

GP Partnership Review

Final Report

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Letter from Dr Nigel Watson, Chair of the Review, to Matt Hancock and Simon Stevens



Dear Matt and Simon,

In February 2018, the former Secretary of State for Health and Social Care announced an independent review into the partnership model of general practice, to consider the challenges that currently face GP partnerships and make recommendations that would revitalise and transform the model, to benefit all those who currently work in general practice, our patients and our NHS.

It has been an honour and a privilege to chair this review, working closely with the Department of Health and Social Care (DHSC), NHS England (NHSE), the General Practitioners Committee (GPC) of the British Medical Association (BMA) and the Royal College of General Practitioners (RCGP), as well as all those who work in and support general practice who have shared their thoughts and evidence with the review. In this report I set out a number of recommendations for action that I believe could make a real difference to general practice, our patients and communities, and the wider NHS.

These recommendations are the culmination of several months of discussion and engagement, starting with our [Key Lines of Enquiry](#) in July 2018 and continued in the [Interim Report](#) of this Review in October, but they are not the end. General practice needs to feel valued and requires new resources to expand the workforce and address the workload it faces now, let alone in the future. In that light I was pleased to see the clear commitment in the [NHS Long Term Plan](#) to boost 'out-of-hospital' care and dissolve the historic divide between primary and community health services, with spending on these services to be at least £4.5 billion higher in five years' time.

Alongside the recommendations I have made to Government, NHS England and other national and representative bodies, we also need a clear vision of the vital role general practice and primary care must play in a future NHS. Partnerships need to own this vision, and lead the change that is required to create and promote a positive future for general practice.

I would like to thank all of the organisations and individuals who have supported, challenged and advised me over the last six months. I would also like to thank the team from the Department of Health and Social Care who have supported me throughout the review.

I now have the pleasure of presenting you with this final report, with recommendations which I believe will address many of the challenges we face, revitalise the valuable partnership model, and make general practice a great place to work once again.



Dr Nigel Watson

Independent Chair, GP Partnership Review

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

Chief Executive, Wessex Local Medical Committees

Member of the General Practitioners Committee of the BMA

Foreword

General practice is one of the most important and respected institutions in our communities; it is the foundation of the NHS. It has been credited as a major reason for the [NHS being one of the most cost-effective models of healthcare](#), outperforming many countries in the Western world which spend significantly more on their health care systems.

The strengths of general practice that deliver these outcomes include:

- organising care based on a registered list, [with the vast majority of the population registered with a practice](#);
- providing care from cradle to grave;
- having a holistic approach to care, looking after the whole person and not simply focusing on one disease or a single episode of care;
- knowing more than one generation in a family, having a lifelong medical record;
- providing continuity of care where needed;
- and managing the undifferentiated presentation of symptoms.

The partnership model has underpinned general practice since before the establishment of the NHS, and is thought to be a major component of the success of English general practice. General practice has continued to evolve, with the [average size of individual practices increasing](#), an increase in the number of [GPs working in a salaried \(employed\) role, and a trend towards more part-time and flexible working](#).

However, in recent years we also know that partnerships have become less popular with GPs and there is a risk that, without both the continued commitment of existing partners and the input of new partners, the model could be lost. In my view, and the views of the vast majority of those who have contributed to this review, this would be a real loss to both general practice and the patients and communities it serves.

I firmly believe it is important to consider the strengths of the partnership model of general practice, and what value the model offers above and beyond an alternative salaried model.

From our engagement work throughout this review, GPs and others working in general practice have identified some of the strengths of partnerships as:

- a freedom to innovate;

- relative autonomy in decisions relating to patient care, with the ability to act as a powerful independent advocate for patients;
- being part of, and accountable to, a community;
- creating the desire to succeed as business owners;
- providing value for money.

Alongside these views on the strengths and value of the partnership model and of general practice, I have also heard from staff about their concerns and challenges.

Over the course of the last six months, I have heard repeatedly that GPs do not feel valued as a profession, and that general practice does not feel valued in all local health systems.

GPs have also told me they feel that workload is exceeding capacity, the working day feels unmanageable, and the intensity of work and the complexity of patients has risen, with inevitable challenges in terms of managing clinical risk.

We must improve the balance between continuity of care and access to services, as care over a period of time with a person you know and trust ('relational continuity') is at the heart of general practice, valued by patients and GPs alike and [shown to deliver better outcomes](#).

But while there are challenges, there is also hope.

The current model of care in the NHS is too dependent on hospital-based care. This model is not sustainable, and we cannot move forward without change that includes general practice and partnerships at its heart. We are moving towards a team based multi-disciplinary way of delivering care, which must involve general practice working more closely with colleagues in primary, secondary and community care and ensuring we make the best use of all our skills.

In recent years an increasing share of the NHS budget has been invested in hospital-based care at the expense of general practice, community services and mental health. The additional £4.5 billion of investment for primary and community care recently announced in the NHS Long Term Plan is, therefore, a welcome step in the right direction, which will need clear local commitment as well as national.

We also now have more GPs entering training than ever before, addressing some of the important concerns around recruitment. Younger GPs have told me that, despite concerns around flexibility and individual risk, they still see partnership as something they will consider in the future.

The partnership model is not dead. We have visited many practices who are working as partnerships delivering high quality, person-centred care, and who are expanding the services they deliver to their communities by working with others.

The partnership model is also not the only model currently delivering general practice and, while partnerships holding a GP contract will continue to be in the majority, it is important that a plurality of sustainable alternative models are available where the difficulties of recruitment and retention mean that a partnership model cannot thrive. As part of the review I have therefore deliberately visited parts of the country that are reported to be under the greatest strain, to learn from their experiences. We have also visited places like Wolverhampton, where a number of practices are working as part of a hospital trust in a model of vertical integration.

There is no single, simple solution. The challenge is about reducing workload to a manageable level; expanding the workforce to support staff, patients and the system; reducing unjustified risk to individuals; and providing a high quality, person-centred service that GPs and others working in primary care find varied and rewarding, now and in the future.

This report, with the associated recommendations, will, I hope, both identify the issues and challenges of today, and propose some of the solutions which can revitalise the partnership model and reinvigorate it for the long-term future of general practice and the NHS.

Dr Nigel Watson

Independent Chair, GP Partnership Review

Executive summary

This document is the final report of an independent review into the partnership model of general practice, as commissioned by the Secretary of State for Health and Social Care in 2018.

The partnership model, wherein GPs operate as self-employed independent contractors, has underpinned general practice since before the establishment of the NHS, and is thought to be a major component of the success of English general practice. However, in recent years we also know that partnerships have become less popular with GPs.

Dr Nigel Watson, an experienced GP partner and the chair of Wessex Local Medical Committees (LMC), was appointed as chair of the review, and has worked closely with the Department of Health and Social Care, NHS England, the Royal College of GPs and the General Practitioners Committee of the British Medical Association. [Terms of Reference](#) and [Key Lines of Enquiry](#) were published in Summer 2018, and an [Interim Report](#) published in October 2018.

The review was asked to consider and make recommendations on:

- 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
- the benefits and shortcomings of the partnership model for patients, partners, salaried GPs, locum GPs, broader practice staff, for example practice nurses, and the wider NHS
- how best to reinvigorate the partnership model to equip it to help the transformation of general practice, benefiting patients and staff including GPs

This final report completes the review's work and makes recommendations to both the Secretary of State for Health and Social Care and the Chief Executive of NHS England, to reinvigorate the partnership model to equip it for the future.

Chapter one sets out the purpose of the review and how its work has progressed, with an overview of the feedback received from individuals and organisations. A more detailed summary of feedback and engagement is included in the [Interim Report](#) published in October 2018.

Chapter two describes the challenges and issues which the review has heard are currently dissuading people from working in general practice. These include workload burdens, workforce recruitment and retention difficulties, an increasing level of personal

risk, and a feeling that general practice is not always valued as an important part of the wider health system.

Chapter three describes the benefits and challenges of the partnership model, as identified by those who have engaged with the review.

Chapter four proposes seven high level recommendations, including both 'quick wins' and longer-term projects which aim to address the challenges of risk and flexibility in the partnership model; workforce issues of recruitment, retention and education and training; workload, both clinical and administrative; the status and role of partnerships and primary care networks in their local health systems; and the emerging opportunities for primary care in terms of digital and technology. The recommendations aim to be focused, affordable and practical.

The current model of care in the NHS is too dependent on hospital-based care. This model is not sustainable, and we cannot move forward without change that includes general practice and partnerships at its heart.

Summary of recommendations

Full detail of the recommendations is set out in Chapter 4 and a full list of recommendations is set out at Annex A.

Recommendation 1: There are significant opportunities that should be taken forward to reduce the personal risk and unlimited liability currently associated with GP partnerships.

Recommendation 2: The number of General Practitioners who work in practices, and in roles that support the delivery of direct patient care, should be increased and funded.

Recommendation 3: The capacity and range of healthcare professionals available to support patients in the community should be increased, through services embedded in partnership with general practice.

Recommendation 4: Medical training should be refocused to increase the time spent in general practice, to develop a better understanding of the strengths and opportunities of primary care partnerships and how they fit into the wider health system.

Recommendation 5: Primary Care Networks should be established and operate in a way that makes constituent practices more sustainable and enables partners to address workload and safe working capacity, while continuing to support continuity of high quality, personalised, holistic care.

Recommendation 6: General practice must have a strong, consistent and fully representative voice at system level.

Recommendation 7: There are opportunities that should be taken to enable practices to use resources more efficiently by ensuring access to both essential IT equipment and innovative digital services.

1. Introduction

Developing the recommendations

- 1.1 The former Secretary of State for Health and Social Care announced a review of the GP partnership model in February 2018, appointing Dr Nigel Watson as Chair. The review reports jointly to the Secretary of State for Health and Social Care and to Simon Stevens, CEO of NHS England and has worked in partnership with the Department of Health and Social Care, NHS England, the RCGP and the GPC of the BMA.
- 1.2 The [Key Lines of Enquiry](#), published in July 2018, set out the early direction of travel for the review, with key questions across the four areas of workforce, workload, the role of general practice in local healthcare systems, and the business model of general practice. This document formed the basis for the engagement that was undertaken over the summer and autumn. The [Interim Report](#), published in October 2018, summarised the feedback received and set the direction for the developing recommendations. Further engagement and testing with key stakeholders and partners has resulted in the final recommendations set out in this report.
- 1.3 Throughout the review the Chair has provided advice, views and support for projects linked to the development of the recommendations. For example, the [ongoing review by NHS England of GP premises](#), and the development of Primary Care Networks and other primary care proposals set out in the [NHS Long Term Plan](#).

Terms of reference

- 1.4 This review was tasked to consider and, where appropriate, make focused, affordable and practical recommendations, in the following areas:
 - 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;
 - The benefits and challenges of the partnership model for patients, partners, salaried GPs, locum GPs, broader practice staff, for example practice nurses, and the wider NHS;

- Drawing on the points above, consider how best to reinvigorate the partnership model to equip it to support the transformation of general practice, benefiting patients and staff including GPs.

Governance of the review

- 1.5 The Partnership Review has been chaired by Dr Nigel Watson and reports jointly to the Secretary of State for Health and Social Care and Simon Stevens, NHS England. The Department of Health and Social Care, NHS England, the RCGP and the GPC have worked in partnership to support the Chair. Secretariat functions for the review have been provided by the Department of Health and Social Care.
- 1.6 Governance arrangements for the review were conducted by a senior project board, chaired by Dr Nigel Watson. The project board had oversight for the development of the recommendations, and was supported by a working group. Both the project board and working group had representatives from the four organisations involved with supporting the review.
- 1.7 A reference group, made up of key stakeholders including organisations such as The King's Fund and the Nuffield Trust, the National Association of Primary Care, representatives from practice nursing, practice management, the acute hospital sector and from committees of the BMA and RCGP, as well as GP partners, salaried and locum GPs, met twice in person over the course of the review and provided advice when requested.

Engagement

Objectives

- 1.8 The review set objectives to hear from all interested parties and organisations, and to use the feedback received to inform the review into the GP partnership model. Interested parties ranged from patients, partners, salaried GPs, locum GPs, trainees, broader practice staff (including practice nurses and practice managers) and the wider NHS. The review aimed to work transparently with stakeholders and to provide ongoing information and regular progress updates.

Feedback received

- 1.9 The review received written feedback from over 120 individuals and organisations. The review also visited over 25 practices around the country, ranging from small practices to super partnerships, from those who are in parts of the country where they are experiencing the greatest difficulty in recruiting GPs, to other areas where general practice is in a much better place.
- 1.10 The review has also held over 40 meetings which have included presentations, round table discussions, some hosted by Local Medical Committees (LMCs) and others involving Health Education England (HEE), RCGP Council, groups of early career GPs and trainees, the Next Generation GP Programme, GPC, and the national LMC annual conference.
- 1.11 The review team hosted a patient involvement event, with participants including representatives from the BMA, RCGP and the Academy of Medical Royal Colleges' patient groups, Healthwatch, and members of the Health and Wellbeing Alliance.

Process

- 1.12 Early discussions with stakeholders and partners shaped the [Key Lines of Enquiry](#) and the questions that the review set out. Stakeholders were asked for views on the key questions, and the feedback on these questions and other key issues shaped the [Interim Report](#).
- 1.13 The [Interim Report](#) set out how thinking was developing in each area. Further engagement was undertaken to develop and test the emerging recommendations. This report is a culmination of extensive engagement from a wide range of stakeholders and their views of the current challenges and recommended solutions have all shaped the final recommendations.
- 1.14 Nigel and the review team would like to thank all organisations and individuals who have contributed to the review.

2. Challenges

2.1 Throughout the process of the review we have heard about the pressure general practice is under from increasing demand for services. This is backed up by the [March 2018 Quarterly Monitoring Report](#) from the Kings Fund in which 67 per cent of CCG finance leads felt either concerned or very concerned about the ability of general practice to meet demand in their area. In addition, while [patient overall satisfaction](#) with the services remains consistently high, it has started to fall. Between 2012 and 2018 satisfaction fell by 4.9 percentage points, which may be an indicator of the pressure the system is under.

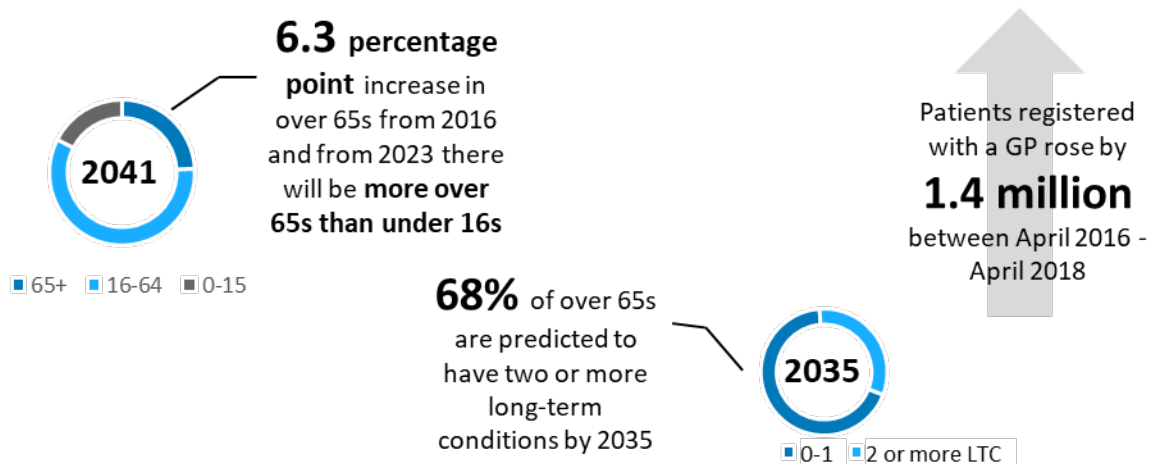


Figure 1

Sources: [Population projections, ONS](#); [Projections of multi-morbidity in the older population in England to 2035](#); [Patients registered at a GP Practice, NHS Digital](#)

2.2 As described in both the [Key Lines of Enquiry](#) for the review in July 2018, and the [Interim Report](#) in October 2018, there are a number of challenges which currently face both general practice and the wider NHS in England.

Workload

2.3 General practice is facing an unprecedented [increase in demand](#) for services. A key reason for this is the [changing population demographics](#).

2.4 We know that GPs and other staff working in general practice are seeing more patients. In [2016 the King’s Fund reported](#) that, over the previous 5 years, there was a 15 per cent overall increase in patient contacts in general practice. The Recent [data on appointments](#) published by NHS Digital provides a baseline which will enable us to get a better understanding of activity and how this increases over time. However, this data does not provide detailed information about demand for general practice services.

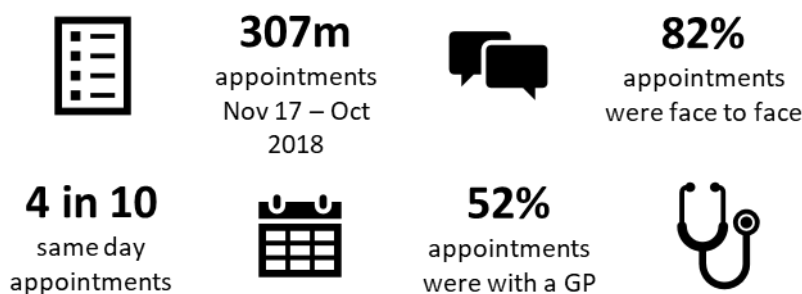


Figure 2

Source: [Appointments in General Practice, October 2018, NHS Digital](#)

Workforce

2.5 Alongside the population changes, general practice is facing major challenges in terms of recruitment and retention. Throughout the review process we heard from practices with vacancies they could not fill; from partners and salaried GPs taking early retirement; and from trainees who had been told repeatedly throughout their training that general practice was not a great place to be.

2.6 [Latest workforce data](#) shows that GP numbers (FTE excluding locums and registrars) fell 3.4 per cent between September 2016 and September 2018.

2.7 The [GP work life survey](#) shows high numbers of GPs intending to leave direct patient care in the next five years. This was reflected in the findings of a recent [survey conducted by Wessex LMCs](#) on behalf of the partnership review, who found that nearly 20 per cent of GPs nationally who responded to the survey were either planning to leave practice within the next 2 years, or to retire early.

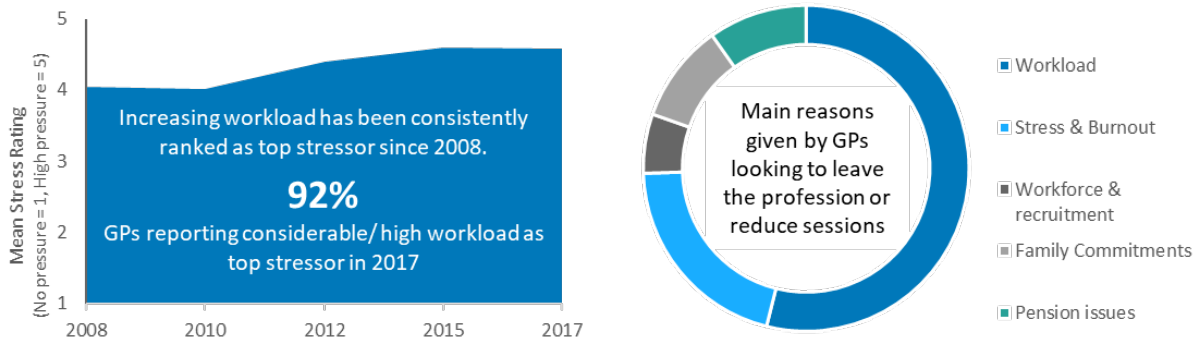


Figure 3

Sources: [GP work life survey 2017, PRUComm](#); [GP Workforce survey 2018, Wessex LMCs](#)

2.8 The numbers of GP partners are falling as a proportion of the general practice workforce. Research in 2018 by the Kings Fund found that only [37 per cent of GP trainees](#) planned to be GP partners. However, this research also showed that the intention to become a partner grew with time. Feedback to the review from newly qualified GPs and trainees showed that this group remain interested in partnerships, but often did not wish to take on this role straight after finishing training.



Figure 4

Source: [The King's Fund, Wessex LMCs](#)

- 2.9 In 2018, there were a record number of doctors entering GP training and the [fill rate for training places](#) is over 100 per cent. At present we do not have a good understanding of how fill rates of training places translate into GPs taking up substantive roles in the workforce.
- 2.10 The figures are more positive for the rest of the workforce, with numbers of general practice staff providing direct patient care and administrative and non-clinical staff numbers [both rising by 2.6 per cent between September 2016 and September 2018](#).
- 2.11 The [NHS Long Term Plan](#) was published on 7th January 2019 and included a commitment to increase investment in primary medical and community health services as a share of the total national NHS revenue spend across the five years from 2019/20 to 2023/24. This commitment will mean spending on these services will be at least £4.5 billion higher by 2023/24. This commitment is a 'floor' level of investment that is being nationally guaranteed, that local Clinical Commissioning Groups (CCGs) and Integrated Care Systems (ICSs) are likely to supplement further. This investment guarantee is set to fund demand pressures, workforce expansion, and new services to meet relevant goals set out across the plan.

Risk

- 2.12 GPs told the review that an increasing level of personal risk is one of the major reasons they were opting not to join partnerships, or to leave them prematurely. [The survey by Wessex LMCs](#) found that reducing financial risk and reducing premises risks would make GPs more likely to join a partnership.
- 2.13 Throughout the review process, we have heard concerns regarding the risk of 'last partner standing'. This refers to a situation when one or more partners retire from a practice and the practice is unable to recruit any replacement partners. In some cases, the instability caused can result in the majority indicating they wish to resign as partners. This could potentially mean all the risk and liability held by the partnership sits with the last partner remaining.
- 2.14 The financial risk, whether real or perceived, largely sits with premises ownership or lease holding, but is also associated with medical indemnity and the personal financial risk of being an unlimited liability partnership.
- 2.15 While every partnership should have an up to date partnership agreement, and taking appropriate legal and financial advice should help to reduce such risks, recruitment and retention issues and concern about the future of the partnership model have all significantly increased this concern.

The role of general practice in the wider NHS

- 2.16 Through the review we heard from a number of GPs and organisations about their fatigue with change to the structures of the health service, and to how general practice is funded and commissioned. From GP fund-holding in the 1990s, to the wide scale reform under the Health and Social Care Act in 2012, to the introduction of Sustainability and Transformation Partnerships (STPs) in 2016, NHS policy and the involvement of GPs within that has changed significantly in the last 30 years.
- 2.17 We also heard how general practice has struggled to find a united voice in the wider system because of the number and diversity of practices, both locally and regionally. Practices do work together locally, but there are barriers and challenges. GPs are passionate about their communities, and want to be involved in setting the direction and building better services for everyone in their community.

3. Benefits and challenges of the partnership model

- 3.1 The [Terms of Reference](#) for the review set requirements to consider both the benefits and challenges of the partnership model for patients, partners, salaried GPs, locum GPs, broader practice staff and the wider NHS.

General practice

- 3.2 General practice forms the foundation of the health service. It is often the first point of contact, [seeing over 1 million patients a day every weekday in October](#). GPs provide holistic care for their patients, referring on where specialist care is required.
- 3.3 The partnership model of general practice is a cost-effective delivery model. As with other small businesses, for the most part, the income of the partnership is set by the services they are contracted to provide which provides a strong incentive to run an efficient and effective service.
- 3.4 General practice is funded via a [capitated budget](#) based on the registered patient list. Funding general practice in this way is cost effective; however, it is not aligned to secondary care, funded for the most part by activity, or community health services. This can cause challenges in setting priorities and integrated working, as financial incentives often do not align across the system.
- 3.5 Partners, with local knowledge of their population, can help shape service provision. One of the key benefits of the partnership model is that it engenders a long term and deep understanding of a local population's needs, combined with the flexibility to respond to those needs.
- 3.6 GPs are medical generalists who get to know their patients over time, providing continuity of care often across generations. Through the review process we heard a lot about the benefits of continuity of care, and evidence suggests that [providing continuity of care can improve outcomes and reduce the burden of demand on other services](#). The stability of the partnership model supports and enables continuity of care. The review heard that it forms one of the reasons doctors train as GPs, and why they feel general practice can provide the best possible service for their patients. However, continuity of care was also one of the areas of practice that was felt to be most at risk with recruitment and retention challenges, and with increased access requirements.

The partnership model in general practice

- 3.7 The partnership model has been the main legal structure for GP practices delivering primary medical care for over 100 years – the Royal College of General Practitioners holds records of [attempts to establish a representative body for general practice as early as 1844](#). It is the flexibility and adaptability of the model that mean it can still thrive today.
- 3.8 Partnerships are independent, autonomous businesses and are based on a partnership agreement that sets out the terms and conditions of how the business will be run. Partnerships can hold a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contract to deliver primary medical services. [Approximately 69 per cent of practices hold a GMS contract](#). This is commonly seen as the most desirable contract type for practices as it is held in perpetuity, providing stability for service provision.
- 3.9 General practice partnerships are diverse; list size and number of partners vary, as well as whether partners own or lease premises, the technology they use and the population they serve. Partnerships are usually small to medium businesses which means that they have the flexibility and freedom to innovate. As a result, GPs are often first adopters of new technologies and the ability of partnerships to implement change at pace is a key strength of the model.
- 3.10 For GP partners there are many benefits and challenges of taking on a partnership. The partnership model itself is a very flexible legal structure. The review met many practices taking advantage of this, with some partners working part time to develop other clinical interests, often taking on system wide roles or developing a specialism, or to allow for family responsibilities. There are specific challenges that come with part time working. In particular, those on training and study leave will be pro-rata, which does not reflect the fact that they will most likely need the same amount of training and development as a GP working full time. Often, in this situation, training is undertaken in non-working time.
- 3.11 There are some practices with hierarchies which offer progression schemes within partnerships, where a managing partner takes on more of the business leadership role for example. Some of the different structures and ways of working heard about by the review are set out in the accompanying case studies document.
- 3.12 However, the disadvantages of being a small business are also reflected in the partnership model. In an unlimited liability partnership (which most GP partnerships are), partners are personally responsible for the liabilities of the business. This can take the form of indemnity costs, premises costs and staff

costs. The review has clearly heard that the personal risk partners take on can be a barrier to GPs becoming partners.

- 3.13 The partnership model is only as successful as the GP partners holding the contract. Falling overall workforce numbers have impacted on the numbers of GPs entering into partnerships, leaving vacancies and some partnerships struggling to maintain service provision. The review received a lot of feedback from both partners and salaried GPs about feeling demoralised, and that they did not feel valued as a profession. [A recent survey by Wessex LMCs](#) carried out on behalf of the review shows the increasing workload for partners and salaried GPs is a reason why some partners are reducing the sessions they work and retiring early, and is a contributing factor to why GPs are not entering into partnerships.
- 3.14 The review has also heard from locums and sessional GPs, who were clear that the risk, workload and perceived lack of flexibility were all reasons why they did not want to take on partnerships.
- 3.15 The review heard feedback that there needs to be a reasonable differential between a salaried GP and a partner, which reflects the responsibility and workload associated with being accountable for a registered population and for running a small business.
- 3.16 The partnership model has many strengths that continue to be relevant in the health service of today and the future. The review has seen many examples of partnerships thriving in local areas, and the accompanying case studies document showcases some examples of how practices have used the flexibility of the partnership model to overcome challenges.

4. Recommendations

- 4.1 The review was tasked to make focused, affordable and practical recommendations which would reinvigorate the partnership model and equip it to support the transformation of general practice.
- 4.2 The following recommendations and sub-recommendations are therefore intended to support action which will make the greatest difference to partnerships and practices, in light of the challenges and opportunities heard throughout the review's process of engagement with different groups, professions and organisations.
- 4.3 Suggested organisations responsible for actioning each recommendation are included in brackets at the end of each sub-recommendation.

Risk and flexibility in the partnership model

- 4.4 An increasing level of personal risk is one of the major reasons GPs told the review they were opting not to join partnerships, or to leave them prematurely. The financial risk, whether real or perceived, largely sits with premises ownership or lease holding, but is also associated with medical indemnity and the personal financial risk of being an unlimited liability partnership.
- 4.5 New business models could support a reduction of risk for individuals. More flexible approaches to partnership are also needed, to help meet the needs and aspirations of the next and future generations of GPs and partners in general practice.

Recommendation 1: There are significant opportunities that should be taken forward to reduce the personal risk and unlimited liability currently associated with GP partnerships.

1.a. NHS England's review of primary care premises should develop proposals to mitigate the personal risk associated with being a lease holder or property owner; and provide support and guidance to partnerships on property ownership. (NHSE, GPC)

- 4.6 These proposals should support the introduction of a more comprehensive assignment clause to leases where premises are agreed to be 'fit for the future' and required for the delivery of primary care.

- 4.7 Currently practices who lease their premises receive reimbursement from the NHS. Leases for practice premises are normally for a period of 20 years, and may contain break clauses at 10 or 15 years. There is significant concern from some GP partners that, if the practice resigned from their GP contract, the individual partners would still remain liable for the full term of the lease. An assignment clause could allow the NHS to continue paying lease costs in agreed circumstances. While the Premises Costs Directions governing rent reimbursement do already permit this, a clearer set of objective criteria describing when this discretionary option would be used would represent a further step towards de-risking leases that offers reassurance to existing and future partners.
- 4.8 NHS England and GPC should also provide more support and guidance for partnerships on how to separate property ownership from other aspects of the partnership model. NHS England should work with the GPC, and take into account the work of the NHS Property Board to develop a primary and community care estates framework.

1.b. The Government should introduce the option of GP Partnerships holding a GMS or PMS contract under a different legal model, such as Limited Liability Partnerships and Mutuels. (DHSC, GPC)

- 4.9 The risks of being a partner are now considered by some GPs to be significantly greater than the benefits, particularly in relation to the unlimited liability of the basic partnership model. There has been much discussion throughout the course of the review about different business vehicles and legal structures which could be used to mitigate the risk of unlimited liability based on experiences in other sectors. These include, for example, Limited Liability Partnerships (LLPs), Social Enterprises (including Mutuels or employee-owned models) or Companies Limited by Shares or Guarantee.
- 4.10 While GP partnerships holding an APMS contract are able to operate under a variety of legal structures, changes to primary legislation would be required for a GMS or PMS contract to be held by some alternative business models such as LLPs. There are also other considerations relating to LLPs in particular which mean they may not be the preferred model for all partnerships. For example, additional administrative requirements relating to the publication of accounts and other corporate information.
- 4.11 In addition, an organisation changing legal structure may be subject to open tendering for existing contracts.
- 4.12 The work of the review has highlighted that there is currently a lack of clarity and understanding in the law surrounding this area. A rapid focussed piece of work

should therefore be undertaken by DHSC, to report within the next six months, which will require both specific legal advice and further engagement with the profession via the GPC. This will enable all parties to better understand the perceived benefits and potential risks of the available options to opening up the market to different legal structures, and allow the removal of any unjustified restrictions.

1.c. The Government and all relevant stakeholders must continue to support the final negotiations to introduce a state backed indemnity scheme from 1 April 2019, for all GPs and for those who work in and for practices. (DHSC, NHSE, BMA)

4.13 To attract more GP partners, the new state backed scheme must provide more stable, sustainable indemnity for clinical negligence for all GPs. This should include partners and those who work in and for practices, without undermining the financial stability of a practice.

Workforce

4.14 To help manage current and future workload there needs to be an increase in full-time equivalent GPs and in other clinical and administrative staff, and there must be more effective collaboration with other clinicians and staff working in community health services.

4.15 If more resources were to go directly to general practice and primary care, more time could be given to manage patients with complex problems, have protected learning time and reduce the number of patients an individual clinician consults within a day to make the working day more manageable.

4.16 In the past many doctors chose general practice as a career because of the flexibility it offered, but as the workload for practices has increased some of that flexibility has gone. The sessional workforce, both salaried and locum GPs, will continue to be a vital part of flexible and responsive general practice, but partnerships looking towards the future should consider options for re-introducing flexibility to the working day that could enable them to recruit and retain a broader range of partners and staff. This is not always easy for smaller practices, but may be facilitated across a larger network.

Recommendation 2: The number of General Practitioners who work in practices, and in roles that support the delivery of direct patient care, should be increased and funded.

- 4.17 The Secretary of State has reaffirmed the [Government's commitment to increase the full-time equivalent \(FTE\) GP numbers by 5,000](#), a commitment originally made in 2014. However, since 2015, the numbers of FTE GPs have decreased despite a year on year increase in doctors entering training. To have an impact, more of these new trainees need to enter the substantive workforce on completion of their training and GPs need to be supported not to leave the profession prematurely.
- 4.18 GPs at all stages in their career have told the review they want more time to enable them to provide better and safer care for patients with complex problems; to reduce the number of patients seen in a normal working day; and to have protected time for personal learning and development. This can only occur if resources are made available, the workforce is expanded, and workload is reduced.
- 4.19 The review has looked more closely at the issues and potential solutions at each stage of a GP's career.

2.a. Early career – A new employment opportunity for newly qualified GPs, a Primary Care Fellowship, should be launched by NHS England and HEE. This will support the development of primary care and community health staff in a range of areas appropriate to their future needs and the needs of patients. (NHSE, HEE)

- 4.20 After completing compulsory GP training, we know that some will opt to go straight into partnership and others may opt for a salaried role. Some also opt to become locums, as this can be seen as offering greater flexibility, less financial risk and a greater ability to manage workload.
- 4.21 It is true that some GPs have no plan to join a partnership, particularly when the risks of partnership are viewed as greater than the benefits. The review has concluded that if nothing changes, the partnership model has no future, as it cannot survive without new partners.
- 4.22 However, the review has also been told by many GPs early in their career that they do have an interest in partnership in future, but they may want to approach this in a different way. They would like the opportunity to work in different practices, to experience different partnerships before they decide which one they might want to join. They would also like to have time to build on their experience

and develop a significant area of clinical expertise, learn more about the potential opportunities and benefits of partnership, and gain more knowledge and experience of the business skills necessary for partnership.

- 4.23 While these kinds of opportunities have begun to be offered in some areas, they are not yet universal or comprehensive. These Primary Care Fellowships are therefore intended to allow newly qualified GPs to gain experience as a valuable employed member of the practice team, in a supported environment.
- 4.24 They should not be seen as a compulsory extension to the GP training programme. GPs who have passed their MRCGP are deemed to be competent in their speciality, but for a variety of reasons may not feel ready to become a partner. Similarly, the establishment of this scheme should not prevent qualified GPs becoming partners early in their career, as they may acquire the relevant skills and confidence through other experiences. But this route would represent a clear, alternative option to a more traditional partner or sessional role.
- 4.25 Primary Care Fellowships should be offered for a meaningful period, such as an initial expectation of a two-year commitment, and available early in the GP career, when individuals may be at greatest need of support and guidance, and provide an attractive salary and incentives.
- 4.26 These fellowships should be based in each Primary Care Network and funded as part of the Long Term Plan for the future of the NHS. Timing to introduce these posts should be linked to the development of Primary Care Networks. Consideration should be given to extending the scheme beyond early career GPs to other professions or other points in the GP career in due course.

2.b. Mid-career - Improve career opportunities and training for future leaders. (CCGs, STPs/ICSs, HEE, RCGP, NHS Leadership Academy)

- 4.27 [Recent evidence published by the King's Fund](#) has shown that many GPs, at various stages in their career, wish to develop a portfolio career. Currently there are well developed opportunities in education and commissioning, particularly towards the beginning and end of a career in general practice. More opportunities now need to be created and funded in clinical areas for the established mid-career professional, which support general practice and are based in the community. These could include specialties such as diabetes, dermatology, frailty or musculoskeletal conditions. (HEE, CCGs, STPs/ICSs, NHSE)
- 4.28 These posts should be accredited in line with the [GPs with Extended Scope of Practice framework](#) developed by the RCGP. This will need to be supported by

appropriate funding. These posts should be primarily based in Primary Care Networks with links to specialist colleagues. (HEE, RCGP, NHSE)

- 4.29 Specific training on leadership, quality improvement and management should also be provided to support GP development throughout their careers, funded by the NHS Leadership Academy and HEE. This should support the sustainability of the GP profession and the ongoing involvement of primary care and general practice at a system level. It should also provide further career structure and options for mid-career GPs. (NHS Leadership Academy, HEE)

2.c. Late career - Funded time should be provided for GPs considering early retirement to undertake a variety of different roles which would support primary care. (NHSE, CCGs, HEE)

- 4.30 GPs in the latter part of their career are often very experienced and have gained significant wisdom. However, they may not be able or may not wish to work at the same pace in terms of delivering direct clinical care as they did when they first qualified. This is particularly the case when experienced GPs are holding a more complex case load, or have taken on greater practice, partnership or network level responsibilities.

- 4.31 Building on the successes of the existing GP Retention Scheme and the GP Career Plus Pilots (and subsequent Local Retention Schemes), experienced GPs and partners in general practice should have access to a range of broader opportunities. This could include mentoring and supporting staff on the Primary Care Fellowship scheme; or providing specialist services such as frailty clinics, managing complex patients, managing care home patients or being part of a locality-wide home visiting service. (NHSE, CCGs, HEE)

2.d. The review encourages ongoing action by the Government, GMC and other national bodies to streamline and simplify the process by which doctors are able to return to the UK to practice after working abroad for an extended period of time. (DHSC, GMC, HEE, RCGP)

- 4.32 While some UK trained GPs can work abroad for short periods of time and return relatively quickly, for those who have been working abroad for more than 2 years or for those who qualified in another country for example, returning can involve significant effort and bureaucracy.

- 4.33 While it is important to have a robust system in place to ensure that GPs are suitably qualified and experienced, it is also a positive step that the Government, with the GMC and others, are considering ways in which this process could be

streamlined and simplified to support the return of GPs to general practice and primary care in England. The review encourages ongoing action to continue this process of simplification.

2.e. A review of the current pensions arrangements for GPs should be undertaken, with clear solutions proposed to address the current negative impact on partnerships. (DHSC, HMT)

- 4.34 National changes to the annual allowance and the lifetime allowance for pensions have had a significant impact on GPs, as relatively high earning professionals.
- 4.35 However, during the course of the review many have said that these changes are leading to significant personal financial impact, even for those relatively early in their career, and pension tax charges are commonly cited as a factor for GPs who are deciding to reduce their clinical commitment, retire prematurely, or opt out of the NHS Pension scheme. These perverse incentives for experienced GPs to reduce sessions, in order to reduce their exposure to additional tax charges, represent poor value for the system given the high cost of training GPs and the increased cost of locum cover to backfill capacity gaps.
- 4.36 Greater flexibility in pension contributions, in line with the flexibilities available to members of other public-sector pension schemes, would support some GPs to remain in practice for longer. The Government should urgently review current arrangements to determine what additional flexibilities could reduce the negative impact on retention of both partners and sessional GPs.

Recommendation 3: The capacity and range of healthcare professionals available to support patients in the community should be increased, through services embedded in partnership with general practice.

3.a. NHS England should expand and fund the wider general practice workforce working in practices and the local community, to support both patients and the GP workforce. (NHSE)

- 4.37 Through PCNs, practices should be supported to work together to embed additional staff in practices. This has the potential to help practices with their existing workload and help with the future demand.
- 4.38 The role of the advanced nurse practitioner should be developed to help with the direct management of patients with long term conditions and minor illnesses.

- 4.39 Pharmacists can play an important role in practices and other primary care settings, supporting the care of patients with long term conditions and minor illnesses. They have been shown to address issues of polypharmacy, medication wastage, admission and discharge medication facilitation, and the management of repeat prescriptions. There are benefits to practices, but also to the local health care system with significant savings potential. For example, West Hampshire CCG has shown a return on investment of £2 for every £1 invested in a practice-based pharmacist.
- 4.40 A musculoskeletal (MSK) therapist based in a practice can be a first point of contact for some patients presenting with an MSK problem. This would help with GP workload and reduce referrals to hospital, diagnostic tests and medication prescribed. The case studies show examples of where this has worked in practice and the [NHS Long Term Plan](#) sets a commitment to build on work already underway to ensure direct access to MSK First Contact Practitioners.
- 4.41 Mental health is a major issue for the NHS and the workload associated with this has increased significantly. There has been much focus on crisis intervention and the burden on Accident and Emergency Departments. However there remains a significant gap in the provision of adult and older people's mental health services in the community, and this has a major impact on general practice. The further development of the Community Psychiatric Nurse role could bridge the gap between general practice and mental health services. Consideration should be given for a number of posts to be established with time spent as part of the practice team, as well as the community mental health team.
- 4.42 Other NHS staff such as paramedics, care coordinators and social prescribers could make a positive contribution to practice workload and to the health of the population. Encouraging a wider scope of practitioners to work together will enhance the service provided to patients and prevent professional isolation. Significant efforts will be needed in parallel to ensure that staff are appropriately trained to work in general practice in sufficient numbers.
- 4.43 Further training and development to support practice managers should also be rolled out. Better-equipped practice managers will make a significant difference to current workload burdens, enabling partners to take on a more strategic decision-making role while a business manager oversees the day-to-day operational running of the practice, for example.
- 4.44 Timing should be linked to the development of PCNs and staff funded as part of the NHS Long Term Plan, and the accompanying workforce strategy. (NHSE)

3.b. HEE should further develop the role of Practice Nurses. (HEE)

4.45 Practice nurses play an increasingly important role in primary care, particularly in the management of long-term conditions and urgent care. This should be recognised with an agreed programme to develop these roles, with funded training and increased targeted investment that will make a real impact on the expansion of the nursing workforce. This could include the equivalent of a trainer's grant for nurses placed in practices. The long term aim should be to develop an integrated nursing team which includes practice, district and specialist nurses. (HEE)

3.c. NHS England should support emerging Primary Care Networks to make better use of the existing community health services workforce to support practices, by working more effectively with community health teams and by enabling the creation of population-based multi-professional teams across primary and community care. (NHSE)

4.46 Multi-professional community health teams should be based in primary care networks and work under the clinical and service direction of the PCN. They could remain employed by their existing employer while being more closely partnered with, and embedded in, practices day to day. This should include creating a single team using a common health record, sharing the same caseload, and removing the need for referrals. Wherever possible, the community team should also be co-located with the constituent practices of the network.

4.47 NHS England, in partnership with other bodies such as Training Hubs, will need to support PCNs and community health services to work together more effectively and become more than the sum of their parts. (NHSE)

Recommendation 4: Medical training should be refocused to increase the time spent in general practice, to develop a better understanding of the strengths and opportunities of primary care partnerships and how they fit into the wider health system.

4.a. Medical students, Foundation year doctors, GPs in Specialty Training and other clinical professions with a clear opportunity to support primary care should spend more time in general practice and in community-based roles. (HEE, RCGP, GMC, DHSC, NHSE, AoMRC)

4.48 HEE should work with the GMC and medical royal colleges to explore options for including more time in general practice in training curricula at all stages of medical training. The GMC also has a role to consider how any changes agreed could be

accommodated within their role to set standards for training and outcomes for medical education in the UK. (GMC, RCGP, AoMRC)

- 4.49 This should include the agreement of a tariff for funding undergraduate medical training placements that reflects the true cost of delivering placements in general practice and does not discriminate between hospital and general practice placements. (HEE, NHSE, DHSC)

4.b. Expand training opportunities for GPs in practices and in the community. (NHSE, HEE)

- 4.50 The process to becoming a trainer and a training practice should be consistent and simplified, whilst maintaining standards, to encourage more practices to take on this role. This is expected to support recruitment and retention by increasing the number of training practices. Sufficient funding should be made available to enable and incentivise practices to take on this role. (HEE)
- 4.51 Every PCN should be in partnership with, or become, a Training Hub, ensuring the place-based delivery of education and training in primary care for GPs and other staff working in general practice and staff aligned with the Primary Care Network. All of England should be covered by Training Hubs.

Workload

- 4.52 The current workforce in general practice and primary care is not sufficient to effectively manage the current clinical and administrative workload. With the inevitable increase in patient demand due to an ageing population and more people with long term conditions, there is an urgent need to address this. Workload is the major factor that is causing GPs to leave the profession and discouraging GPs joining partnerships. GPs at all stages of their career have identified that they would like to have more time with patients, to be able to reduce the number of patient contacts in a day, and to be able to spend longer with those patients whose complex needs require this.
- 4.53 To address the issue of workload and reverse this trend, the working day in general practice must feel safer and more manageable. This needs an expansion of the workforce to support general practice - more GPs, other healthcare professionals and non-clinical staff - with more resources going directly to practices.
- 4.54 Working at scale in a model that supports natural communities of care, such as a primary care network (PCN), could offer a route for directing the available

resources to support general practice, but it is essential that incentives to support this way of working align across the system.

Recommendation 5: Primary Care Networks should be established and operate in a way that makes constituent practices more sustainable and enables partners to address workload and safe working capacity, while continuing to support continuity of high quality, personalised, holistic care.

5.a. Primary Care Networks should be enabled to determine how best to address the balance between urgent and routine appointments during extended opening hours and weekends. (NHSE)

4.55 Extended access services in many areas are attracting GPs away from practices.

4.56 NHS England should therefore consider how existing funding for extended access and opening could be allocated through PCNs as they mature, to enable local decision making on managing demand appropriately. This should also support partnerships to feel a greater sense of control and influence over managing the safety of their working day. It could also reduce fragmentation of services and increase opportunities to improve continuity of care.

5.b. The review supports the work of NHS England and other national partners to reduce unnecessary bureaucracy, but progress must be monitored closely, and further action must be taken to ensure successful implementation. (NHSE, DHSC, and other national bodies)

4.57 The Primary and Secondary Care Interface Working Group should evaluate the success of the measures recently put in place to improve the primary and secondary care interface, and identify any further actions to be taken. This includes ensuring that hospital service providers manage patient and referrer queries in relation to their service. Where the Working Group finds that NHS Standard Contract conditions are not being met or are not having the required effect, effective solutions must be found. A report on progress and any further actions required should be made within 6 months.

4.58 Other areas of unnecessary administrative burden for partnerships include:

- Local contracts commissioned by CCGs, which frequently require reporting and monitoring that is not proportionate in terms of the contract value and activity levels. Often these contracts can be for single services and for relatively small sums of money. Performance management of local contracts should be simplified and supported through a suite of easy to use resources provided to practices. Commissioners should look to rationalise or bundle together practice level contracts to reduce their number and complexity, where this will reduce bureaucracy and provide value for money. Similarly, any new PCN level contract should have simplicity at its heart. (CCGs, NHSE)
- Unresolved issues with Capita relating to the administration of the Performers List, payments to practices and pension deductions. An urgent timescale for resolution needs to be agreed for both outstanding and future issues. (NHSE)
- Disputes between NHS Property Services or Community Health Partnerships and a number of their practice tenants, in relation to both reimbursable and non-reimbursable costs (including rent, service charges and lease terms). Where local discussions between the landlord and tenant have not achieved a resolution, these issues may need urgent mediation and action. (Practices, NHSPS, CHP, CCGs, NHSE, DHSC)
- Significant bureaucracy associated with Care Quality Commission (CQC) processes, including the registering and de-registering of partners, becoming a registered manager, and reported inconsistency in the inspection process for general practice. Recent work between the CQC and GPC means that a number of changes should shortly take place to address these problems, including: changes to the online system for adding or removing a partner, aiming to reduce the time taken from 10 weeks to three days; making changes of registered manager automatic where the change is from a GP to a GP; and giving a clear focus to clinical outcomes of care for future inspections. The planned improvements must be kept under review. (CQC, GPC)
- Inconsistency in the annual appraisal requirements and associated recording of information for GPs, despite a national agreement. There needs to be a review and standardisation of the appraisal system for GPs, in partnership with the profession. (NHSE, GMC, RCGP, BMA)
- Additional workload placed on practices and practice staff by recent GDPR changes. While the requirements of General Data Protection Regulation (GDPR) legislation are not unique to general practice and there are opportunities to mitigate the impact - for example by proactively offering access to patient records online - it is likely that requests for copies of patients' clinical records in primary care may exceed requests in most other types of organisations. This burden

should be recognised and supported, which could include the provision of resources such as a Data Protection Officer by CCGs. (CCGs, NHSE, GPC)

5.c. RCGP, GPC, NHSE and DHSC should develop an agreed strategy for the effective use of workload data, to support practices and partnerships to manage workload. (RCGP, GPC, NHSE, DHSC)

4.59 NHS England should continue to support and expand current initiatives to collect workload data, for example by the RCGP Research and Surveillance Centre and NHS Digital. Further work should be undertaken by RCGP, GPC, NHSE and DHSC to consider where workload data collections can be aligned and simplified to support practices, partnerships and the system to have the accurate and transparent information they need. (RCGP, GPC, NHSE, DHSC)

The status and role of Partnerships and Primary Care Networks in their local health systems

4.60 There is a clear case for partnerships and general practice to be the building blocks and leaders within their local healthcare system, working across boundaries with other services to provide high quality personalised care. Across the country a variety of models of working at scale are already forming, including the development of a number of Primary Care Networks covering populations of 30,000 to 50,000 people. Despite this, many GPs still feel that primary care does not yet have a meaningful seat at the table for discussions and planning at a system level.

4.61 There are also continuing concerns that the value and importance of general practice as a profession is not universally recognised, exacerbated by structural arrangements such as the separate GMC register.

Recommendation 6: General practice must have a strong, consistent and fully representative voice at system level.

6.a. General practice should be recognised by the GMC and Government as a specialty. (GMC, DHSC)

4.62 As highlighted in the interim report of the review, the GMC in the UK holds two lists: one for generalists (GPs), and one for specialists (hospital doctors). This disparity needs to be addressed. The review has written to the GMC to reaffirm the

importance of this view for the GP profession, and also supports the similar action taken on this subject by the GPC and RCGP. (GMC, DHSC)

6.b. The recommendations in the report led by Professor Val Wass and co-sponsored by the Medical Schools Council and HEE - 'By choice - not by chance: Supporting medical students towards future careers in general practice', must be implemented as soon as possible. (DHSC, GMC, other national organisations including HEE, and the Medical Royal Colleges)

4.63 The [Wass report](#) made several recommendations which have been echoed by this review, such as the recommendation for the creation of a single combined register by the GMC (see recommendation 6.a above), and the need to make changes to medical training arrangements (see recommendation 5).

4.64 The Wass report also highlighted the negative attitude towards general practice that is prevalent during time spent in hospitals as a medical student and in the early part of a doctor's career. In every part of the country the review visited, young GPs reported that they had personally experienced this negative attitude towards general practice during their training. This needs to be addressed urgently as it has a significant impact on career choices and ongoing relationships between primary, secondary and community care. Continued work should take place to prevent this negativity undermining recruitment into general practice. (Medical schools, RCGP, BMA, AoMRC, GMC, HEE)

6.c. Working at scale, for example through Primary Care Networks, has the potential to improve and support general practice influence at a system level if the right incentives and expectations are put in place. (STPs/ICSs, NHSE)

4.65 The health system of the future will be different. It will operate more in primary and community care settings. Primary care will be an integral part of managing the health of the population more effectively, keeping people out of hospital where possible. Primary care will work more as part of one local health system, often as part of an Integrated Care System (ICS).

4.66 To support this, NHSE should introduce a requirement for all STPs or ICSs to have a primary care plan that has been developed in conjunction with the Local Medical Committees in that area, that details the future vision for the delivery of primary care, with general practice at its core. Each STP or ICS must demonstrate the involvement of members of staff currently working in general practice and the community in the construction of the plan. In return, primary care must step up to the plate and play its part in the wider system. It will increasingly need to work with

others, to help manage the health of the population and keep people out of hospital when possible.

- 4.67 Additional support, clear guidance, and resources should be provided to help practices to develop their Primary Care Networks. Networks should form one new route for additional resources to be invested directly into general practice, as part of the planned significant shift of funding into primary and community care. (NHSE)

Digital and technology

- 4.68 While digital solutions were not always the first solution that came to mind for those responding to the review, the current key challenges for GP partnerships are workload and workforce. The provision of both essential IT equipment and innovative digital services could help to lessen these pressures and allow general practice to flourish.
- 4.69 Core IT estate that meets current standards of security and resilience must be the norm. With this in place, practices can confidently take a digitally-enabled approach. Digitally-enabled records will lessen the administrative burden on GPs and other members of the primary care workforce that currently exists in relation to creating, editing and transferring patient information. Patient access to these paperless and interoperable records is also key, both for ensuring patients are empowered by a transparent system and for ending the burden of Subject Access Requests that the review has heard are currently diverting so much frontline NHS resource.
- 4.70 Patient records are not the only documents that GPs must access to read, complete and send out; across the review's engagement, frustration with other forms of documentation not being available in an intuitive format has been consistent. Documents such as forms from national bodies and agencies add to GPs' non-clinical workload, and could be redesigned with a greater focus on the GP user.
- 4.71 The use of telephone contact has expanded significantly with the development of telephone triage and consultations. The introduction of algorithmic symptom checkers has also shown potential. While there is reasonable caution within the profession about Artificial Intelligence (AI) providing substantive care, these interfaces can now provide a useful triage function, akin to that performed by the NHS 111 algorithms. In some cases, this can mean directing patients to self-care, reducing demand on overstretched services. Video consultation, too, can save clinician time, but must come alongside mobile working solutions for GPs, and adequate training for all staff.

- 4.72 The Department of Health and Social Care published [The future of healthcare: our vision for digital, data and technology in health and care](#), a policy paper laying out the Secretary of State's vision for technology within the NHS and beyond, in October 2018. This included three priorities: putting in place the right infrastructure; ensuring that digital services meet people's needs; and developing the right skills, capabilities and culture.

Recommendation 7: There are opportunities that should be taken to enable practices to use resources more efficiently by ensuring access to both essential IT equipment and innovative digital services.

7.a. There should be acceleration of current work to ensure universal, paperless and interoperable systems, and scoping of new, related work where this is resource-efficient. (NHSE, NHSD, DHSC)

- 4.73 Existing work in this area includes the Electronic Prescription Service (EPS), GP2GP, and the roll-out of the NHS app, and the potential to digitalise historic Lloyd George records.
- 4.74 Digital records and the functionalities that can be built upon them can prevent clinicians and their staff from handling paper and re-keying data. In addition, a practice that is storing less paper may be able to free up more physical space on its premises. These systems need to be up-to-date, lightning fast, stable and resilient. Clinicians and staff need to be confident and supported in their use.
- 4.75 Interoperability that involves clinical correspondence being delivered electronically, and seamlessly integrated into the patient's GP-held record, as structured coded data, is essential if the NHS is to achieve its paperless potential. Nationwide implementation of properly interoperable and work-flowed clinical communications is the next step change in improving efficiency for primary care. This year's adoption of SNOMED is a sound foundation for this next step, and further significant investment should be expected through the NHS Long Term Plan.

7.b. Practices would benefit from a streamlined digital platform which could be used to access and share common documents and information. Opportunities to streamline the extraction of information from GPs by other national bodies should also be considered. (NHSE, DHSC)

- 4.76 Bodies such as NHS England, the CQC, the National Institute for Health and Care Excellence (NICE), Public Health England (PHE) and the GMC should be required to produce standardised documentation sets. This could potentially involve the creation of an intuitive online platform from which practices can use commonly accessed and shared documents - for example, the NHS Performers List and standard guidance on infection control.
- 4.77 Interactions with other agencies and national bodies, such as the Department for Work and Pensions or the Driver and Vehicle Licensing Authority, can also create an administrative burden for GPs. There may therefore also be scope to streamline and simplify these extractions which the Government should consider. (DHSC).

7.c. Digital solutions should be introduced for every practice, that can support GPs and others working in primary and community care in their roles and career choices - including support for working at scale. (NHSE, GPC)

- 4.78 This must include mobile working solutions. For example, smart phones enable real-time video consultation and, if used appropriately, can help both the patient and the GP. Additionally, tablets can enable clinicians to remotely access and input into electronic patient health records. Continuity of care may no longer need to be constrained by geographical location. However, such technologies are reliant on high-speed broadband or 4G+ infrastructures. [Mobile and broadband coverage are improving in the UK, but coverage continues to be patchy in many rural areas.](#) Mobile working should therefore be harnessed in innovative ways to support the general practice workforce. (NHSE)
- 4.79 There must also be support for practices that wish to work at scale, with digital solutions in place that can facilitate the development of practice-based multidisciplinary teams across a community of care. This should include the sharing of records between practice-based and community teams, as well as efficient messaging solutions for both text and images.

7.d The GP IT estate should be brought up to current standards of security and resilience, with appropriate support and training on relevant systems and basic cyber security hygiene for all staff working in general practice. (NHSE, DHSC)

- 4.80 In many areas, the GP IT estate does not do justice to the workforce it serves. Following the Wannacry incident of May 2017, the GPIT Operating Model 2016-18 was strengthened, but continued additional investment in the GP IT estate should be expected as part of the NHS Long Term Plan, to continue to improve cyber security and resilience.

- 4.81 It is essential that all staff working in general practice receive appropriate support and training on all relevant systems and basic cyber security hygiene, to play their part in upholding basic standards of security and resilience.

Conclusion

Without general practice the health of our population will worsen, access to specialist care will become more difficult and the cost of providing health care will increase significantly. This is what we already risk in some parts of the country. With an ageing population and increases in the number of patients with long term conditions, the future looks bleak for general practice unless action is taken now.

There have been some important initiatives in the recent past. The [GP Forward View \(GPFV\)](#) committed to investing £2.4bn annually by 2020/21 to support general practice, yet many practices have reported that they have not seen significant benefits from this investment. There are too many small sums of money, with an overly complex bidding process and funding is all too often non-recurrent. The GPFV and the NHS Long Term Plan must invest in services that help and directly support general practice at the heart of primary and community care, and ensure there is clear benefit to direct patient care. Significant additional resources are required, which must go to the practices and localities that develop services and the workforce needed to manage demand.

We need a clear vision for the future and the role that general practice and partnerships will play in that. We must also not forget other initiatives that are currently underway to support general practice. These include the planned introduction of a state backed indemnity scheme, a review of GP premises and the rules that surround this, and the contract negotiations underway between the GPC and NHS England for next year.

This review will be presented to the Government and to NHS England, for them to consider the recommendations and decide how best to deliver them along with other national bodies. The GP profession and representatives of those working in primary care will also want to consider the recommendations. Some need urgent action and resources, but others may require a change of culture and mindset.

Doing nothing cannot be an option. The consequences would be clear - the widening of health inequalities, with areas of the country where general practice will struggle to continue, the inevitable rise in pressure and costs in the rest of the health and care system, worsening clinical outcomes, and falling patient trust in the NHS.

I therefore hope the review will gain widespread support, and drive the change and additional investment that is urgently needed.

Annexes

Annex A - Full list of recommendations

Recommendation 1: There are significant opportunities that should be taken forward to reduce the personal risk and unlimited liability currently associated with GP partnerships.

1.a. NHS England's review of primary care premises should develop proposals to mitigate the personal risk associated with being a lease holder or property owner; and provide support and guidance to partnerships on property ownership. (NHSE, GPC)

1.b. The Government should introduce the option of GP Partnerships holding a GMS or PMS contract under a different legal model, such as Limited Liability Partnerships and Mutuels. (DHSC, GPC)

1.c. The Government and all relevant stakeholders must continue to support the final negotiations to introduce a state backed indemnity scheme from 1 April 2019, for all GPs and for those who work in and for practices. (DHSC, NHS England, BMA)

Recommendation 2: The number of General Practitioners who work in practices, and in roles that support the delivery of direct patient care, should be increased and funded.

2.a. Early career – A new employment opportunity for newly qualified GPs, a Primary Care Fellowship, should be launched by NHS England and HEE. This will support the development of primary care and community health staff in a range of areas appropriate to their future needs and the needs of patients. (NHSE, HEE)

2.b. Mid-career - Improve career opportunities and training for future leaders. (CCGs, STPs/ICSs, HEE, RCGP, NHS Leadership Academy)

2.c. Late career - Funded time should be provided for GPs considering early retirement to undertake a variety of different roles which would support primary care. (NHSE, CCGs, HEE)

2.d. The review encourages ongoing action by the Government, GMC and other national bodies to streamline and simplify the process by which doctors are able to return to the UK to practice after working abroad for an extended period of time. (DHSC, GMC, HEE, RCGP)

2.e. A review of the current pensions arrangements for GPs should be undertaken, with clear solutions proposed to address the current negative impact on partnerships. (DHSC, HMT)

Recommendation 3: The capacity and range of healthcare professionals available to support patients in the community should be increased, through services embedded in partnership with general practice.

3.a. NHS England should expand and fund the wider general practice workforce working in practices and the local community, to support both patients and the GP workforce. (NHSE)

3.b. HEE should further develop the role of Practice Nurses. (HEE)

3.c. NHS England should support emerging Primary Care Networks to make better use of the existing community health services workforce to support practices, by working more effectively with community health teams and by enabling the creation of population-based multi-professional teams across primary and community care. (NHSE)

Recommendation 4: Medical training should be refocused to increase the time spent in general practice, to develop a better understanding of the strengths and opportunities of primary care partnerships and how they fit into the wider health system.

4.a. Medical students, Foundation year doctors, GPs in Specialty Training and other clinical professions with a clear opportunity to support primary care should spend more time in general practice and in community-based roles. (HEE, RCGP, GMC, DHSC, NHSE, AoMRC)

4.b. Expand training opportunities for GPs in practices and in the community. (NHS England, HEE)

Recommendation 5: Primary Care Networks should be established and operate in a way that makes constituent practices more sustainable and enables partners to address workload and safe working capacity, while continuing to support continuity of high quality, personalised, holistic care.

5.a. Primary Care Networks should be enabled to determine how best to address the balance between urgent and routine appointments during extended opening hours and weekends. (NHSE)

5.b. The review supports the work of NHS England and other national partners to reduce unnecessary bureaucracy, but progress must be monitored closely, and further action must be taken to ensure successful implementation. (NHSE, DHSC, and other national bodies)

5.c. RCGP, GPC, NHSE and DHSC should develop an agreed strategy for the effective use of workload data, to support practices and partnerships to manage workload. (RCGP, GPC, NHSE, DHSC)

Recommendation 6: General practice must have a strong, consistent and fully representative voice at system level.

6.a. General practice should be recognised by the GMC and Government as a specialty. (GMC, DHSC)

6.b. The recommendations in the report led by Professor Val Wass and co-sponsored by the Medical Schools Council and HEE - By choice - not by chance: Supporting medical students towards future careers in general practice, must be implemented as soon as possible. (DHSC, GMC, other national organisations including HEE, and the Medical Royal Colleges).

6.c. Working at scale, for example through Primary Care Networks, has the potential to improve and support general practice influence at a system level if the right incentives and expectations are put in place (STPs/ICSSs, NHSE).

Recommendation 7: There are opportunities that should be taken to enable practices to use resources more efficiently by ensuring access to both essential IT equipment and innovative digital services.

7.a. There should be acceleration of current work to ensure universal, paperless and interoperable systems, and scoping of new, related work where this is resource-efficient. (NHSE, NHSD, DHSC)

7.b. Practices would benefit from a streamlined digital platform which could be used to access and share common documents and information. Opportunities to streamline the extraction of information from GPs by other national bodies should also be considered. (NHSE, DHSC)

7.c. Digital solutions should be introduced for every practice, that can support GPs and others working in primary and community care in their roles and career choices - including support for working at scale. (NHSE, GPC)

7.d The GP IT estate should be brought up to current standards of security and resilience, with appropriate support and training on relevant systems and basic cyber security hygiene for all staff working in general practice. (NHSE, DHSC)

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