

GP Partnership Review

Key lines of enquiry: Call for evidence

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GP Partnership Review

Key lines of enquiry: call for evidence

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Foreword by Dr Nigel Watson, Chair of the Review

In May this year Jeremy Hunt, Secretary of State for Health and Social Care, asked me to Chair a review of the partnership model of general practice. The review will examine the challenges facing the partnership model and consider how best to reinvigorate and equip it to help lead the transformation of general practice for the future. It is an honour and privilege to take on this role; however I do not underestimate the enormity of the task ahead.



I have been a partner in a GP practice for over 30 years and an LMC Chairman and Chief Executive for over 20 years. I understand the daily challenge that GPs and their staff face and have experience of the changing fortunes of GP partnerships.

Our role as GP partners is unique, we are highly skilled consultants in primary care and we are business men and women. It is my view that this dual role is a key driver in the success of the partnership model, alongside our ability to innovate and to deliver rapid change for our patients and local population.

I strongly believe that the partnership model of general practice has not reached the end of the road. It predates the NHS and has evolved to support changing population needs, and will do so in the future. However, it is important to recognise that this model is not the only way to deliver care. We are learning from new models of care, and federations, super partnerships and other models all have a place in primary care.

I will be working closely with the Department of Health and Social Care, NHS England, the Royal College of General Practitioners (RCGP) and the General Practitioners Committee (GPC) of the BMA to develop recommendations to address the challenges we face.

Further details of how you can get involved are set out at the end of the document. I would encourage you to consider the key lines of enquiry and submit your views, or to come and meet us at one of our LMC events. It's our future; and it is up to us to shape it.

A handwritten signature in blue ink, appearing to read 'Nigel Watson', with a stylized flourish at the end.

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

Introduction

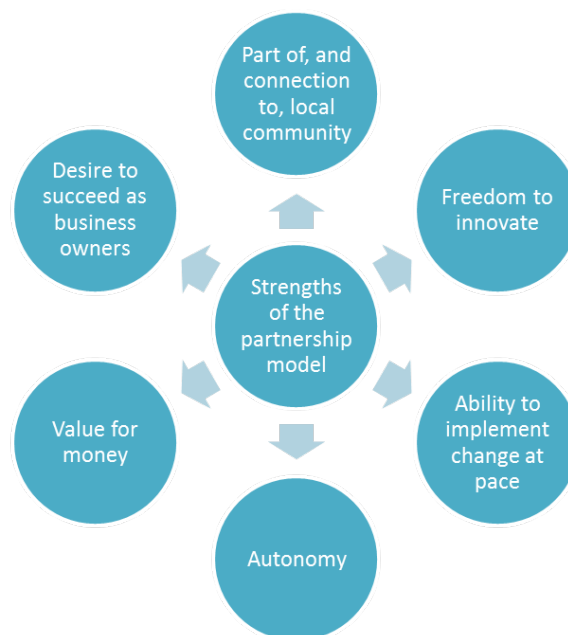
View from the Chair

The strengths of general practice include the holistic and patient centred approach to care, providing care 'from cradle to grave', with a lifelong electronic healthcare record, responsibility to a defined population (the registered list), knowledge of the community and family, being the specialist generalist and having the skill and knowledge to manage clinical risk.

But if this describes the strengths of general practice, what more does the partnership model add to this?

The partnership is a small business and has the freedom to innovate and implement change at pace. There is often a strong connection of accountability and responsibility to the community the practice serves. The partners have the desire to ensure their business is a success and will therefore go above and beyond what would be contractually required of them. GP partnerships provide exceptional value for money - [paid less than £3 per week per patient to provide unlimited access to the population we serve.](#)ⁱ

Figure 1 - Strengths of the partnership model



We are not starting from a blank page. Work has already been undertaken by NHS England, the GPC and the RCGP to try and address the challenges facing general practice. Other work currently under way across the Department of Health and Social Care, NHS England, the BMA and the RCGP will also feed into this review.

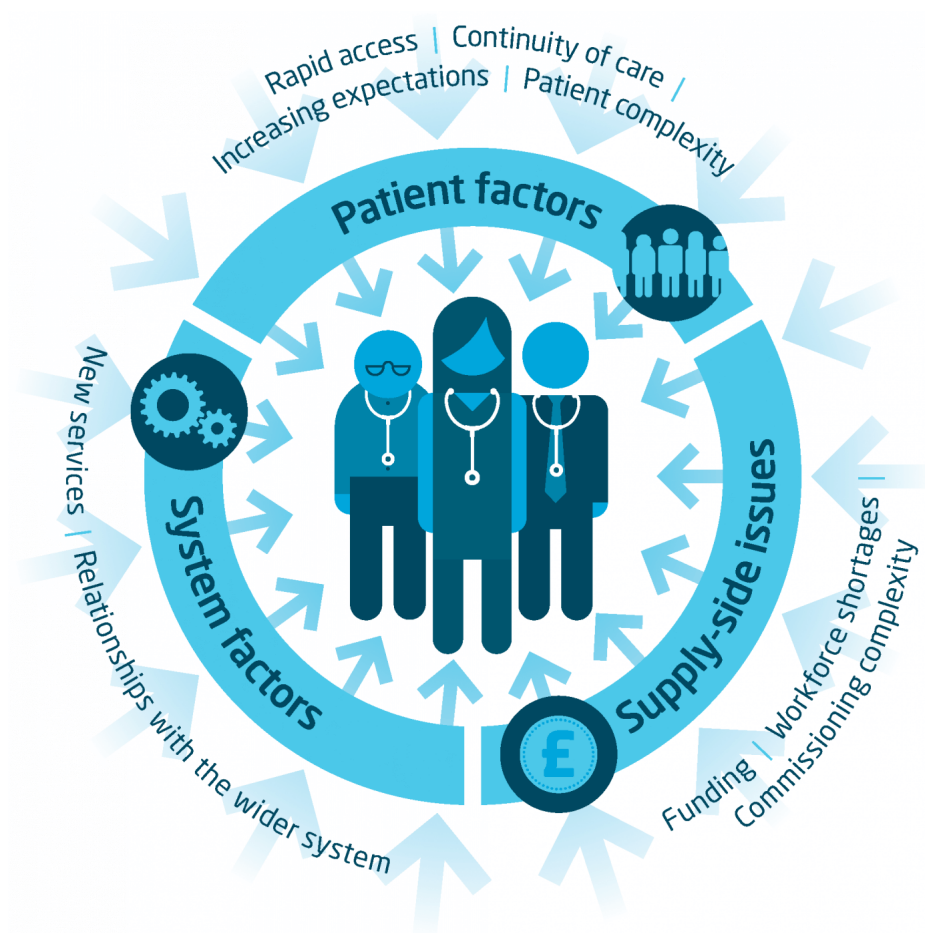
Together these publications and reviews include:

- The [GP Forward View \(GPFV\)](#) produced by NHS Englandⁱⁱ
- The [Government's commitment to introduce a State backed Indemnity Scheme](#) for GPs and others working in Primary Careⁱⁱⁱ

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- General Practice premises policy review
- NHS 70th Birthday and the Government's commitment to a long term NHS plan and funding settlement
- GMS Contract negotiations for 2019/20 and beyond
- The publication of the Doctors and Dentists Review Body report 2018 (DDRB)
- RCGP's ongoing project for 2018/19 [A Future Vision for General Practice](#)^{iv}
- GPC [Urgent Prescription for general practice](#),^v and the [Saving General Practice Campaign](#)^{vi}

Figure 2 - [Understanding the pressures in general practice](#) (Source: The King's Fund)^{vii}



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This is not an exhaustive list but demonstrates that any review of the partnership model of general practice cannot be considered in isolation.

The starting point for the GP Partnership Review will be to consider our 'Key Lines of Enquiry', informed by this context. Our intention is that these lines of enquiry will develop as the review progresses.

There are also several overarching questions which are relevant to all of these thematic areas.

Key questions

1. What can we learn from other industries and sectors who operate in a partnership model?

For example, how have other partnership models reduced or increased workload?
How have other sectors successfully mitigated risk and liabilities for individuals in a partnership?

2. How do the evidence and possible solutions differ for GPs at the early, middle and latter stages of their career?
3. How do the evidence and possible solutions differ between urban and rural areas?
4. What local examples of good practice exist that we could share more widely?
5. What role could digital technology and data play in supporting the partnership model?

For example, what more can technology do to support workload management?
What support do GPs need to use digital technology and data effectively?

Workload

View from the Chair

I regularly hear from fellow GPs that the working day has become longer, more intense and all too often unmanageable. The clinical workload is changing to reflect population demographics and patient expectations and behaviours, as well as the increasing administrative workload. For example, partners can be faced with overly bureaucratic payment systems, the complexity of multiple contracts, and system navigation.

However, the workload issue is not limited to the partners in the practice. Salaried GPs, Practice Nurses, Practice Managers and other staff who work for the practice have also reported rising and more complex workload. If the workload and intensity is too great, this will impact on the quality of the care we are able to provide.

We can deliver more capacity by embedding a wider workforce in general practice either individually or as part of a team. This could include pharmacists, mental health workers, musculoskeletal (MSK), frailty, diabetes, respiratory specialist professionals, and children's services. Digital technology is a key enabler in this area. However, we cannot get away from the fact that we need to recruit more GPs, and this will only happen if we can ensure workload is under control and manageable.

What do we know?

- Workloads have increased and have reached levels that are unmanageable for many GPs. The [2017 GP Work life Survey](#) found that increasing workloads were the number one source of job stress, with 92% of respondents reporting considerable or high pressure.^{viii}
- Surveys of GPs show that they feel that the intensity and demands of their work have increased. [47% of GPs said that they very often worked or trained outside their regular hours, compared to 33% of hospital consultants and 25% of junior doctors.](#)^{ix}
- Increases in workload are only partially due to increased demand and demographic changes.
- GPs reported that over a quarter of their appointments could be dealt with by other health professionals within the practice.
- GPs report low and falling morale.
- [Patient satisfaction has always been high in relation to general practice: 85% in 2017; however, this has fallen significantly over the last 2 years.](#)^x
- Consultation rates continue to rise, and the average time of consulting continues to increase including complexity of consultations.

Figure 3 - Sources and levels of job stress for GPs in England, 2017



Key questions

6. What do partners, salaried GPs and other staff think are the biggest burdens on their clinical workload, and administrative workload?
7. What innovative models have been put in place to help and have they worked?
8. How can we best share learning from what has worked to reduce workload burden for partnerships?

Workforce

View from the Chair

In 2017 we saw a record number of doctors entering GP training, yet [the latest national GP workforce figures show an 8% reduction in the number of GP partners since March 2016](#).^{xi}

We have also seen an increase in non-clinical staff working in practices since September 2015 and although this is positive, numbers are not sufficient to meet the rising demand. These figures do not reflect the significant recruitment and retention issues with practice nursing.

Becoming a partner is a huge commitment, and younger GPs want to feel confident about the future and supported in taking on that responsibility. Currently, training does not prepare young GPs for the non-clinical aspects of partnership, for taking on risk of premises and employment of staff and for a wider role in the community. However, while many of the younger GPs I have spoken to so far do not want to take on a partnership immediately, most would consider this in the future.

We are struggling to retain GP partners at all stages of their careers. Workload has a huge impact on decisions to leave practice and [in 2017 30% of partners stated that there was a high likelihood that they would leave direct patient care within five years](#).^{viii} We cannot continue to lose partners at this rate if we believe the partnership model will continue to have a role in the future NHS. We need to consider what more we can do, and different ways of working to ensure we can retain the experience and expertise of this group.

Locum GPs provide a valuable service to help and support individual practices, to cover absences due to holiday, sickness, or other reasons when a practice does not have the capacity to meet their patient demand.

Working as a locum can be seen as offering more flexibility, greater control of workload and offer less risk than being a partner. However, where recruitment of locum GPs is occurring due to practices being unable to substantively recruit, this is a concern, as growth in the locum workforce will be at the cost of stability in practices and the ability for practices to deliver continuity of care.

A [recent review in the BMJ showed that continuity of care with a GP was associated with lower mortality rates](#), as well as increased patient satisfaction, increased take up of health promotion, greater adherence to medical advice and a reduction in the use of hospital-based services.^{xii} Continuity of care is therefore a fundamental aspect of any successful GP partnership whether delivered by GP Partners, Salaried GPs, Practice Nurses or other allied healthcare professionals.

General practice as a career is changing. As a GP there are many opportunities across primary, secondary and community care, as well as system leadership. I believe it's an exciting time to be a GP.

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The GP is the Consultant in Primary Care and is a specialist generalist. I believe that we need to ensure GPs have equal status with our hospital colleagues, and I am keen to explore this issue further.

What do we know?

- Headcount in terms of GP Trainees is increasing.
- However headcount is falling in terms of GPs (excluding locums and trainees), and due to falling participation rates there is an even steeper loss in full time equivalent workforce.
- GPs leaving/intentions to quit are increasing over time.
- Older GPs, who are more likely to work full-time, are being replaced by younger GPs increasingly wanting to pursue more flexible career paths.
- Not enough younger doctors are choosing general practice and those that are, are not choosing partnership directly after qualifying. Further work needs to be done to understand their motivations and the barriers involved.
- There are many issues impacting on decisions to enter into partnerships. Commonly these include workload, indemnity, and financial risk.
- There is a perceived lack of career structure and opportunities for progression within general practice.
- Earnings are falling for some partners, whilst expenses are increasing.

Key questions

9. What are the key barriers and motivations for GPs in choosing to enter a partnership role?
10. What are the features of other GP career models (e.g. locum, salaried GP) that are attractive to GPs? How could some of these features be introduced into the partnership model to make it more attractive?
11. How can the partnership model support more flexible working and portfolio careers?
12. How could we better structure and recognise progression through a career in general practice, including progression to partnership?
13. What additional support do GPs considering partnership need?
14. How does differential pay between partners and non-partners affect the makeup of the GP workforce?

The role of General Practice in the local healthcare system

View from the Chair

An important strength of general practice is our unique role within the community and the NHS. We are often the first point of contact within the health and care service for our population, and we care for our patients and often their families throughout their lives. We offer proactive public health advice, and direct and support patients in navigating an increasingly complex system. We bring together multi-disciplinary teams to support patient care.

However the local health economy is changing: we are seeing more new models of care, sustainability and transformation partnerships (STPs) continue to develop, and more integrated ways of working evolve. The traditional boundaries between primary, secondary and community care are blurring. More care is being delivered in the community and we need to make sure that general practice is front and centre in this changing environment.

Practices need to work together to enable patients to access a wider range of services, delivered through a multi-disciplinary team in a way that is only possible to deliver with a larger population. Delivering primary care services in the community at scale is not a new concept and has been trialled through initiatives such as the Primary Care Home and Primary Care Networks. Working at scale will enable us to expand capacity and develop a multi professional team supporting, and embedded in, local practices.

A key aspect of working at scale is access to data, either through shared patient records or through audit to promote high quality care and streamline ways of working.

It is my view that the partnership model will continue to be an important part of the local health economy, and our role within the community is perfectly placed to bring together wider teams and work at scale. However, we not only need practices to be stable and resilient; we also need to have community based care delivered at scale supporting individual practices and the natural communities of care.

What do we know?

- There is increasing recognition that general practice and primary care are key to the future sustainability of the wider system – general practice is seen as a key system leader, setting the direction for primary care locally and at a network level.
- Historically, primary care has received a lower rate of increase in funding compared to secondary care. However, the majority of patient contacts with the NHS take place outside of hospital.
- Increasingly, more complex care is being delivered in the community.

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- Community health services vary across the country and are also struggling to meet rising demand.
- Community nursing was more integrated with general practice 30 years ago than it is now.
- Pathways of care can be complex. Duplication and system complexity adds to workload pressures, and increasing bureaucracy.
- Health and social care is all too often delivered by organisations working in silos – general practice, community nursing, social care, and hospitals.
- Where more coordinated working between primary care and secondary care occurs, there is an improvement in patient care and experience, and there can be a reduction in workload at a practice level.
- New clinical delivery models are needed to meet demand, altering the environment in which general practice operates and interacts with individuals, families and local communities.
- Many practices are already working together and at scale through a range of different models, including in networks and federations.
- General practice working together is demonstrating benefits, as is multi-disciplinary team working.
- There is considerable investment in new premises committed through the [GPFV Estates Transformation and Technology Fund \(ETTF\)](#).^{xiii}
- System duplication and lack of interoperable systems comes at a great financial cost to the NHS, General practice and patients

Key questions

15. How can GP partnerships work more effectively with other professionals including pharmacists, nurse practitioners and others, to form more effective multidisciplinary teams?
16. How can partnerships support or hinder greater collaboration between primary, community and secondary care?
17. How can we encourage and incentivise further working at scale and closer working between practices?
18. How do we support general practice to collaborate with other out of hospital services, including community health services and community pharmacy?
19. How do we encourage GPs to take up health system leadership roles, within their local communities and at wider levels?

Business Model of General Practice

View from the Chair

I believe that the Independent Contractor status of general practice is the foundation of the core strengths of general practice. Although we are independent, we are an integral part of the NHS.

Our unique position within the health service provides us with the autonomy and freedom to innovate, alongside our ability to deliver person-centred holistic care based in the communities to whom we are accountable.

Our business model means that partners, and often salaried GPs, have a direct role in the way their practice is run and in delivering services in the most efficient and effective way. As a small business, services can quickly adapt to suit the needs of the local population. However this business model comes with its risks as well as rewards; for example, the burden of holding a large mortgage, employing large numbers of staff and personal financial risk and liability. I am concerned that, for those considering becoming partners either now or in the future years of their career, the risk outweighs the rewards of the job.

One of the key risks in entering into a partnership is related to premises. In the past buying into the practice premises was considered a good investment; however, this is no longer always the case. Taking on responsibility and liability for a building for up to 20 years, often without adequate safeguards if you decide to leave the partnership, your contract is terminated or if a 'last person standing' situation occurs, can mean partners carry unlimited financial risk.

Those who are training to be GPs spend most of their time in general practice preparing for the Applied Knowledge Test (AKT) and the Clinical Skill Assessment (CSA) and spend very little time learning about leadership, the management of a practice and business skills including HR and finance. Therefore, many GP trainees feel ill-equipped to enter into a partnership until later in their career. I believe this is an important consideration when we are discussing why younger GPs are not applying to become partners.

What do we know?

- GPs often hold unlimited personal risk as a partner of their practice. In the past this risk was not considered to be great but this has now become a barrier to many GPs considering becoming a partner in a practice. This is compounded by the legislation that prevents Limited Liability Partnerships from holding General Medical Services (GMS) and Personal Medical Services (PMS) contracts.
- Buying into a partnership and premises – for young GPs with increasing financial commitments, the stretch of taking out a mortgage to buy-in to the practice premises, with the risk this entails, is often considered too great.

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- We have seen a number of practices where partners have left and have by necessity been replaced by salaried GPs which means that the ownership and risk of the associated liabilities (for example, for premises and employees) lies with fewer and fewer GP partners – this situation is commonly referred to as ‘last person standing’.
- Uncertainty around the shape of general practice means that some younger GPs are not prepared to be signatories to a 20 year lease with the liabilities that are associated with this.

Key questions

20. Why is there currently a barrier to a practice contract (GMS or PMS) being held by a Limited Liability Partnership (LLP)?
21. What other business models exist that GP partnerships could take the form of?
22. Is there a way to limit the risk to partnerships holding a long term lease? How can the risk of owning a practice building be reduced?
23. How can we reduce the personal risk of employing staff, vicarious liability, and personal name and shaming of a GP (rather than the organisation as would happen with a hospital) following adverse Care Quality Commission (CQC) reports or other incidents?

Next Steps

Over the next couple of months I will be travelling around the country meeting GPs and front line staff, practice managers, patients and others, to seek their opinions and collect views on what works and what doesn't work. We have established a reference group with wide representation from stakeholders with an interest in general practice and the future of the partnership model, to inform the development of the recommendations.

Key to the review will be gathering information and insight in relation to these early lines of enquiry, both on a local and national scale so we can develop solutions that will be applicable to all. I am keen to take an in depth look at the commonly raised issues and anecdotes, and do a bit of myth busting where the perceived issues with the partnership model are not borne out by the evidence.

The review will look at these key themes and any other issues that are raised during the course of our information gathering. We will then look to explore potential solutions to these problems and seek consensus on these priorities for action.

I will be publishing an interim report in the Autumn, and will report back to Jeremy Hunt, Secretary of State for Health and Social Care, and to Simon Stevens, Chief Executive of NHS England, at the end of the year.

How to contact us

We welcome contributions from any interested party. You can email Nigel and the review team at: GPPartnershipReview@dh.gsi.gov.uk

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

We will be holding webinars, where you can feed in your views and hear about our progress. Details will be publicised through Local Medical Committees or our partners to the review (RCGP, GPC, DHSC, NHS England).

Follow us on Twitter @gppartnershipr1

Annex 1: Terms of Reference

I have been asked to consider, and where appropriate, make recommendations in the following areas:

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

I will submit my findings to the Secretary of State for Health and Social Care and the Chief Executive of NHS England, providing interim conclusions in the Autumn 2018 and a final report at the end of 2018.

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