Partnership Model Review Survey

Background

Jeremy Hunt commissioned a major independent review of the partnership model to look into how General Practice needs to evolve in the modern NHS. The Partnership Model Review is intended to consider how to reinvigorate the partnership model of General Practice and equip it to help lead the transformation of General Practice for the future. The review is supported by:

- Department of Health
- NHS England
- General Practitioners Committee of the BMA
- Royal College of General Practitioners

The Chief Executive of Wessex LMCs, Dr Nigel Watson was appointed chair and is overseeing the review. Dr Nigel Watson has been asked to produce an interim report by the end of September with a final report by the end of the year. The report aims to make recommendations that will rivitalise the partnership model and ensure that it has considered GPs, other staff working in general practice, patients and the wider system.

The role of YORLMC

YORLMC has been invited to contribute directly to the review.

YORLMC circulated a survey monkey survey to all North Yorkshire & York and Bradford, Airedale, Wharfedale & Craven GPs and practice staff to seek opinions and collect views on what works and what doesn't work. YORLMC has also arranged local discussions/visits between Dr Nigel Watson and his review team and a couple of local practices to help inform the review.

The information captured during the survey will be used to both inform a round table discussion between Dr Nigel Watson and his review team and Officers of the North Yorkshire and Bradford & Airedale branches of YORLMC and will be fed directly into the overarching review.

Quick link to the challenges currently facing partnerships

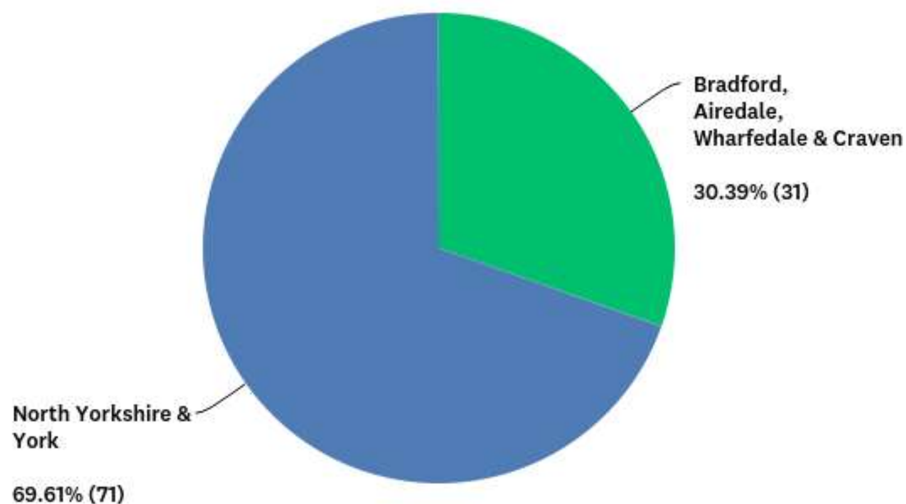
Quick link to how does the current model of service delivery meet or make worse the challenges faced

Quick link to the benefits of the partnership model for patients, partners, salaried GPs, broader practice staff and the wider NHS

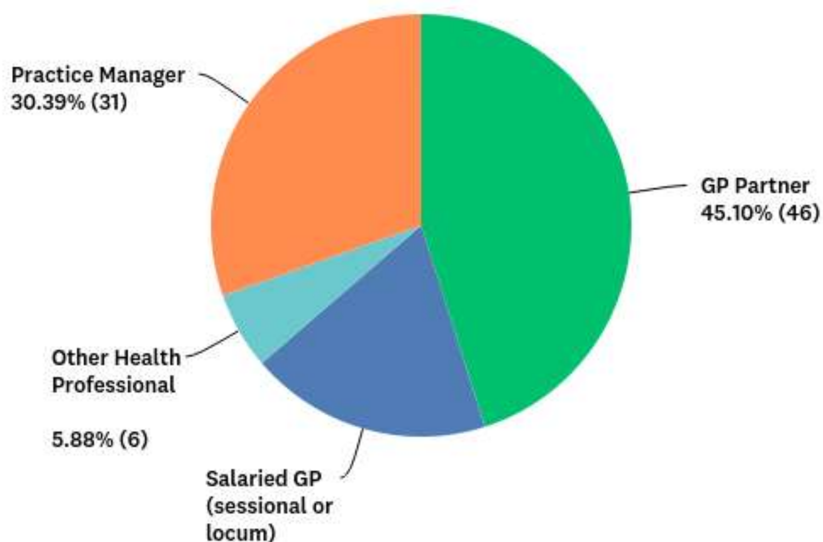
Quick link to the shortcomings of the partnership model for patients, partners, salaried GPs, locum GPs, broader practice staff and the wider NHS

Quick link to what is needed to reinvigorate the partnership model to equip it to help the transformation of General Practice, benefiting patients and staff including GPs

Q1 Where do you do the majority of your work?

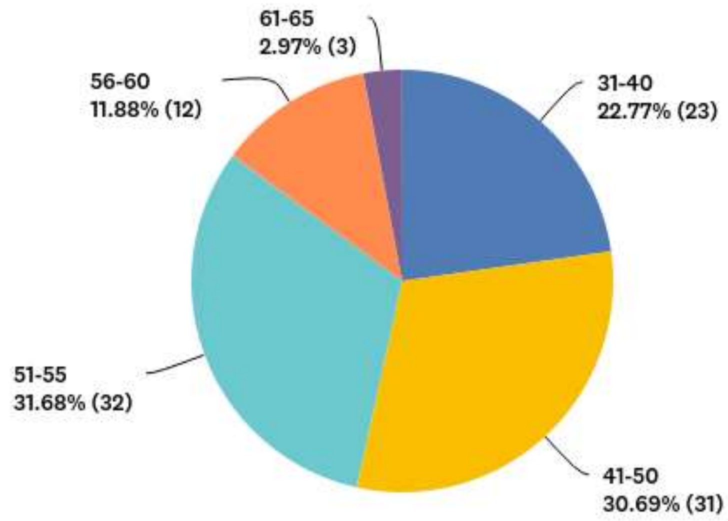


Q2 Are you a:



CHOICES	RESPONSES
GP Partner	45.10% (46)
Salaried GP (sessional or locum)	18.63% (19)
GPR	0.00% (0)
Other Health Professional	5.88% (6)
Practice Manager	30.39% (31)
Other Practice Staff	0.00% (0)

Q3 What is your age group?



Q4 What do you consider to be the challenges currently facing partnerships within the context of General Practice and the wider NHS?

Key themes are:

- Recruitment crisis / Staff retention
- Partnership no longer an attractive model
- Premises barrier
- Financial uncertainty of buying into a partnership
- Time pressures
- Unnecessary administrative burden
- Excessive workload
- Lack of NHS investment in General Practice
- Patient expectations/demand
- Increasing patient complexity
- Low morale/demoralised workforce
- Constant change of pathways/monitoring of referrals
- Political agenda

Full detailed responses:

1. Workload, succession planning (recruitment and retention)
2. Recruitment is becoming increasingly difficult, which results in partners having to stay later in the evening to get all the work done as they still have a contractual obligation (not to mention a sense of duty). Premises - a huge barrier to new partners joining in terms of financial risk, and real difficulties for current partners raising finance in some circumstances. Given there is no limited liability there is a real risk to partners families and livelihoods, and understandably when that risk starts to become greater partners leave, a domino effect happens, and you are into last man standing scenario. Premises inadequacy is also a huge issue and ETTF is just not delivering. We have spent 18months negotiating with other local practices to look at merging into a new building only for the bid to be rejected in the need by the CCG due to financial constraints and concerns re: on-going revenue implications. Workload - this is becoming unsustainable. The aligned incentive schemes with the CCGs and trusts only work to manage their debt, and exclude primary care, with a real risk that even more unfunded work will flow into our block contract whilst they wish to do as little as possible in their 'block contract' to save money. We are not on a level playing field and can no longer absorb any more work. This pace of work is unsafe, unhealthy and non-sustainable -why would anyone want to become a partner in the current climate? The buck stops with you, locums and salaried GPs go home, we have to still do the work, and out of a sense of pride and
duty we put patients first, but only for so long as it will impact significantly on our own health. Every practice is vulnerable and just one step away from crisis, and this risk is continuously hanging over you.
3. Bureaucracy an unnecessary administrative burden
4 Excessive workload lack of time lack of skill mix
5 Underfunding, and shortage of GPs to provide services even were funding to be available
6 Lack of resources/support. Constant change. Poor IT intercommunication
7 Sustainable work force planning
8. Lack of GPs lack of practice nurses lack of specialist nurses. Lack of support for primary care centrally Shift of work into primary care from secondary care. Erosion of community services through poor funding. Poor mental health services. Short sightedness of NHS funding
9 Recruitment/Retention Finances Estates
10. Recruitment of clinical staff - GPs and nurses. Financial pressures - being asked continually to do more for less. Pressure of work - I regularly work a 12+ hour day and there is simply no time or energy left for thinking/reflection/strategic planning - this is not safe or sustainable in the long term. I can sustain this at the moment because I know it is only going to be for a few more

years for me. I think it is fairly clear that NHS England wants to see an end to partnerships because it fundamentally distrusts GPs because of their Independent Contractor status, whereas the reality is that GPs have the power to be the saviours of the NHS, if only NHS England would trust them.

11. Recruitment and lack of support for primary care in general
12. Resources. Increasing demands on the services. Funding. Recruitment and retention of both GP's and experienced nurses.
13. Recruitment & retention, funding

14 Who will want to take it on, huge responsibility and risk, both personally, professionally and financially.

15 Recruitment difficulties Burden of management and administration- the more joined-up working we do the more we have to attend meetings and emails to contribute to those forums, taking us away from practice.

16 Recruitment - seen to be a stressful job with not a great deal of extra benefit compared to salaried and locum which are becoming increasing well paid.

17 Under funding of the practice. We have seen an exponential rise in workload with a flat lining of funding for many years and what new money comes in it attached to new work. There has been a massive shift of workload from secondary care and a worsening social care. Along with increased regulation this has led to a toxic environment. We used to be trusted to run practices and look after patients as professionals. There is the also the aging population and increase multi-morbidity. We still nun on 10-minute consultations which is also no sustainable, we need at least 15-20 min now for large numbers of patients, but we cannot do this whilst we are at the current funding. When I 1st started almost 20 years ago, you could get a routine appointment then same or next day, we are now at 4 weeks

18 Time pressure. Patient expectations. Staffing issues low morale due to low wages. Standards being set which fit urban practices not rural practices for example working at scale. Social care being underfunded therefore patients are being admitted to hospital as there is no care for them.

19 Insufficient GP workforce. Growing burden on primary care workload. Increasing patient expectations and demands. Financial pressures on practices. Fewer GPs wanting to become partners. Limitations to the work that allied primary care professionals can do compared to GPs Increased litigation. Not enough time to spend with patients which affects quality of care and ultimately safety. Less job satisfaction for those working within primary care due to the above factors.

20 Decreasing resources - financial + workforce. Increasing patient complexity and demands.

21 Recruitment and retention of staff - at all levels. GPs is the most obvious but all areas of the primary care model are suffering from the lack of investment to make the roles attractive.

22 Lack of young doctors being attracted to Partnerships as the current financial and regulatory environment has made them unattractive and risky

23 Lack of finances. Lack of GPs.

24 Recruitment crisis and increasing workload and reduced income making the model unsustainable

25 poor funding, unreasonable patient and politician demands, too much work being sloped from secondary care, too much bureaucracy - eg RSS difficulty recruiting partners

26 Lack of Trainees and subsequently Doctors applying to fill vacant posts.

27 Partnership too tying, no guaranteed profit in it

28 Increased workload, increased pressures from CCGs to save money at the cost of patient best interests, lack of GPs to employ, increased patient demands

29 Lack of GPs.

30 Demoralised work force not enough staff- old budgets and staffing levels not reflecting the huge increase in demand, complexity and age of populations too much dumping from secondary care unrealistic patient expectations and attitudes - lack of self-responsibility and self-care

31 Retention Recruitment

32 Increasing demand and expectations of patients. Increased complexity of the range of medical treatments provided with the offloading of work from secondary to primary care. No resources provided to primary care to manage this extra workload. Many years of poor recruitment to General Practice and Community care means no staff available to continue the service.

33 Reduction in partnership pay due to constant battles re contracts and funding more recently qualified doctors don’t want to be partners due to pay reduction they will be better off if not

34 Recruiting GPs who want to be Partners, taking on the additional responsibilities. DoH antipathy to the partnership model. Amalgamation of GP Practices to bigger units. Increasing regulation Finance

35 Underfunding of Primary Care Ageing population and increasing demand on Primary Care Difficulties recruiting GPs and Practice nurses Difficulties retaining GPs

36 Falling finances. Alteration in GP training not preparing trainees for partnership. Falling income of GP partners. Increasing workloads. Haemorrhage of older GPs. Increasing locum costs.

37 Cannot see partnerships surviving in the future poor funding not enough GPs excessive work load

38 GP partners drawings decreasing and effectively earning the same as salaried GP's

39 Increasing complexity of running a GP surgery.

40 The lack of stability. How can a partner buy in to a practice over 25 years when they don't know what will be decided in 5?

41 GP's no longer want to buy into the model and tie money into property and retiring GP's cannot get Their money out. Most solutions are sale and lease back. By becoming a salaried GP there is less responsibility and it seems an easier option. Locums have crucified General Practice by being allowed to charge significantly higher rates in Practices that are already struggling to maintain cash flow.

42 Workforce Workload

43 Overwhelming workload, reduced funding and shortages of staff of all types, Drs nurses etc.

44 Workload. Difficulty recruiting GPs

45 Dealing with an ageing population, and a crisis in social care.

46 Defunding, deskilling of workforce, lack of appropriate resources. Low morale, early retirement, burnout, lack of new GPs. Incremental privatisation/outsourcing of NHS.

47 Rising responsibility reducing reward inability to recruit GPs unlimited liability of partnership

48 not enough money or practitioners to meet the public demand

49 Existing partners working excessively long days (typically 12 hours+) to meet ever increasing demand with fewer resources. This is now making it difficult to recruit new partners in an environment where this a growing shortage of GPs generally

50 Recruitment and income preservation whilst also investing in staff and premises.

51 chasing funds, patient demand

52 Income, difficulties in recruitment, work load unrealistic, aging population and increasing complexity of patient needs, patient expectations and conflicts in referral restrictions, out dated model of 10minute appt- unrealistic and increasing administration work

53 Lack of funding Increased demand Difficulty in recruitment Part time working

54 Recruitment, and the number of females wanting part time work, with males having to pick up the pieces, I am the only full-time partner in our practice, it seems full time work will no longer be sustainable, as the demands of covering absent partners is huge. Also, retention of staff, I am considering a move to Australia or doing locum work as opposed to staying in partnership. Also, since we struggle to recruit, and there is a buy in, we have a major back load, which hits our earnings, so we work harder, get paid less cannot continue. How we can provide 8 to 8 on top of this, I do not know

55 Falling income Pension contributions and loss of tax relief - GPs are disproportionately affected compared to secondary care Future recruitment PFI premises liability Desire from NHSE for mergers and GP working at scale - this is difficult to achieve with current partnership model as lots of GPs are near retirement and don't want to change anything. Fear that if partnership model is changed those of us who have bought into partnerships will lose out massively. If practices around you collapse it will be your practice that ends up taking the strain

56 Underfunding, low morale, drowning in paperwork and ever-increasing courses and training for things we have been doing for years. As generalists this takes a huge amount of time away from patient facing work. Everything is needing diplomas with regular updates and we just do not have the time. Guidance for this always seems to come from people who do not actually currently work in front line positions. Patient demand far exceeds clinician availability. Demand is encouraged by politicians and media telling people they 'cannot be too careful' and have the right to be seen. Some people are no longer trying to self-care as they want everything to be checked out 'just in case'. Fear of complaints and the huge amount of time and stress involved with dealing with them. Seems to be a push towards federations and I think that is not in the interests of the patients. Underfunding.

57 Huge admin workload to be fitted in to huge clinical workload Premises uncertainty- lack of investment means our plans to merge with other practices will be challenging

58 Under funding. Constant change of pathways, referral guidance, IT systems, monitoring of referrals even though we are low referrers. Recruiting partners in our area to date has not been difficult but changes in secondary care and reduced junior training in our local DGH in Northallerton, reduces those expressing an interest locally. I am frustrated with the constant discussion re merger and cluster which may be appropriate for some inner-city areas but our geography and demography are different and our patient knowledge and their accessibility and feedback is excellent. If patients are happy then life as a GP is more fruitful and rewarding, get bigger and doctor/ patient continuity is lost and then everyone gets frustrated. Filling in the gaps for patients where secondary care does not is also time consuming and getting rather tired of

mopping up patient's frustrations re hospital wait and communication (or rather lack of). I have excellent young, innovative partners but increasing salaried doctors loses ownership of the whole package and I am not sure how we get that back. GPs save the NHS a fortune, ultimately fair pay and adequate numb bees of DRs and nurses are the answer together with national directives on what the NHS will not provide with clear information delivered to the Public. Patient expectations have to be challenged and managed publicly.

59 Succession plans for bring in new partners in to the businesses are not in place. lack of GPs with business training and business knowledge.

60 Ongoing underfunding of the whole NHS. Work being moved from secondary care to primary care with insufficient funding. So more work in primary for the same level of funding. Very little in the way of monies for new premises/premises improvements.

61 General feeling of uncertainty in the sector and political pressure against GPs

62 Lack of NHS investment in General Practice by the NHS, difficulties recruiting Doctors into General Practice and retaining existing ones & the consequent financial instability of running a practice and providing safe services

63 Recruitment Falling income

64 Providing good quality care Recruitment Motivation to continue

65 Recruitment. Managing a small business makes it difficult have a contingency plan for employees leaving sick leave. Also, larger organisations benefit from economies of scale e.g. can hire specialist staff/work more efficiently

66 I am a non-GP Partner (which was not an option above. The challenge is that GP's are not coming through training seeing partnership as a good option, as there is a career path as a salaried GP with the security of employment many see this as the 'usual' route. There are still some that are interested but these are fewer and many don't have business acumen. The model needs to encourage other people into partnership who can run successful ethical business

67 Recruitment, capital required to buy in to a practice, impact of ownership of property, disparity between partner working v salaried GP contract

68 Locally younger GPs are keen to be more involved and in partnerships so that they have some say in and some control of their working conditions. One of the significant local issues is that salaried doctors can be paid less to do similar amounts of work / greater amounts of work and GP partners who are used to the historically high incomes they received under the last government can continue to draw high incomes. Sadly, this is short sighted and means many salaried GPs are taking up less stressful locum roles and are not staying long term in practices. At some point the current 50+ generation will retire and leave behind generations of GPs who have not been given the opportunity or necessity to develop the skills required of partners.

69 Lack of practice income. Our practice profits have decreased by 30% in a two-year period. This means that we have had to make cuts to both clinical and non-staffing at a time when patient demands and non-clinical workload have significantly increased (including workload driven by NHS England, CCG and capita). Partners have all taken a large pay cut and to be able to afford this some have been forced to take on other (better paid) employment out with the Partnership. Our Partners are now paid around the same amount as our salaries GPs yet work an awful lot more hours with more responsibility. Promises of increased funding to General Practice have not hit front line General practice or have been ring-fenced into un-needed areas and therefore been ineffective (sometimes it appears additional funding has simply lined the pockets of private
companies providing externals contracts (e.g IT, reports, project management).

70. Work load not enough pay in most partnerships. no long term plan. Yearly changes in QOF etc, there is no consistency, each government in power want to make it mark on GP whether it is a good thing long term or not

71. Financial survival Recruiting and retaining both GPs and health care professionals Increasing workload and pressure

72. patient expectation and complaints under resourced

73. Increasing demand and reduced workforce

74. Ever increasing workload

75. Lack of young GPs and fact that those that do come into practice do not want partnership Lack of finances - we are increasingly asked to take on more and more work with NO real increase in remuneration. I am part of a newly merged organisation of 4 practices - somewhere the money was supposed to be and frankly are receiving little support

76 Sustainability- workforce, financial, political, in the face of unquenchable demand, increased scrutiny & palpable accountability. All those wider factors mean that Doctors & other potential partners (managers & nursing etc) are reluctant to take on Partnership, & senior Partners like me are thinking twice about continuing. And there's the significant toll on our personal lives.

77 Burn out - simply too much work too for the funding we receive - can't get enough staff and risk of reducing income each year

78 Recruitment Ability to fulfil contract Cherry picking of services by private companies Increasing costs and workload Limited sources of increase income apart from extended hours which is not needed or wanted in this area

79 Under funding. Difficulty in attracting GPs, nurses and other staff due to a shortage of these nationally.

80 Property ownership (recruiting new partners who want to buy into property) Partnership recruitment Increasing staff costs and overheads Workload levels - clinical and non-clinical

81 Sufficient members willing to take on the responsibility and liability of a practice partnership, willingness/ability to 'buy in' to partnerships

82 Excess workload Unpaid work transferred from secondary care PMS funding reduction Retiring GPS Pension changes meaning GPS leaving the scheme 60% of training places filled Negative press Increasingly demanding patients Increasingly complex patients

83 Lots of change. Staff morale. Patient demand.

84 recruitment & patient demand/expectations more complex needs

85 Maintaining levels of income Dealing with increasing demands on services Retaining staff. Recruiting trained staff (Practice nurse, Practice HCAs, Primary Care Pharmacists, Practice mental health staff...) Resilience of GPs and their teams Working at scale /collaborative working is hard to achieve because of pension rules, VAT rules, indemnity cover issues, data rules etc. We are trying to move in this direction but there are too many brick walls Short term finding of projects. Regular major restructuring of associated organisations (PCTs to CCGs / NHS England / PCSE). The lack of funding coming out of secondary care as work drips out

86 Work load and stress

87 Workload and lack of GP's wanting to sign up as a partner causing problems with buy in to the premises and cash flow in current account

88 Moving work from secondary care into primary care without any additional funds to do that work. The work itself is appropriate for primary care but we have no resources with which to take it on.

89 Making it an attractive option for GPs to become Partners. Ensuring the balance between workload and financial reward is appropriate. There has to be a financial benefit to take on the additional risk and responsibility of being a partner. Supporting GPs to make the transition to partners. Providing non-clinical training (business, finance, HR etc) to give GPs an overview of their role as a Partner. They don't need to be experts (that's why they employ business managers etc) but they need to gain an understanding of their role and responsibility. The premise risk of an issue for practices who have existing partners in a building that is either not fit for purposes now or the financial costs to 'buy-in' are prohibitive.

90 Work-life balance

91 Financial Uncertainty as to whether to buy into a Partnership. The increased costs of buying into Premises.

92 Attracting new Partners with older Partners retiring. Working at scale and reviewing how/if Practices should merge. Prohibitive costs of new Partners buying into property/working capital. Lack of business skills of potential new Partners

93 Lack of GPs and in particular GPs wanting to buy into the partnership model and more wanting portfolio careers. More female GPs needing time off for maternity leave and part time working with a family. More GPs at the end of their career and wanting earlier retirement due to pressure of work. Gap in training of new GPs in recent years. Less partners means that salaried GPs not necessarily wanting to take ownership of the business responsibilities and day to day support for practice staff and attending meetings which affect the practice's future. Pressure from CCG's/NHSE to make changes at short notice. Payment issues from PCSE have compounded financial pressures and the ability to run the business.

94 All aspects of running the Practice in primary care at the same time being given the requirement to bid to provide services in the practice boundaries with little funding and raising costs.

95 Unreasonable patient expectation/demand & a lack of any political willingness to address it. Recruitment Lack of funding Political considerations affecting practical delivery of care

96 Increased exposure to litigation, lack of support infrastructure (PCSE/eMBED/CCG), no capacity to improve and deliver on the 5YFV, staff on low wages but receive daily pressure from patients with unrealistic expectations, often fostered by national PR, a lot of people who are not performing at a required level but the culture often too supportive, practice management has no recognition but is a key driver for general practice improvement, GPs want to progress when they start at salaried level but you can only have so many partners.

97 Partnership is no longer attractive to incoming GPs. They see that Partners carry excessive workloads and have no control over the demands placed upon them. Salaried GPs can "work to rule" and thus control their daily work.

98 Simple - lack of trained GP's. Existing GP's retiring

99 Working at scale / consolidation of practices driving efficiency to remain profitable and worthwhile increased pressures on general practice from whole system pressures need to innovate and develop to meet the changing needs of our patients and wider system changes

100 Underinvestment in GP partnerships. New GPs coming out of training who are not "work ready" particularly after the new contract was negotiated which has had a negatively impacted on the quality of GP coming through GP school GP partnership work is no longer an attractive option because new doctors can earn more as a locum and have much less stress GP partners have to many demands from the wider NHS (CCG board, Bradford Care alliance and now Primary care home) GPs are no longer given any professional credit and are completely undermined by secondary care and Media as being lazy, greedy etc

101 Finance, Working at Scale and meeting the political agenda which doesn’t fit with delivery of Service

Q5 How does the current model of service delivery meet or make worse the challenges faced?

Key themes are:

Meets

- The current model is by and large effective. Partnerships are good at managing resources and budgets
- Partnership allows practices to adapt quickly to respond to local demands and changes in service models
- Partnerships have over decades been shown to be the most efficient part of the NHS
- Partners are driven by the desire to provide a quality service
- Primary care still manages to face and meet the continual challenges thrown at it.
- By being rapidly flexible & adaptable, Partnership allows more flexibility, more control and inclusion
- Current model has nothing to do with the challenges faced

Makes worse

- Financially
- Stress on Partners
- Impossible to sustain
- Current unsustainable workload - allows work to be shifted in an unlimited way
- New GPs do not want to be partners - they prefer a salaried or locum approach
- Partners retiring, not able to be replace
- Notional rent does not cover all the costs of loan to buy into property
- Lack of certainty about GP contract
- Partners are not always close to what is happening on the Horizon, it tends to be Practice managers that scan, feedback and strategize

Full detailed responses:

1. The partnership model results in the buck stopping with us, and us just absorbing everything else from all angles, because we have no-where else to send it. General practice has only survived for as long as it has because of the additional sweat and tears partners up and down the country put in day after day to ensure their practice continues to offer a good service. Whilst ever we are the Cinderella of the NHS on a block contract this situation is unlikely to change. The challenges have only been met through the diligence and extra work of partners (any many other practice staff) keeping general practice afloat.
2. It's repeated in every practice - large or small, near or far
3. not enough appts appts not long enough
4. The flexibility and dedication of the partnership model makes the best of the difficult circumstances
5. Lots of top down direction with limited support for enabling big level change
6. Ownership of the practice includes commitment to wider needs of patients, not opting out when it gets tough, but also this due to workforce not being sustainable is making resulting in early leaving from profession, and such high levels of stress and burnout that the workforce still at work are working a low levels of effectiveness
7. Challenges made worse because it’s too easy to dump work in primary care. Hospitals are paid per unit of work done, GPs have an annual tariff. We all need to be funded the same way GP partnerships can provide brilliant care to their patient population, but it is not sustainable when the funding is not there to make the job attractive but also to allow you to do a good job - administrative load/lack of services/high demand

8 Partnership allows practices to adapt quickly to respond to local demands and changes in service models eg employing and training AHPs to strengthen the workforce. It potentially makes things worse as stakes are high for partners and risks may not be taken.

9 Our current model of service delivery works well for our local population but requires a lot of hard work from the team, and the partners in particular. The main problem we face is the relentless pressure on appointments. The danger with "Improving Access to General Practice" and other such schemes is, because this is expected to be delivered by an existing workforce which is stretched to breaking-point (and sometimes beyond) the practical effect in many places may be to REDUCE access to the GP that a patient wants to see, because he/she has had to reduce the daytime availability in order to work at a different time, possibly in a different part of the locality.
That makes absolutely no sense whatsoever and has not been requested by our patients.

10 Local GPs who know and understand the needs of their local populations, however poor and fragmented roll out of services depending on support and engagement of local CCG's

11 The current model is by and large effective. Partnerships are good at managing resources and budgets. Secondary care could learn lessons. General practice serves local communities well with accessibility for patients and continuity of care.

12 Huge demand & time pressures

13 The focus on practices working together is hugely time consuming with little or no benefit for patients. It helps the central orgs who agree on funding etc to work with fewer larger organisations. To date, it doesn't appear to help patients much. There needs to be more support

14 GP partners give over and above to meet the challenges of the NHS they can think out of the box, make changes quickly.

15 The problem with general practice is not the model delivery, partnerships have over decades been shown to be the most efficient part of the NHS, it is the chronic underfunding and over regulation (see above)

16 Working at scale for certain bids is not practical in rural locations ie the pharmacist bid

17 It is an out-dated model which no longer is the correct solution to the needs of the current and emerging primary care (including GP) workforce. In many ways, it is also unable to meet the requirements of the patients too.

18 Distracts GP partners away from clinical work + innovation.

19 Patient expectations of access to primary care is constantly being increased through various models- i.e. .Extended Access - weekend service.

20 If supported by adequate resource commitment and stability partnership remains the best way of delivering long term continuity to patients and commitment of doctors to a community

21 Meets challenges purely due to current GPs working above and beyond a sustainable level for little income and no gratitude.

22 Partners work extremely long hours to deliver the level of care needed in very challenging circumstances, salaried doctors in the main work to rule and do not intend to expand their working hours to meet fluctuations in demand. The workload would not be covered by making all GP's resort to a salaried post as less work would be undertaken overall.

23 The current model of service delivery seems impossible to sustain. We spend far too much time dealing with "refused" referrals and other ridiculous bureaucratic tasks. The pharmacy regulations are far too restrictive as are some of the barriers to providing private services. We have had requests for private treatments (for example minor surgery) that we have not been able to fulfil

24 Often Patients are sent out of hospital without the reason for admission being fully addressed, GP's then have to spend valuable time picking up the pieces & often readmitting them a few days later!

25 It is failing due to a diminishing workforce

26 Many new GPs do not want to be partners - they prefer a salaried or locum approach. Working on a partnership-based model puts a lot of people off.

27 Secondary care under too much pressure to get people out so people discharged not properly treated or diagnosed, lack of holistic care or seeing the wider picture so reducing health care and running up costs long term and ends up dumping on primary care

28 Business success /stability of the practice is not shared by all clinicians-- those wishing to just do a clinical job can do so with the avoidance of financial incentives which make the business model work

29 Encouragement for services to be moved into primary and community care with no resources or staffing to manage this work.

30 The current model has worked well in that most partners are driven by the desire to provide a quality service, have taken on extra responsibilities and have put their patient and practice needs before their own. They have often worked far more than contracted hours, have had to

adapt to continual changes from DH and increasingly commissioners. But that workload brings a toll and that is telling. As a long-standing GP with over 34 years' experience, I am now working 3 days only, but that if full time + for most other professionals in that I still do in excess of 40 hours per week. I am not alone That model of service delivery is not sustainable long term for any one. I shall be retiring in the next 12 months so can continue to do this

31 Lack of clarity on what is core GMS, means GPs become dumping ground for everything and anything that Secondary care/ Mental health services/ Social care choose to define as not within their remit.

32 Heavy workload of partners puts off trainees/ salaried GPs/ locums applying for these roles. Partners retiring and not being able to be replaced.

33 There are not enough GPs to meet the demands of the population.

34 Underfunding in general practice

35 There is a drive to increasing practice size to spread the cost of support services, but with increased size comes further complexity and a move away from personalised patient care from a known GP with easy access to the service.

36 We need stability, guarantees that "you can expect this to be the case for this long.."

37 Workload not proportionately funded

38 Current model allows work to be shifted in an unlimited way. If we had time limited job slots like hospital Drs the amount of work being done might be better recognised.

39 Historically it has met them. I'm not convinced there is a model that would meet the challenges any better than the present one, although I do think bigger practices would help

40 Limited options to care for the elderly in the community

41 It is not adequately supported, nor are concerns adequately responded to and honestly addressed by government

42 Current unsustainable workload on individual clinical work

43 Very scantily, working to the bare bones

44 The current model encourages partners to work longer hours and pick up work that salaried colleagues may not feel obliged to do. This keeps up the illusion that practices are coping with demand but at the same time pushes partners towards early retirement through burn out.

45 Variable income because of short term funding pots to bid for makes longer term planning difficult particularly when recruiting great staff. Unless a staff member leaves or retires it is difficult to be innovative or to involve yourself in these projects when you work in a smaller practice where all extra expense hits the partners straight in the pocket.

46 Demand exceeds supply- poor recruitment and increasing workload makes GP unsustainable and unattractive career choice

47 Ownership encourages personal responsibility for issues. Problems are often sorted more efficiently on smaller scale. Having worked as both salaried and as a partner I feel a model is required that encourages a GP to take responsibility for issues rather than expecting the system or someone else to do it.

48 We have a personal list size which enables us to respond to same day appointments, and wish this to continue, yet some form of working closer together with other practices seems inevitable, but we do not want to lose our core beliefs, which patients also lie and are flocking to us, our list size continues to increase

49 Lack of certainty about GP contract - the fact it's not clear ahead of the financial year is ludicrous. Partners constantly end up taking on more work with no additional funding as work is moved into the primary care sector GPFV funds are difficult to access

50 System can be played by regular attenders who seems to appear every few day but patients who rarely attend struggle to get appts. too much emphasis on wants rather than needs. Very difficult to judge how many on the day and book in advance appointments are needed. There are never enough of either and patients are frustrated by not being able to be seen when they want and by whom, it is difficult to deal with these unrealistic expectations.

51 Fragmented mental health service poor community staff do not work in partnership with practices and are rarely seen. Very restrictive in what they will do, meaning more patients get admitted to hospital

52 No correlation between patient demand and funding

53 Where we are in rural North Yorkshire, small is good and doesn't need to change in terms of patient communication, funding for back room staff and joined up approach across practices in terms of HR, GDPR, CQC and some clinical support ok but we ain't broken so don't fix it so it is not recognisable.

54 Need more GPs in practice Delivery the service that is most convenient for the patients.

55 Primary care still manages to face and meet the continual challenges thrown at it. It doesn't worsen the challenges. Consecutive governments have ramped up patient expectations over many years, telling them that they "need" a 24/7 365 service, when in actual fact they don't. They might want it, but they don't need it. Actually, the current model with daytime, afternoon

and some evening appointments with OOH picking up covering 6pm to 8am and weekends works brilliantly. We now need to concentrate effort on educating patients to self-care (not come and see the doctor with a cold or sore throat or flu immediately it starts etc) Patients have been told year upon year what their rights are, this must be balanced with their responsibilities which include not abusing the NHS which appears to be happening on a huge scale. It isn't a free service, it is paid for out of our taxes.

56 Current model is adaptable and can change, companies can be too rigid, larger organisations too unwieldy.

57 As most of general Practices are run as small businesses, they have been seen as responsible for the difficulties of General Practice & the overall NHS response to the current crisis has been slow and inadequate

58 Staff expect wage increments annually in line with hospitals, but our income goes down. If we can recruit we make the current model work well. We are considering employing a paramedic for the visits, as the increase in workload at the surgery makes visits more inefficient. Increase in doctors preferring to be salaried (due to falling partnership incomes) means that they work to rule with admin putting more admin onto partners.

59 Partnership model is dead. Not enough young GPs want to or can afford to be partners. The lifelong responsibility and lack of easy ability to leave put people off. The model of GPs leading primary care is dead too. A whole MDT approach is needed

61 Pro - flexible, reactive, established Against - scale is more difficult, large numbers of partners running a business is a challenge

62 Greater flexibility with partnership model as opposed to salaried model allowing demands to be met easier

63 The current systems place high time demands on all. Our shortly anticipated new contract with the hospital wishes to drastically cut referrals to the hospital. However, with current pressures on GP time and the lack of continuity of care due to so many part time and locum roles, it is harder to provide quality care which would prevent over referral and admissions.

64 There is an awful lot of praise for GP partnerships from patient feedbacks and CQC reports. I am not convinced alternative models would provide successful long-term solutions. The partnership model relies on a great deal of goodwill from GP Partners which of paid for via an alternative model may well cost a great deal more. My current day is around 12-13 hours and I get paid around the same as a salaried GP doing an 8-hour protected role. If the government wishes to change the Partnership model I expect patient care to decrease as the ownership may be lacking and the service cost to increase as there will be less ‘goodwill’.

65 Struggling to recruit salaried GP and locums GP limit their work so more stress on the team. There is too much instability. forcing GPs to vary their skill profile therefore less boots on the ground for basic GP work which is stressful.

66 We seem to have a changing world every time there is a political shift as though the NHS can be tweaked to help their own party-political pledges and stance We are constantly expanding and working at scale then contracting into more localism. It is hard to plan ahead as agendas are set by each government and season!

67 No one wants partnership so pressure on current partners to provide service

68 Frustrations of patients unable to access appointments. Minimal finances in social and mental health care

69 Harder to find good employees and the buck stops with the partners

70 All the responsibility is with the shrinking pool of partners. We are expected to absorb everything - by everyone - staff and DoH alike

71 Meets- by being rapidly flexible & adaptable, especially as well-developed IT. Committed workforce which works flexibly, not restrained by working time directives. Very close to & responsive to the needs of its own patient population. Track record of innovation. Exacerbates: frustration, cynicism & fatigue of Partners, related to numerous NHS reorganisations with political rather than health motivations. The instability of funding streams with including expenses means that we often have to focus on maintaining the current provision, with reduced capacity to innovate & transform as we would wish to.

72 any changes currently impact on the take home pay of partners - this just creates extra stress in the practice as we can't afford to get enough staff in

73 Increased responsibility and workload for partners Lack of interested younger doctors wishing to commit Partnership model can be satisfying as ability to control how patient need is met and flexibility Partnership model highly efficient Stress on partners with increased time Away from clinical care since CCG and localities came in. increased management for Which we are not trained or interested in Increased responsibility with CQC registration and GDPR, employment appraisal and management of staff becoming ever more onerous and expensive

74 Partnership allows more flexibility, more control and inclusion. Many GPs prefer this. I’m a non-GP Partner and it’s good to be an equal and make the practice a success.

75	Notional rent does not cover all the costs of loan to buy into property - therefore not attractive for new partners to buy into property Very difficult/impossible to get funding for expansion of or new premises meaning will be extremely difficult to increase clinical capacity as our local population rapidly increases in size.
76	There is no support in general practice - a constant sea of people requiring help and care with little or no respite in the pressure/volume.
77	If you implement a salaried only model general practice is finished. The NHS abuses goodwill that is why it is successful. If it is altered to a model of purely salaried staff, there will be no one there to mop up the extra work
78	Its probably good for patients? The partners are accountable for their list... if I was made salaried I am sure I would work much less hours!
79	Partnership model needs to be more financially lucrative to attract interest
80	Too many small businesses are inefficient and are not able to offer good access to the range of services larger practice can. General practice provides very good value for money compared. We are increasingly in need of specialist skills in general practice but are too small to be able to afford them. GP Partners work very differently to salaried GPs. If everyone becomes salaried you better staff up because they don't go home at 6.00pm!
81	Lack of resources and funding makes it harder to cope with current model
82	No partners wanting to join partnership
83	The current model has nothing to do with the challenges faced. I am horrified that the model might be yet another scapegoat for the failure of an under-resourced NHS
84	Having total unlimited liability is a risk to partners. Being able to become a Limited Liability Partnership (LLP) would reduce the risk for partners taking on the responsibility in this every changing NHS environment. The current model ensures the people working in General Practice have a vested interest (as partners) in making the services work for the patient. A salaried model has not direct 'buy-in' to go that extra mile (although most staff in the profession to go above and beyond what is being asked)
85	Currently GP practice has not mechanism to control/ limit the work load coming through. A&E departments are able to divert ambulances away when they are full, but GP practices are simply expected to soak it up every time. 2- Every other part of the NHS views the patient as the "GP's patient" and fail to take ownership of the patient. When in doubt as the GP to chase it up/ recheck it etc.
86	Extremely financially unstable.
87	Partners are not always close to what is happening on the Horizon, it tends to be PM's that scan and feedback and strategize.
88	The marketplace bidding for all services and only core payment being guaranteed places pressure on recruitment. 8 to 8 opening will only make matters worse. Being a rural practice 8 to 8 is not necessary for our patients but the money would be better spent investing in current opening hours. Instead we are having to invest this funding within the area for a central hub which none of our patients will find convenient. Dispensing, which is a highly valued service by our patients is being eroded by privatisation and online pharmacy hounding patients to register and feel that the 1.6k rule should be abolished to enable rural practices to survive in such a competitive market.
89	GPs are taken out of surgeries seeing patients to attend meetings about providing services, improved access etc. Bidding to provide services is challenging as it is new to primary care and not what GPs or Practice Managers went into the role to do. Lack of funds does not improve in this area. Our practice has no issues in meeting demand; it seems to be the larger practices 'working at scale' that have the problems. rethink required there I think.
91	the funding streams are all over the place, its so hard to decipher how you are doing without spending hours unpicking, we need systems and processes that are proven to work in other sectors to help us manage more efficiently. We should be influencing what infrastructure support is being commissioned, PCSE is one example of an unmitigated disaster for general practice.
92	The current model works well as partners are picking up the slack. Under a contracted employee model, the additional work they would need to do would need remunerating and this would be unaffordable
93	We are local for our patients - something we should never lose It is not truly joined up healthcare system - different parts of the system fight for the same pound! The "always open" ethos of GP world is not sustainable Smaller practices cannot survive in the new world - we need to drive scale for efficiency we cannot keep on driving more and more work onto GPs for less money - we are encouraging GPs with lots of experience to retire early; new GPs not to enter into Partnerships and destabilising the bed rock of our health care system
94	Its pathetic

95 Practices at present can work in isolation and this isn’t always the most efficient model however Traditional medical practice has been the backbone of the NHS System for many years. When properly funded it can support the wider NHs objectives but over the last 10 years this has been eroded

Q6 What are the benefits of the partnership model for patients, partners, salaried GPs, broader practice staff (practice nurses etc) and the wider NHS?

Key themes are

- Ability to take ownership
- Ability to Influence, be responsive and shape services locally
- Flexibility and adaptable (to meet local needs)
- Continuity of care for patients
- Greater sense of personal connection and responsibility for patients/sense of belonging
- Most efficient way of providing a comprehensive service to the population
- 'Our business' – staff and patient wellbeing a high priority
- Partners ensure pride in work and commitment to a community and their team. Wider benefit to the NHS

Full detailed responses

1 Improved stability, improved continuity, greater 'buy-in' by partners to all that is GP, substantial amount of unresourced work.

2 Moan over - there are huge benefits - ability to take ownership, influence and shape services locally, be responsive and makes changes easily without the big cogs of trusts interfering. Patients benefit through partners investing emotionally in the practice / community and giving 110% to ensure a good service to their patients / colleagues / neighbours etc. Endless extra hours are put in by partners to ensure practices continue to run - this would be lost without a partnership model and General Practice would collapse very soon (but of course that additional investment isn't measurable so isn't seen or recognised). I think all staff benefit from belonging to a team, all having a shared collective responsibility and sense of drive and similar objectives based around patient care.

3\. We can offer a friendly, familiar yet professional service offering knowledge and care from cradle to grave

4 A sense of belonging continuity of care - in theory

5 Far and away the most efficient way of providing a comprehensive service to the population, flexible and responsive

6 Small team working, good for morale, patient continuity, commitment to role, chance to develop within a team.

7 Continuity

8 Partnerships can run incredibly efficiently, providing high class health care. Partners 'get the job done'

9 Independency - easily adaptable. For patient's partners have made a commitment under GMS to a population to look after their health - this is a contractual but also moral commitment way above that of an employee - the practical impact of this is the huge workload that is absorbed by GPs as goodwill - this I believe if lost would be catastrophic for the NHS.

10 Continuity of care provided by a coherent local team who know the patients, know what they need, and know how to provide it. The wider NHS benefits hugely (although it probably doesn't realise it) from the large amounts of extra work put in by partners like me in maintaining our building (work that would not be done by a Salaried service and would need to be paid for by the NHS, at great extra expense). Partners have a direct personal incentive to ensure that the partnership thrives and is innovative, whereas Salaried GPs don't. Losing the partnership model would be an unbelievably short-sighted and foolish move for NHS management to make - and one they would bitterly regret afterwards.

11 GP's who know and understand their local population. working as small business has it's benefits and drawbacks. being employed by GPs means greater variations in pay for practice staff leading to poaching depending on who can pay the highest. not good for morale. however, I'd rather be employed by a small organisaiton who cares for its staff, than a large trust where you're just another number.

12 Accessibility and continuity of care for patients. Working within a well-developed team for staff members is positive. Autonomy of practice

13 Greater control, targeting needs to patient population, varied working models dependent of staff/patient needs.
14 As partners, we will go above and beyond what an employed doctor would do, we don't claim overtime, work in our own time, attend meetings when needed with no financial compensation. We constantly want to be able to give the best service to patients and take that home with us as we are proud of our small business and focussed on delivering high quality care.
15 Partners work infinitely harder than salaried GPs. They are willing to work longer hours, to see the job in the round with finances and legacy a principle element of their work. GPs having ownership of their working week is a massive draw to getting GPs to stay in practice. GPs do not like working within large corporate models by and large.
16 Because this is our business we put in whatever it takes to make it succeed. So, for us staff and patient wellbeing is high on out priority list. We can respond quickly to patient demands
17 It is efficient, we have a vested interest in running a practice as efficiently as we can. I feel there is also a greater commitment to the practice as a whole, including staff and patients.
18 Being in a partnership means we have a say in how our patients care is delivered appropriately.
19 The partners have ownership and therefore greater incentive/drive to keep a practice going. There is (usually!) greater stability in key workforce.
20 Increased responsibilities by GP partners. Working beyond the 'contracted hours' to get the job done.
21 Access to the right level of support for the patients at a time suitable for them. For the staff it means hopefully being freed up to deal with the issues that they are trained to deal with . For secondary care it should reduce the need for patients to attend as a last resort to access clinical care.
22 Partnerships deliver continuity for patients and stability / leadership for registrars / salaried / nurses / students. As partnerships fail the infrastructure for the other professions / grades fail and cannot be replaced by commercial organisations with no day to day presences and commitment and clinical leadership. Partners are delivering a huge amount of unrecognised clinical work and training and supervision over and above their daily clinical workload
23 Patient continuity of care. Adaptability to suit local needs.
24 Services can be delivered in a bespoke manner to reflect the local population, partnership model usually means a more stable work force of committed GP's who can then deliver the most cost effective and tailored service to their patients.
25 We provide great continuity of care and can take decisions at a local level to prioritise services that are most needed for our patients, whilst still running an efficient business and maintaining job security for our staff
26 Huge - patients need to know there is a Doctor/Surgery that knows them as a person and will fight their corner. Also Doctors get support from their partners which is hard to obtain when working as a locum.
27 Guarantees continuity of care as partners are tied in/ committed
28 Leadership and experienced GPs
29 Service commitment, continuity of care for patients and staff.
30 Super partnerships better but the liability issue of these partnerships off -putting.
31 Sense of ownership means less sickness absence (virtually nil) and huge time commitment from partners (to their detriment) this benefits patients most but also provides support and job security for practice staff
32 The partnership model provides local medical services for patients with continuity of care. The service is very efficient and inexpensive.
33 continuity and stability
34 I think the commitment from partners to provide a quality service that is flexible, local and adaptable are key aspects. Staff also like being part of a recognised team. Speaking to other staff members they dread being moved round different premises because they have got particular skills. This particularly applies to Practice Nurses but I am sure Reception and other admin staff will feel the same. Having said that we are increasingly all stuck in front of our computers meaning less time to interact with other staff. This is not good either.
35 Allows flexibility, rapid adaptation to change, much more efficient than Secondary Care.
36 Continuity of care. Efficiency. More cost effective than locums by far. Flexibility
37 I do not see any benefits at the moment.
38 Efficient, responsive, local service for patients
39 The partnership model has been the tried and tested model which developed from singlehanded general practitioners. As long as the scale and size does not become too big individual patient care can be provided by a doctor who knows the patient and is known by the patient in an accessible way.
40 Continuity. Flexibility, speed of being able to change within a practice. Less bureaucracy
41 Long term Continuity and Loyalty

42 Tighter more efficient, reduced wastage.
43 It works! I don't think the partnership model is the problem. There might be advantages to other models, but they would bring more problems and disadvantages
44 Not sure
45 No comment
45 practices managed efficiently by working GPs who know their staff and patients
47 hopefully to improve services
48 Operational flexibility and having a greater sense of personal connection and responsibility for patients. A sense of being part of the community with a direct connection to patients.
49 They ensure pride in work and commitment to a community and their team. The wider NHS gets a lot more work out of the GP partners for the money invested than they would from any medical employee.
50 Patients- stability and consistency in seeing same GP who knows them and can build long lasting relationship and trust that patients seek from their doctor. Partners- limited benefits at current time other than control of managing business Salaried GP- potential for job stability and leadership in future partner roles
51 Allows local solutions to be achieved quickly to problems but requires funding.
52 good access to all primary health care team members
53 Encourages innovation and gives you a sense of ownership of your practice. Should hopefully allow a progression from salaried GP and once they are happy in that practice then they can commit to it. The benefit for patients is commitment to a practice. If you are making the financial commitment to buy in then you would expect to be in that area for some time and not just be able to move to a different trust for better working conditions.
54 Smaller units, patients get to know the clinicians which is important for the long term therapeutic relationship that is needed in the general practice setting where care is over a lifetime.
55 Partners enjoy the entrepreneurial side aspect (although no opportunity for this at present) Patients benefit from a sense of ownership which means partners have a pride in service offered. Continuity of care good. Salaried docs now often have better deal than partners, which is not sustainable
56 You get continuity of care, and doctors interested in efficiency, quality, and shaping services for the future. Practices run by large organisations and staffed by salaried doctors can never achieve this.
57 Partners lead. They accept the obligation to their staff and patients. They go the extra mile, they provide stability and continuity and come cheap at the price!
58 Localized, personalized decisions can be made. decision making power sits locally.
59 Patients value the family doctor approach offered by partnerships. If asked and given the choice, they would rather see someone who knows them and their history than have to see a different doctor who doesn't know them in a "supersized" practice and have to repeat their history over and over again, which takes time and as such cannot result in time saving/money saving. One size of practice does not fit all and never will. Patient choice has been emphasized to our patients over the years and this is THE most vital area of choice for them. Imposition of "supersized" practices would be another huge NHS disaster and further waste of public money. GP partners have control of their own practice and direction of travel. The whole practice works brilliantly together, we are a close, professional, friendly team. We have excellent GP and staff retention, low levels of absence. Despite the challenges, morale is high. We all have the benefit of knowing that we have a good working environment, interacting with one another on an almost daily basis. The partnership model also benefits the local hospitals, in that local consultants and GPs are well known to one another and communication is invariably good.
60 Can adapt and grow as necessary. Gives ownership and responsibility to the Partners which helps to keep Practices going. Staff are working for someone they work with rather than a remote boss, they can be part of a team.
61 Historically more financial independence & autonomy
62 Control of your own destiny (within limits).
63 Continuity
64 Patients - more caring/passionate GPs.
65 Control. Adapt to local needs, agile
66 Continuity, commitment & development
67 Ownership of practices motivates all involved to provide quality and cost-effective care. Direct employment of practice nurses / HCAs etc. means the people on the ground with the greatest understanding of their population can tailor their team to best meet the needs of their community. For instance, areas with poor mental health provision can target salaried GPs with skills in mental health, thus reducing referral numbers and saving money. Secondly responsibility for buildings, equipment, specialist clinics means resources are used effectively and not wasted to the degree I have seen in hospital where no one has direct responsibility and

ownership. For patients, being directly able to consult and meet with their local care providers encourages trust, translucency and means that they can discuss how care is provided. The care can then be modelled for them e.g. a patient with complex care needs can raise their concerns and plans can be made as to how your primary care group meets their needs in a responsive fashion. This is far easier and effective for patients and far more cost effective than other models.

68 Patient and practice needs can be decided at practice level.

69 you will have the same GPs with invested interest in the practice to move it forward, but patients now have no continuity any way due to less boots on the ground.

70 Partners personally invest and have deep commitment and responsibility often at a personal and family cost. Patients still like named GP contact and really value the continuity that we provide. Partners have some degree of strategic input, priority setting and personal service. Each practice still maintains some degree of personality and ability to innovate and adjust to local population needs when we have the breathing space to do so!

71 Ownership by partners to provide effective and cost-efficient care to patients

72 GPs are able to deliver specific community care of their patients

73 Security of service delivery

74 As partners we have a vested interest in our practices staff and patients - we will generally do whatever is needed to provide service - this is what NHS relies on and increasingly is leading to its demise as young doctors only used to shift working and feeling entitled to have high salaries for little work do not want the responsibility. The service at this rate will become completely salaried and patients will lose because of it

75 Commitment & building strong long-term relationships with all of the above. This leads to productive, cost effective & high quality of care, valued by wider society. Stable partnerships have fewer distractions & can focus on quality, gaining trust. We are probably more conscious of NHS resources than say secondary care as we can see the impact on our patients. It is a rapidly adaptable model. It can offer a wide variety of services & innovate.

76 That personal buy in and commitment to the local population like you would not get from an employment model

77 Stability of team Satisfaction of long term commitment and continuity which is the basis of general practice Salaried can work there and decide if it’s the right place for them as apprenticeship building up to taking on partnership Patients have continuity and an advocate who knows them. This improves dr patient relationship reduces hospital admissions and quality of care Practice staff get to know each other and the foibles of each, stability of working for someone with a long-term commitment not someone who is going move on after s year or two

78 Good hierarchy, opportunity to become a partner and have more involvement and ownership. They balance their books. Most financially viable part of the NHS despite continued underfunding.

79 Able to shape the development of the practice and the wider local health service Feeling of ownership Greater long-term commitment to the practice and patients when one is a partner over salaried GP Leadership for staff of the practice Partners will frequently do a greater level of work than non-partners

80 Tailored locally, clear commitment and loyalty to ensure an effective and quality service is provided. Incentive to keep trying to improve and provide better services and more of them.

81 Partners go beyond the norm. This is why it works. Pay us properly, make it attractive, stop the slaying in the press and it may have a chance. Otherwise it is UK dentist model and that does not work

82 Ownership of our team and how we work. Accountability.

83 Commitment to improvement and continuity of care

84 Staff have a special commitment to the practice and the patients that comes from being in a small team working in a none corporate way. Patients value continuity of care and knowing their GP. this is disappearing as the traditional partnership model breaks down.

85 Partners are aware of local needs and hence better at prioritising patient needs in the area and service delivery

86 Someone to take ownership. Patients have named GP. Staff security

87 Genuine care in patient care. Owners are on the 'shop floor' seeing patients. GPs are not money driven, they are care driven. They seek appropriate pay, not profit. Extra money is driven back into our practice. We all work many hours longer than our agreements. If I work for someone else, I will not give my time for free any longer.

88 They feel part of a distinct team delivering the patient services. Partnerships have to invest in developing and training staff to adapt to new models and the changing environment. As small businesses they are quick to react and change to the market conditions

89 Can't see any in current climate.

90 A local more realistic grasp on local needs of patients, staff and the health economy.

91 Partners are close to their patients as GPs and do tend to look after their staff generally very well. Partners have a vested interest in ensuring the Practice is run well and profitably. Partners pick up lots of extra work/responsibilities that Salaried GP's would not want to deal with.

92 Huge benefits of the partnership model for patients with GPs taking ownership and running personal lists to provide continuity of care. Is this affordable? It can be if we work with the newer innovate roles (ACP, AP, Clinical Pharmacists etc) in practice provides a gold standard service and gives staff a secure and supported working environment. But must be supported by GPs.

93 Practice are involved in developing primary care.

94 It provides (in most cases) a cohesive unit for delivery of care to the patients who in the main can relate/retain a sense of belonging to that unit. Practice staff perform seem to perform better when they have that sense of belonging to a smaller identifiable unit rather than a monolithic structure.

95 GP's having ownership of their business, it feels connected to the patients and makes the team feel a togetherness that may be harder to achieve under a more "remote" model. It gives potential for colleagues to aspire to partnership (which can still be a positive in the right practice). It enables the freedom to innovate and improve for the benefit of patients.

96 Leadership/experience/vocational. Commitment to the NHS and its patients.

97 Patients know the Partners where they choose to have their care delivered. The can influence the ultimate owners and have more opportunity to drive the changes they would like. Salaried GP's have an opportunity to progress and develop into Partners. The employment model would be stagnant without this. The wider NHS could not afford to disband the model. The work done by Partners could never be funded in a salaried model. The liabilities the partners hold (staff, premises) would also pass to the wider NHS.

98 We care for our teams - we employ them - they are not some generic workforce - we have a vested interest in their wellbeing and performance. We have true accountability for our results and our performance and against the risk we are rewarded for this. But it has to be attractive! If we move away from a Partnership model we will lose thousands and thousands of hours of goodwill per year in and instant. We will lose the soul of General Practice and our patients will see and feel a very different service and the changes will not be positive.

99 CQC are looking for good leadership and in my experience, this means having happy partners who are earning enough money to invest in their business and develop their business plan and make a happy place to work. More carrots - less sticks

100 Ownership. It is owned by a group of similar likeminded individuals who have supported their decision by buying into a business and placing great personal risk to themselves in order to provide the best healthcare they can to patients in the locality. Like most small business they have a part to play in society and the NHS and both value their employees and patients

Q7 What are the shortcomings of the partnership model for patients, partners, salaried GPs, locum GPs, broader practice staff (practice nurses etc) and the wider NHS?

Key themes are:

- Financial - including risk to income
- Stress & pressure
- Burnout / excessive workload
- Annual leave and benefits are not in line with secondary care
- Lack of funding and lack of support from central government
- Funding short term and varying therefore hard to have a stable business
- Can lead to a divide between partners and salaried GPs
- Inadequate funding preventing investment and change
- Recruitment - current partnerships not attractive to younger salaried GPs
- Can lead to too much individuality across the area and resistance to change
- Risk to patients if partnership fails
- No shortcomings of the partnership model, if appropriate funding is forthcoming

Full detailed responses

1. This means GP is not strictly speaking NHS which increases vulnerability to private sector take-over of practices.
2. Risks financially including risk to income. Hourly rate of partners is significantly lower than other doctors is a lot of practices due to the sheer number of hours worked. Partnership model does mean people like independence, and are reluctant to change and work with partners, which from an NHS perspective makes it harder to have system change. Salaried GPs / locums I imagine can feel undervalued in some practices and could be treated differently than partners. All are treated the same workload wise in our practice with very little divide.

3 none - I think GP works very efficiently. The inefficiencies come from the large public sector bodies we have to link in with.

4 none significant

5 Small cog in a big machine. Too many hoops to jump through eg to bid for IAGP or funding for premises. No experience at this level and no resources in place to achieve these goals.

6 with fiscal demands, a widening of top income/low income gap, which will always impact performance of teams.

7 As far as I can see the only failures are due to the lack of funding and lack of support from central government

8 Risk adversity. Funding difference to secondary care makes joint working difficult

9 It may be that in a different system, there might be more flexibility in terms of the skill-mix of staff that can be employed, and the ease with which that mixture of staff can be altered. This isn't, however, a recipe either for contented staff or continuity of care for patients, both things that are highly prized in the organisation that I work in.

10 lots of small businesses all trying to their best with no overall vision. leads to variation in services. Huge financial stress for the partners.

11 Employed by the partners so annual leave and benefits are not in line with secondary care. Challenges of increasing demands and increasingly limited resources are making the job as both a GP and nurse much less attractive. Patient's may feel restricted by lack of availability of appointments & access to their 'own' GP. This is particularly pertinent for the elderly. Should anybody have to wait 2 to 3 weeks for a routine appointment? Opening of surgery hours remains restrictive and does not reflect a modern workforce/society. Not all GP practices have a good skill mix of healthcare professionals; there needs to be much better use of advanced practitioners/physiotherapists/psychotherapists/counsellors/nurses etc

12 Recruitment
13 For partners we put ourselves at risk financially. This has the potential to leave a practice population with no GP and staff out of work if for some reason the business is no longer viable, which is happening up and down the country.
14 Shortage of available partners- recruitment. Salaried GPs do not have a good understanding of the overall GP system. In dysfunctional partnerships patient care can be affected. (the converse is also true) GP partnerships save the NHS money- they are highly motivated and conscientious models.
15 That it is seen to be very stressful for not much gain
16 We flog ourselves to near exhaustion to keep the system working, we work excessive hours as partners.
17 None
18 It doesn't always support the scale of general practice which is required to move forwards. There are insufficient GPs wanting to become partners. Partnership duties can take GPs away from delivering patient care. It can result in a two-tier model within some practices between the way partners and salaried GPs are treated.
19 Clinical GPs taking time to attend meetings, deal with partnership related issues etc. Risk to patients. If partnership fails.
20 Changing the mind set of all those involved. Clinical and non-clinical NHS workers and patients.
21 Lack of stability means difficulty recruiting and then there is nobody left to supervise / lead the rest of the team
22 Current lack of GPs to fill posts
23 Lack of progression to partnership status frustrates some salaried doctors who then leave to find alternative posts. There needs to be a way of developing younger GPs to get the level of experience and knowledge of a practice so they can become a partner but ultimately not every GP can be a decision-making partner in a practice for financial and practical reasons
24 I do not believe there are any shortcomings of the partnership model, if appropriate funding is Forthcoming
25 If we can't recruit the staff needed then it will fail
26 Partnership is outdated and helps to create a them and us / upstairs downstairs dynamic within the practice
27 Lack of willing GPs wanting to be partners
28 Lack of people wanting to be partners
29 Too much pressure on partners, too much thrown at practice with too short lead in time, funding short term and varying so hard to have financial predictions and have stable business. GPs are doctors not business managers
30 The current pressures on partners are clearly visible to students, trainees and recently qualified GPs making it appear less attractive. Inequalities in income--whether definite or imagined create resentments.
31 Lack of staffing, poor recruitment and poor publicity for General Practice.
32 I think the biggest problem is that it no longer appeals to newer GPs
33 Lack of consistency can be difficult for other parts of NHS/ other agencies
34 Partners becoming burnout
35 responsibilities for staff and building with decreasing funding I would be concerned about taking on such financial liability.
36 different level of service at each practice
37 The model works unless it is starved of resource.
38 It's been a great system, but it needs stability to be workable
39 Unsustainable with current funding model
40 Provided there are enough Drs and nurses to work in the system there are limited disadvantages. I suppose there is more disparity with income but that occurs with historic funding and inverse care law anyway!
41 Not integrated into secondary care or social care
42 Not sure
43 No comment
44 2 tiers of GPs. salaried GPs can be excluded
45 Insufficient practitioners
46 In the current under resourced environment, too much responsibility on placed on individuals especially when recruitment difficulties result in under staffed services. Often too much is dependent on the attitude of individual partners sometimes resulting in inconsistent clinical practice. GP partners who may not be qualified for or suited to management responsibilities can make poor management and business decisions that would otherwise be made by professional

managers in a more corporate model. Personal liability even when indemnified can lead to suboptimal decisions

47 The model depends on a flow of newly qualified GPs (this is not now the case in all areas) who also want to take on the commitment of business ownership. More and more this is not the case. In terms of wider staff the only shortcoming could be onward development as in a small team this may not be possible.

48 Poor income, poor recruitment, increasing workload, unsustainable. Patients not seeing same GP, poor continuity of care as it stands, current partnerships not attractive to younger salaried GPs

49 Not enough funding is preventing investment and change. The current model is likely to continue to be effective, but only if adequately funded. Many of my peers do not feel the small increase in earnings is worth the risk or extra time required, hence there is increasingly smaller uptake.

50 all practices end up re-inventing the wheel, working closer, but not merging, can help to address this, perhaps working with a super practice [vanguard site] can help, without the merger, that would not be our style

51 Can lead to too much individuality across the area and resistance to change. Makes operating in primary health care very personality dependant. Can lead to a divide between partners and salaried GPs

52 Unable to do 24/7 routine appointments but I do not think that is a realistic expectation anyway, I don't think that is where funding should be directed. We need sufficient funding to offer excellent in hours care before considering offering more. DNA rate is high and no incentive for patients to cancel or be concerned about this.

53 See above

54 I think it is obvious that the model works fine if it is not starved of funding but chronic underfunding leads to recruitment problems and then practices start to close. There is nothing wrong with the partnership model, but it has been chronically abused.

55 Income not reactive to when we do more, the improved financial cover for locums has been well received however. Is it going to be more difficult to recruit locally in the future as the name of GP has been smeared and government have acted too little too late. I know many youngsters who would give their left arm to go to medical school and more likely to stick with it as from average homes and not genii.

56 no wider/ funded support to understand the basic business models or running of a business

57 For partners, stress. However, I cannot see that altering with "reinvigoration" of the partnership model. With patient expectations now so incredibly high, the amount of work will continue to increase.

58 Responsibility can seem too high for some therefore recruitment can become an issue. Disparity in how practices are run and the cost per patient varies per practice.

59 The model cannot respond to the current needs of Primary care. The business is too dependant on its main contractor, the NHS and in 99% of areas in the UK cannot diversify its income enough to maintain the businesses financial stability. There are too many financial disincentives to new graduating Doctors, to prevent them from wanting to enter General Practice in its current state (employed colleagues in Hospitals have greater job security, higher incomes and do not have to pay tens of thousands a year in medical indemnity insurance or take on risks involved with running a small business)

60 As above

61 see Q4

62 New partners are less available, small businesses are vulnerable if not run well and are working under financial strain could go under

63 Succession planning can out practices at risk

64 I feel if run well history has shown that globally our model of partnership provides cost effective, quality care. However, the lack of GPS, increasing funding issues and lack of time for planning and training means that many partnerships cannot run as well as they have done and high rates of retirement without planned succession of GPS threatens future productivity etc. Basically, the main shortcoming is a lack of GPS, nurses and funds means many partnerships cannot do their job.

65 Real-time Reduction in practice funding and profits regardless of what central government think.

66 Patients now have no continuity due to less boots on the ground due to the fact GPs now have to diversify.

67 Stressed and pressurised GPs with income, recruitment and premises worries vs faceless nameless “doc in a box “corporate companies who GPs feel that they’ve had to sell out to. A lack of proactive action although better stability financially and more security for continuity of the practice albeit in a different shape and form

68 no one wants to deal with headache of management

69 Not enough funding to provide the quality of care or satisfactory workforce needed to deliver this care

70 Spiralling costs and a less of a financial incentive to become / remain as a partner

71 Virtually everybody wins EXCEPT partners. Patients get better service. Staff are supported, and salaried GPs get a lovely easy ride most of the time. Meanwhile I am on my knees most of the time

72 Active competition between partnerships is more prevalent now as we all scrabble for the same meagre pot of primary care resources. Being independent businesses means that we poach from each other's workforce, try to gain preferential influence over commissioners & a variety of predatory behaviours. Collaboration can be an uphill slog. It can be very personality determined, possibly negatively influencing the practice culture for all & so potentially unstable. Other providers & commissioners struggle to clearly identify who represents primary care, making us look like a ragged bunch, with reduced credibility. Makes us less influential politically, hence the funding issues compared to secondary care.

73 Sometimes leads to perverse incentives, variable quality between practices

74 Partners: personal liability of actions of employees Level of responsibility, clinical and non-clinical workload Buck stops with you Threat of having to keep service going if someone off sick Financial outlay GPs not generally good with finances or staff management Salaried GPs can be exploited or feel undervalued if partners take advantage however lack of understanding of amount of non-clinical work Expectations difficult to fulfil especially for older doctors Locums happy to see patients but increasingly unlikely to wish to help with admin. Difficulties with regular sessions for locums who do not wish to be classed as salaried. Patients suffer if staff are struggling. May have long term relationships with partner which make new models of working more difficult - over dependence and demand for established partner. Practice nurses and staff might not be able to be offered same rates at smaller surgeries or fill gaps Increased need for administrators with constantly changing roles. Level of Support and management, general climate depends on the individual partners rather than the business vision I think there is a role for managing partner towards the end of career being able to drop clinical and concentrate on management rather than trying to juggle clinical commitments with management which can cause resentment for all parties. This would allow younger doctors to concentrate on clinical matters while learning management skills from senior partner

75 Uncertainty for the future due to lack of funding.

76 Failure of the practice if unable to recruit new partners or the overheads become too great

77 I do not think there are any

78 None

79 Staff recruitment. Change- silly incentive schemes which are politically not patient care driven. Not knowing our funding levels so we cannot invest in permanent staff. Keeping good staff without offering pay rises.

80 Hierarchy?

81 We are losing our resilience and our ability to provide good family GP services. I believe though that we just have to get over what we used to have and look forward to what is sustainable, is rewarding for staff and still delivers a quality service to patients.
None if there are GP's wanting to become partners

82 Any shortcomings of the partnership model are more than offset by the lack of goodwill this sort of survey creates. If the partnership model ends, I think the GP workforce will halve. I will certainly have had enough. The partnership model is NOT the problem.

83 They can become insular if they do not engage in the wider developments across the area. Could `be some duplication across an area without collaboration.

84 For patients there is a group of partners who are accountable for care provided and often sacrifice a lot of their personal time to mop up deficiencies in the system.

85 Financially unstable and uncertain.

86 Partners are often remote from the political landscape and changing times. Often reliant on PM's informing them of changes/suggested strategies.

87 Working longer hours to provide a good and accessible service. Less funding available for developments and improving services.

88 Funding in our area is the biggest shortcomings. Being asked to provide services on little resources to fund workforce, IT, premises etc

89 N/A

90 Increased exposure to litigation, funding pressures can make it less attractive to new incumbents, building ownership can be an issue.

91 Inability to control workload. Reduced income but increasing workload. Lack of new incoming GPs means they are bearing ever more of the burden with diminishing returns.

92 Salaried GP's are reluctant to become partners at present due to the workload. This could be addressed with appropriate recruitment levels into General Practice

93 It can lead to some Partners behaving unilaterally or dictatorially but this tends to be in single handed or smaller partnerships. Larger partnerships in my experience can and do work more as a team and as a true democracy.

94 CAPITA - if they could get themselves in gear and manage the administration that would make things a lot easier. minimal short comings. Partners work harder, longer hours, more commitment to care, more effectively, more efficiently - the whole deal

95 Risk and ownership. With increasing property costs, pressures and workload issues many are not willing to accept this risk

Q8 In your opinion, what is needed to reinvigorate the partnership model to equip it to help the transformation of General Practice, benefiting patients and staff including GPs?

Key themes are:

- Work around the risks associated with owning (or leasing) premises
- Increase funding / investment in primary care
- Financial stability/security
- Parity with Consultant colleagues in terms of remuneration and Crown indemnity
- Incentives for practice development and innovation
- Backfill given for management time
- Firm commitment from NHSE that this remains the favoured model and that it will be adequately resourced and supported
- Changes to GP contract
- Moving from the drive to be able to access GP services all of the time
- Encouragement to stay in the profession (ie seniority improved pension)
- Prioritise the teaching and training of new GPs
- Enhanced business training / medium term strategic planning
- Improved mentoring/coaching for everyone
- Not capping overseas GPs as they are key to getting baseline work done well
- Locality federations providing support and striving towards best practice
- Sharing of resources, expertise and equipment
- Reward structure for salaried colleagues
- Move to a more business orientated model / explore alternative models

Full detailed responses

1 Addressing workload issues and improving morale making GP a more attractive option to newly qualified doctors.

2. Work around the risk associated with owning (or leasing) premises - barrier to further recruitment and to retention. Work around reducing the risk re unlimited liability. No practice can work more collaboratively sharing budgets across a healthcare system if they could personally be made bankrupt if it went wrong whilst the trust etc would simply get a slap on the wrist. This risk makes GPs reluctant to try something new, as it risks their livelihoods if it goes wrong. Make it easier for partners to leave and move area without tie in to premises etc so new younger partners don't have
to commit to one area for 30 years. Funding - general practice desperately needs more funding to allow more staff to be employed etc to manage the workload. There needs to be some way that partners / practices don't become the dumping ground of the NHS with no ability to pass work elsewhere, or the workload and working conditions will never attract new GPs who rightfully want a better work life balance

3 Stop the continuous bids, returns, statutory declarations, and other administrative requirements - particularly those where we have to jump through hoops to achieve the income we used to get as part of our global sum. This is not helping patient care as it uses up scare resources in practice to achieve the same outcome.

4 More GPs and funding for them

5 More funding. One IT system across whole NHS

6 A sustainable work load, which will include a sustainable workforce across the board.

7 Make the job attractive - funding and services. Move services into the communities. Fund general practice in the same way as hospitals

8 Support from government to allow greater flexibility to reduce risk to individuals - eg guarantee premises costs/provide crown indemnity/allow different vehicles eg Ltd Liability

9 Appropriate (increased) funding to allow us to run a properly staffed service, trust from NHS management that GPs know what they are doing and are very good at it (this is demonstrated repeatedly in all the available metrics where I work), and the removal of unnecessary

bureaucracy/tick-box exercises. In short, proper funding and Evidence-Based Politics please.

10 Realisation that to improve services GPs and primary care needs more investment. We can't continue taking work out of hospitals and giving it to primary care without the associated funding. Community care and district nursing should also be the responsibility of the GP practice, as this would massively improve efficiencies.

11 There needs to be an insightful review of healthcare requirements in the 21st century. Stop plugging holes and look at the bigger picture. Do we want the NHS to be a world class service or a third-rate provider of mediocre care? Funding is needed. Resources are needed. Looking at how care is provided and who is providing it; does the patient need to see a dr or would another HCP be more appropriate. using the available resources in a more cost-effective manner with improved access to sharing resources with other practices where applicable. Looking at wastage: drugs in particular. The volume of returned drugs mostly unused or simply over ordered must cost the NHS billions of pounds a year. Working hours and workload must be addressed. Educating the public to self-manage healthcare particularly for minor ailments.

12 Funding, staffing, better support for managing complex patients in the community

13 There needs to be recognition that partnerships need to be cost effective to survive and that there are circumstances in which higher bodies need to step in and look at cases where practices are struggling and need some financial support.

14 Need more GPs urgently. Current proposals to fix the recruitment gap have failed.

15 More finance and recognition for innovation and forward-thinking projects 6/20/2018 7:25 PM

16 Increased funding without extra work, guaranteed sick pay, and reverse some of the pension changes. Allow shift to longer consultations and stop the workload shift, we are not a bottomless pit. Give us crown indemnity. Stop quadruple jeopardy. Reduce the regulation and monitoring just trust us to work as professionals to look after the patients best we can.

17 Backfill given for management time

18 I don't see the current partnership model as being viable in the long term. I think we need to look at alternative models which offer the best solutions to the current and future requirements of both the patient population and the primary care workforce. I sincerely believe that we should not be spending precious time and resource tweaking an outdated model when we need to look at alternatives that are likely to be sustainable once the current partners have retired.

19 'Protected', funded time for partners to do the partnership work to transform patient care for the better. Addressing concerns raised by non-GP partners as to why they do not want to be partners.

20 The acceptance by the public and the NHS that the existing model is not working and that this is the only option. Just because we have always done something in a certain way does not mean it is fi for purpose anymore. Change or become obsolete.

21 Firm commitments from NHSE that this remains the favoured model and that it will be adequately resourced and supported

22 More money. More GPs. New health secretary

23 More certainty around funding and the ability to provide local enhanced services to our patients. Ultimately to try to resolve the recruitment crisis as we cannot be effective in forward thinking transformation plans if we are always firefighting the immediate capacity crisis on a daily basis

24 Moving away from the incessant drive to be able to access GP services all of the time - ear wax does not need to be dealt with late in the evening. We pander to patient and politician wants, not actual needs We have been chronically underfunded for a decade and cannot invest in services that will improve the situation. All the goals set for us are short-sighted and driven by political decisions aimed at winning the next election

25 Let GP's get back to basics and not have to do everyone else's jobs!

26 Change the rules/ finances re building ownership/ buy in etc

27 Promote General Practice to younger doctors but this needs better working conditions

28 Scarp it. bring primary care into the NHS and treat GPs like consultant with pay scales etc. that way "profits" go back into NHS not partners pockets.

29 Much more understanding from government about realities of practice. More predictable comprehensible and reliable funding for more stability Make patients more aware of own responsibilities eg buying own over the counter meds and not being so aggressive and demanding- more respect for the service we try to offer under difficult circumstances and with ever increasing cuts including to our own income.

30 Some return of linkage of staff reimbursement to partner numbers. A financial encouragement to become a partner. minimum "salary "guarantee from GMS. Generally, more money in GMS to allow workloads to become manageable Maximum clinical workload per day agreed

31 Increased investment in primary care and community services. Encouragement for Doctors and Nurses to join this worthwhile and dedicated profession.

32 Increase pay incentive to become and stay a partner increase control of income

33	I think investment in primary care is key. It is talked about but does not seem to follow the rhetoric. Increasing the attractiveness of GP services to clinical staff is key. Patients also value continuity and this is increasingly missing fragmenting care more. Therefore, GPs need more resources, better staffing and a recognition form the Secretary of State for Health down that the service they provide is also valued by DH; it has been denigrated by every Secretary of State since around 2006, so no wonder new Drs do not want to become GPs. But even after all these years I STILL enjoy coming to work, I find it enjoyable and satisfying. Patients are still generally pleased with the service we give, but the change in policies, the box ticking that is of no value etc is wearing
34	Clearer definition of what is in the GMS contract. Funding model reviewed to better reflect the demands of ageing population with multiple co-morbidities most of which are managed by GP rather than specialists. Review impact of pension changes and withdrawing seniority payments – to try and retain GPs longer.
35	Better funding. Changes to GP contract to give better exposure to work as a partner. Making partnership attractive to younger GPs. Help with buy in to partnerships / properties.
36	GPs need more funding, indemnity needs to be paid. Encouragement to stay in the profession (ie seniority), pension payments are too steep given the below inflation rise seen in wages. Ultimately, we need more GPs
37	An increase in funding not linked to targets or reporting data.
38	For a system to work in a market economy it needs to have sufficient resource to create the motivation for people to work within the system
39	Stability. Long term plans and guarantees so that people can make financial commitments.
40	Greater links between funding and workload. Greater link between funding and quality
41	More staff - knit a few more GPs!
42	Enthusiastic
43	Adequate support, concerns adequately responded to and honestly addressed by government
44	More money, less constraint eg no QOF. take buildings funding out eg into national ownership.
45	More staff and encourage practitioners to work in general practice
46	Proper levels of funding on a fairly distributed basis recognising the levels of growing patient demand and ever-increasing workloads resulting from constantly changing clinical guidance and government policy and the level of resource required to meet those demands. Funded management training to help salaried GPs transition into a partnership role.
47	A recognition that this is a small business with all the risks and responsibilities this entails. Why become a partner when you can earn more as a locum or an almost equal amount as a salaried GP. The funding model needs to reflect the additional work done, if partnership disappears they will need a lot more doctors and a huge number of managers to cover this work that at the moment is done through goodwill.
48	More funding
49	More investment in primary care, patient education. Rehaul of current appointment system and realistic numbers of patient contacts, sufficient administration time, making GP attractive, training increasing numbers of GP, making partnership attractive to salaried GPs, reducing indemnity fees
50	Increase funding significantly.
51	Better pay, better support in recruiting and making general practice a career that people want to enter, forcing hard working GPs to do extended hours is just going to diminish the workforce further and exacerbate things
52	Financial security - stop incomes falling. If there is financial parity between partners and salaried GPs no one in their right mind would want to be a partner given the risk and responsibility you're exposed to. Partnerships need help to work at scale which is easily accessible and is well supported. The contract needs to be altered to reflect the desire to work at scale but ensuring those who have invested time, money and huge amounts of effort into their partnership don't lose out
53	Adequate funding
54	Better financial investment in primary care. Shifting of funds from 2ary care. Return to community staff being practice based and visible. Get rid of purchaser provider split and fragmentation it produces eg mental health. Cut bureaucracy. Scale down CQC and make inspection a more useful process. Invest in IT to allow GPs/ OOH/ ambulance and hospitals and patients to have better access to records
55	Simply fund the service to the level required
56	Better public patient education of when to come to their GP and medico-legal backing to say no to inappropriate requests. Funding for more doctors and good quality community nurses who can deliver IVIs and really make a difference in keeping elderly patients at home. We are very transparent and easily accessible in our Practice, good for patients but may be not so for ourselves. Pay care staff in the community more appropriately

57 Economic and business knowledge/ training support for key decision makers in the practices.
58 Ongoing larger increases in funding.
59 I think we need to feel that the practices are valued at all levels and tell practices they are doing a good job. Patient demand never stops increasing, we need to find a way to maintain service delivery whilst tackling the ongoing long-term health issues of diabetes, COPD, dementia, etc. If the basic practice allowance (or something similar) was reintroduced, then perhaps partnership could be made more attractive to salaried GPs. For many years a lot of GPs didn't think of themselves as business people, they are, and they need to recognise that business isn't always easy, hard decisions need to be made but we should all be striving to deliver the best service possible with the means we are given.
60 To be blunt, experienced GPs need parity with Consultant colleagues in terms of remuneration and Crown indemnity, if there was a level playing field then more medical graduates would want to enter the Speciality. In terms of the Partnership model, this could only be done by greater support & stability of Core General Practice funding and implementing a Crown indemnity scheme now not in 2, 3 or 5 years' time
61 Make sure incomes rise again and there are enough staff to do the work
62 Kill the partnership model. Move to a more business orientated model. Demand consistency of care from general practice, with good access. The delivery of health care should not be decided by the whim of individual partners or their preference to maintain personal income over patient care
63 Operating as larger organisations. I don't see the federated model working as individual practices are still focussed on their own needs. larger organisations can have a bigger staffing pool, specialist skills, shared policies and processes etc
64 To allow a limited liability type option as in other business, to encourage wider partnership outside just GP's. Non-clinical staff can be very invested in success of general practice
65 Equity of workload, premises ownership
66 Funds soon for our local services. Particularly our mental health services which are in a terrible state and place a lot of pressure on primary care. But furthermore, our social care services as many patients are struggling due to living in the incorrect setting and these people use up a lot of our time and resources. Training for my current generation of GPs so that we have the skills to run successful businesses and prevent waste of resources. Sharing of examples of good practice nationally would be useful.
67 More 'real' funding 6
68 More GPs please, less "GP bashing" in the press and government. if something benefits the GP (partners, salaried and locums) it will trickle down to the patients automatically. so don't worry about the patients! focus on the grass roots, the GPs
69 Better enhanced business training and strategic planning that is medium term, rather than it fluctuating every financial year. Funding that is robust. Not capping overseas GPs as they are key to getting baseline work done well. Locality federations providing support and striving towards best practice. Sharing of resources expertise and equipment. Remuneration of GPs as we are GP consultants. Better pay / reward structure for salaried colleagues. Better formalised mentoring / coaching for everyone not just prominent characters Options for practice development and innovation should have incentives / be encouraged Teaching and training of the new generations needs to take precedence.
70 Take away issues related to complaints / HR / ineffective bureaucracy and stop trying to reinvent the wheel every 2 years
71 Increased financial support to allow the delivery of care, and allowing a more diverse workforce to help ease the strain and continue to provide high standard of care with time to review and look after patients properly
72 Less ridiculous targets.
73 Financial incentives to become partners Allowing partnerships to be LLPs so better legal and financial protection Overall REAL increase in baseline funding - not pretend funding
74 More than just the current lip service to sustaining primary care. Simplified funding streams. Acknowledgement of increasing expenses. Focus NHS transformation out from the patient, to primary care then the expensive secondary care services, eg using our clinical software as the primary patient record, for others to input into directly. Currently the focus is on maintaining secondary care & we have many historic wasteful processes eg referral letters, discharge letter coding & transcription of medicines. Acknowledgement of the strengths of GP. Base community teams with us so we can better coordinate patient care. Protect Partners from burnout. Ideally it would be a hybrid of the current model & consultant contracts. Standardised competencies & performance standards for our staff would save a lot of time & distraction. Specific training to be a Partner (eg financial, HR, IT).

75 Quite simply money - not so we earn more but so we can employ more staff to do the work more thoroughly and create some time and head space in the working week - then we might have half a chance of helping to shape the future NHS as part of an integrated care model

76 Financial incentives Increased support for staffing and premises Risk of financial outlay for premises should be removed Risk of hiking leases should be removed - the CCG or NHS England should be willing to hold leader

77 Fund it in realistic terms for all the work being done. Ensure the funding allows for expansion of workforce and services without it having to go through CCGs. CCGs are in deficit so they swallow up funding that should be going to practices to help them balance their books. Pay Practices for the work being done.

78 More assistance with property problems. Make it attractive for partners to buy into the property. Make partnership attractive again over being a salaried GP. Essentially young GPs need to know that being a partner is not going to just mean higher levels of stress and financial burden with minimal income benefits over a salaried GP

79 Support and business training for Managers and their GPs if they require it.

80 Cash

81 Money. Make GP less political. Be realistic about what GPs can achieve. Better working with the hospital consultant teams- encourage joint working not political competition between GPs/hospitals.

82 Money

83 A greater % of the NHS budget. Without resources (human and financial) we will continue on a downward spiral. Make collaborative working easier by removing some of the structural barriers that exist. Make it attractive as a career option.

84 Improve funding

85 Needs to be more attractive, less workload, less red tape and more support

86 Sufficient resources to do our job properly. We care. We really care. About patients. Our workload has doubled and our income has fallen. We have to pay our bills.

87 Encouraging a wider skill mix of partners. As a current business partner, I see the benefit a non-clinician brings to the partnership to balance the skill mix. As in any business you need a mix of skills to deliver effective services. I've no real experience of the model but could a 'John Lewis' type option be considered where you encourage staff to 'buy-in' (not in a financial way, but through loyalty, service etc) to the partnership to be rewarded for successful achievement in increasing outcomes for patients. That was just a thought!!

88 There has to be some mechanism to control the work load hitting GP's. NHS workload does not look to be reducing anytime soon- partners should be remunerated for the extra work they put in.

89 A more simplistic financial package for General Practice to remain viable for the future of GP. Currently far too many hoops to go through with no guarantee of finances coming into your Practice.

90 Less Partners across more Practices, or should we replace Partnerships with Ltd companies and allow all Practice staff to have a dividend? Salaried GP's are hard enough to get working full time let alone wanting the responsibilities/financial liabilities of Partnership.

91 In order to make the partnership model more attractive to GPs there should be investment into GP practices who provide the highest proportion of care to patients and have the ability to affect the impact on secondary care through more timely and appropriate intervention if given the resources. Work/life balance is important to prevent burn out and although we are trying to incorporate skill mix with a huge range of different clinicians GPs are still needed and need to act in a consultative role to support this.

92 funding to provide services - linked clinical systems for access to shared care

93 Stabilise practice incomes so that there is some confidence looking forward. Stop moving the goalposts for short term political reasons, and to give the impression that action is being taken to address certain issues (which at times exist only in the imaginations of the press and those with political motivation). The requirement to carry out these actions more often than not detracts from the main focus, which is looking after the patients (eg Friends & Family surveys; absolute nonsense that adds nothing)

94 Revamp the contracting and funding mechanism, make it easy to work with, scrap all the different les/des/nes and give us one contract which covers the population we are working with. Make it easy for us to innovate our IT systems and processes and to deliver better patient service by not shackling us with sub1standard infrastructure. Give us the funding to enable us to attract people, we are competing with supermarkets for admin staff. Help us develop GPs' into consultant generalists! we need more ANPs more Social prescribers, more Pharmacists, we can make the left shift happen if you give us time and space to make changes, to collaborate. we are in the shadows in terms of influence and funding yet are in the best position to help change the way we care for patients and to maximise the efficiency of the system.

95 A pathway to partnership. The ability to define workload and to set a limit on the work done within a day.

96 More GP's

97 Make being a partner an aspirational role again like it used to be in years gone by where you had a vacancy and you would get say 20 applicants! Make it worthwhile where Partners are valued by the wider health economy and not seen as the whipping boys of the system when it is going wrong!

98 More money

99 Investment, support and recognition that it is a valued part of the NHS