Premises Review.

- Medical indemnity

This is a major issue, not only with the rising costs but also for the disproportionate amount that is paid by GPs who work less than full time. A state backed indemnity scheme that covers all clinical staff who work in practices and Primary Care Networks is essential.

Addressing these two major risks will make the partnership model of general practice more attractive.

The review will continue to consider ways of limiting personal risk to partners, whether this is through the business model they work within or changes to how GP premises are managed. The Chair will continue to work closely with NHS England's review of GP premises. There is also further work to be done to support shared learning across different business models.

Overarching and emerging issues

Background and key lines of enquiry

Since we published our Key Lines of Enquiry, and throughout the review's engagement to date, there have also been a number of themes and issues which have either emerged as particularly relevant to multiple areas of our thinking, or as requiring more detailed discussion. The remainder of this chapter highlights some of these overarching and emerging issues which the review will consider further, as final recommendations are developed.

The previous sections of this interim report have described the evidence the review has received, and the development of our thinking as divided into four key themes. Of course, all of these areas also interrelate and overlap – for example, we cannot effectively consider the impact of rising workloads unless we also consider the changing workforce, and the organisations and systems within which they work.

Developing our thinking

There are two main overarching issues which have emerged to date:

- Digital
- Status and morale

Digital

In our Key Lines of Enquiry, digital technology was identified as a key enabler for supporting the workload of general practice and partnerships, but recognised that there was more to do to identify and understand the opportunities, and what support GPs and others working in primary care may need to make best use of the data and technology available.

While our thinking in this area is still developing, the review has initially identified three important user groups. It will be particularly important to consider what the needs of these groups are, and how digital technology and data could effectively support them:

- Patients
- Practices
- Wider health and care system

Patients

There are a range of opportunities to support patients to engage with practices through online methods, including booking appointments, ordering prescriptions and receiving results.

All patients should also be supported to access self-care and self-management apps to empower them to manage their own health and well-being. This could include patients owning and managing access to their own health and care records.

There is also a role for new ways of consulting with patients using digital technology, including video or phone consultations. There is the opportunity here to support both patients and staff - providing personalisation and choice for the former group and flexibility for the latter. However there is a risk that by increasing accessibility the workload will increase and rather than resolve many of the issues, it will only compound them. This clearly needs to be avoided.

Practices

Emerging options for supporting digital patient contacts, including video consulting and video conferencing, could support multi-diciplinary team working and care planning. These tools could also support greater flexibility for remote and home working.

As has already been set out in the chapter on Workload, it is true that GPs play a unique role in co-ordinating care for their patients. However, there may also be opportunities to reduce the weight of this responsibility and share it with other appropriate professionals. Reducing this burden could involve the use of a single technological solution to support the sharing of information and providing evidence and advice.

It is vital that practices are able to work with a common health record, fully interoperable with other parts of the system, in order to enable better patient care and support staff working across traditional practice or organisational boundaries. There are also opportunities to automate standard measurements (such as blood pressure, height and weight) and integrate these with clinical records.

System

Similarly, for the wider health and care system, fully interoperable and accessible patient records are essential. These should be supported by common data sets and a commitment to enabling greater patient ownership and access to their own data.

Self-care and self-management approaches, already being deployed in secondary care and specialist clinics, should be accessible to those whose care is being managed in

general practice, networks or other community settings. There is potential for a greater use of technology to streamline the management of long term conditions and care needs across the wider system.

Digital technology and better data sharing may be able to support emerging examples of wider care and support across a local health system, such as the expansion of social prescribing models.

There may be hardware and facilities requirements to enable some of these opportunities, such as the need for faster internet connections, universal WiFi across buildings, and appropriate printing and scanning facilities.

Status and morale

Status and morale in the profession

The review has received clear feedback from GPs and trainees that the morale within the profession is affecting recruitment. The review has also heard that the negative messaging that students are receiving about general practice throughout medical training, and the status of general practice in relation to other specialisms, are issues affecting both the current and future workforce. The report Destination GP from the RCGP and the report By choice - not by chance from Health Education England and the Medical Schools Council both support the feedback we have received.

'Students said that they have received advice (especially from retiring partners) not to become a partner as it is too stressful and not worth it'

GP trainees

During the review's engagement visits, the Chair has spoken with many GP Trainees and newly qualified GPs, as well as receiving feedback on the Key Lines of Enquiry from medical students and GP trainees about their concerns. These are broadly two-fold: the low morale of existing partners, and a perception that general practice may not be as rewarding a career as other specialties. The review has been repeatedly told that the negative comments staff and trainees have heard about general practice as medical

students have continued during their early careers in hospitals, and that most of these comments come from consultants.

Trainees cannot be continuously bombarded with descriptions of how difficult and unrewarding partnership is and be expected to want to take on partnerships. The profession has a responsibility, as well as the Government and NHS England, to make trainees aware of the benefits and opportunities of general practice and the partnership model. To recruit and retain newly qualified GPs, the profession must be able to articulate the positive future ahead of them - a varied and fulfilling career in general practice.

- The NHS Long Term Plan needs to set out a positive future of primary care, and more specifically general practice, with support from Government and national NHS bodies.

Parity with hospital doctors

One area GPs felt might support the morale of the profession is by improving the way general practice is thought of as a career in relation to other medical specialties. The issue of parity has been described in terms of workload and the continued differential in pay. There are two ways that have been suggested to the review:

- Consultants in general practice
- General practice as a speciality

Consultants in general practice

The Hospital Consultant and the GP have very different roles but should be considered as a spectrum of equals. General practice does not require fewer skills than being a doctor in a secondary care setting. GPs are specialist generalists, in the same way there are specialists in cardiology or pediatrics. While specialists can narrow down the area of medicine they practise, GPs need to know far more about a wide range of clinical conditions, from gynaecology to musculoskeletal problems, to organise prevention for a registered population (for example, vaccination and immunisation), and manage many long-term conditions.

Repeated surveys of the population show that doctors are ranked as the profession that the public most trust, and when divided into professional groups GPs are the most trusted. Many of us will have heard patients describe 'their GP'. The title of General Practitioner or GP is a strong brand which may be diluted by a change in title. However, it is important to feel valued, and to be seen and treated as an equal to Consultants. This could be achieved by a change in name, although it is an area of ongoing debate.

General practice as a speciality

The GMC in the UK holds two lists, one for generalists (GPs) and one for specialists (hospital doctors). This means that general practice in the UK is not formally recognised as a specialty, in contrast to virtually every country in Europe. The GPC and the RCGP have been campaigning for some time to ask the GMC to recognise general practice as a specialty, however this requires legislative change.

- The Chair of the Partnership Review has written to the GMC during the course of our engagement to date, requesting that general practice be recognised as a specialty, to add further support to this debate.

Next steps

In all of these areas the review will continue to further consider the challenges and opportunities as final recommendations are developed. The review would particularly welcome any further evidence of innovative best practice in relation to digital technology and data, to hear what is already making a difference to practices and patients, and supporting partnerships in general practice.

How to Contact Us

The review continues to welcome contributions from any interested party as the final report and recommendations for action are developed. You can email the Chair and the review team at: GPPartnershipReview@dh.gsi.gov.uk

For regular progress updates, the Chair will be blogging at key points throughout the review – please see https://www.wessexlmcs.com/gppartnershipreview

There will be a number of engagement events through the Autumn to discuss the emerging recommendations. Details will be publicised through Local Medical Committees and our partners to the review (RCGP, GPC, DHSC, NHS England).

Follow us on Twitter @gppartnershipr1

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32 RCGP (2018) A survey of English GPs on the General Practice Forward View strategy. Fieldwork was undertaken by ComRes, February 9th – 19th March 2018. 282 said they were unlikely to become a partner. 28% stated reduced workload, 24% stated better pay. 514 GPs answered this question overall. Full survey data available at: http://www.comresglobal.com/polls/royal-college-of-general-practitioners-membership-tracking-survey/