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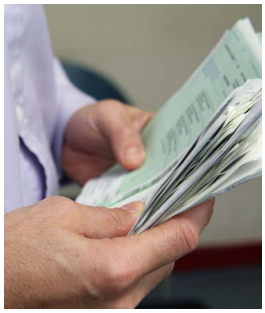
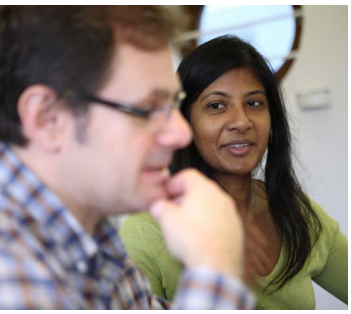
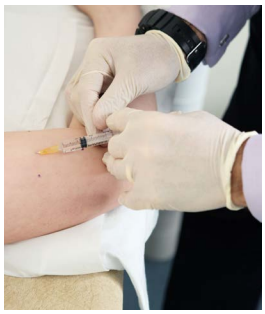
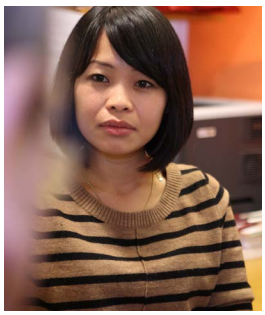


Responsive, safe and sustainable

Towards a new future for general practice

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Responsive, safe and **sustainable**

Towards a new future for general practice

Introduction

General practice is at a critical juncture. While seen by the Government and NHS England as the 'foundation'[1] for the future delivery of healthcare, it is in the midst of a growing crisis – one that threatens to undermine the quality of the care that doctors can give to their patients.

Over the past two years the BMA's General Practitioners Committee (GPC) has undertaken one of its biggest-ever consultation exercises. Through a range of different events, we have spoken to patients, GPs and Local Medical Committees, as well as seeking the views of major stakeholders. We held deliberative events specifically for patients at the beginning of 2015, and also conducted our largest-ever survey of GPs, with 15,560 respondents.[2] We wanted both to ask GPs and patients what they value about general practice and quantify and highlight the extent of the challenges it faces. But more than that, we wanted to use our findings as a basis for outlining positive solutions for a sustainable future for general practice – a future which is reflective of, and responsive to, the changing needs of patients.

Our starting point is the care of patients – the people doctors enter general practice to serve. Their priorities are clear. Patients want high-quality care, provided by a familiar team of GPs who know their medical history, and they want to be able to receive that care in a timely fashion when they need it. And this is what GPs want to be able to give their patients. Both doctors and patients also want to see these priorities delivered while maintaining the core principles of general practice: with GPs leading the provision of primary care in local communities.

But the unsustainable workload GPs face threatens to undermine those principles and the delivery of these shared priorities. That workload has a direct impact on patients: it means longer waits to get an appointment to see a doctor and shorter consultation times when they do get one. Our survey graphically illustrated the problem: it found that more than nine in 10 GPs say their workload has negatively impacted on the quality of care that they give to their patients.

Our starting point is the care of patients – the people doctors enter general practice to serve

1 NHS England, *Five Year Forward View,* (2014) available at http://www.england.nhs.uk/ourwork/futurenhs/
2 BMA *Future of General Practice 2015 Survey,* (2015) available at http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/surveys/future-of-general-practice

At the same time, mounting workloads and falling morale are leading to a recruitment and retention crisis. There are too few GPs, and every indication that the gap between the number of GPs needed and the number we have will widen further through premature retirements, younger GPs opting to leave general practice or work abroad and the fact that medical students are not choosing general practice as a career in anywhere like enough numbers. Underlining the scale of this challenge is the fact that one in three GPs responding to our survey said they hoped to be able to retire within the next five years.

The pressures on general practice look set to grow further. The complexity of managing the growing number of patients with multiple conditions in general practice, many of whom were previously seen solely by hospital specialists, has been increasing and is predicted to continue to do so. Patient expectations are constantly being raised by political initiatives such as routine seven-day working. But unless the current problems facing GPs are addressed, such initiatives have no chance of success and could make matters worse.

There is no easy solution to the many issues facing general practice. But it is clear that they must be addressed, for a revitalised general practice must be at the heart of changes in the way services are organised. GPs recognise the need for significant change and are ready to work together and differently to achieve better-integrated and more local services for patients. They recognise, too, that such changes will improve their own working lives, creating a profession that new doctors will want to join. Our aim should be to establish a virtuous circle whereby GPs can deliver the quality of care to patients they wish to provide and which patients have every right to expect and, in so doing, more medical students will see general practice as a career that fulfils their desire to care for patients.

This report will focus on ways to deliver what patients and GPs have told us they want from primary care, in the context of a rapidly changing external environment where there is unlikely to be one single model, where resources will be at a premium and where any future changes will need to deliver fairness, consistency, stability and security. In order to achieve these aims general practice must adapt. But it must also be supported to deliver what GPs and patients want, and the public and government expect.

This report will not only examine the current problems in general practice, but also look at the future of primary care within a rapidly changing system. We will set out our principles and vision and – by examining what patients want and how practices and practitioners should be configured and assisted to respond – put forward the key actions that will be required to enable us to realise that future vision.

More than **nine** in **10 GPs** say their workload has negatively impacted on the quality of care that they give to their patients


Our Assistant Practitioners
LET'S
TALK

Executive summary

General practice has been at the heart of the delivery of primary healthcare in England for decades.

Today general practice stands at a crossroads. One direction points to a future which threatens an inexorable erosion in the quality of care that GPs provide as they struggle to contend with ever-increasing workloads, rising public expectations and the complex management of a growing number of patients with multiple conditions. All this following on from a decade-long under-investment in general practice.

Another direction points to a different future: one where the core principles of general practice – that doctors lead the provision of primary care in local communities – are maintained but services are modernised and reconfigured in a way which responds to the priorities of patients, promotes better integration and addresses the recruitment and retention crisis which is currently enveloping the profession.

That crisis is underlined by the results of the largest-ever survey of GPs conducted by the BMA's General Practitioners Committee (GPC). It finds that nine in 10 GPs say their workload has had a negative impact on the quality of care that they give to their patients – as well as being the strongest factor which undermines their personal commitment to general practice. The results of this are clear: one-third of GPs hope to retire from general practice in the next five years, while nearly one in five current GP trainees hope to move abroad.

Nine in **10 GPs** say their workload has had a negative impact on the quality of care that they give to their patient

Listening to patients and practitioners

This report draws on findings from one of the biggest-ever consultation exercises that the GPC has undertaken to outline an alternative to simply continuing on the current path and hoping for the best.

In a series of deliberative events, patients said their priorities are most likely to be delivered by community-based GPs continuing to lead the delivery of primary healthcare, and they firmly reject alternative models, such as practices run by commercial companies or surgeries based in hospitals.

GPs share their patients' outlook: 80 per cent of doctors responding to our survey say they greatly valued continuity of care for patients, while having insufficient time with patients ranks in the top three factors that most negatively impacts on their personal commitment to a career in general practice. Moreover, doctors show overwhelming support for GP-led primary healthcare services and the retention of independent contractor status, while equally recognising the wish by a growing number of GPs for alternative contractual options.

The Government has suggested that greater access to care is best provided by a seven-day routine service across the NHS. Patients appear unconvinced about this claim: urgent care at the evening or weekend, yes, but less concerned about being able to book routine appointments throughout the weekend. GPs share their patients' scepticism about this initiative, seeing greater investment in the current 24/7 GP urgent care service as a more sensible way to meet patient need.

However, both patients and doctors recognise the need for change. Patients understand the need to balance access to care with continuity of care. They do not believe that very small practices can deliver the care they need when they need it, and they accept the benefits that larger practices can bring.

At the same time, it is evident that – while there is overwhelming support for the option of independent contractor status – some doctors want to be able to work in new and different ways. Thus while nearly three-quarters of salaried and locum GPs aged 30 and under say they envisage looking for a partnership at some point, two-thirds of salaried and locum GPs as a whole do not.

This report outlines five steps to meeting the aspirations, and responding to the concerns, of patients and their doctors:

- **Developing new models for delivering care.**
- **Addressing the recruitment and retention crisis.**
- **Bridging the primary care funding gap.**
- **Modernising premises and infrastructure.**
- **Realising the potential benefits of IT and other technology.**

Developing new models of delivering care

The independent contractor status model needs to evolve. A collaborative care model – which involves larger practices employing bigger teams which can, in turn, work together in networks, as well as with other local health and social care providers – reflects the core principle of GP-led primary healthcare which doctors and patients wish to see retained.

It also has the potential to deliver many of the other things which, our consultation suggests, they believe primary healthcare should be striving for. It balances convenience and continuity of care, giving patients timely access to a trusted and familiar local practice team, while also offering practices the potential to offer extra services.

Larger practices working together in networks will require:

- *A culture change in the NHS so that the delivery of care in communities is more highly valued.*
- *Investment in the training of additional staff to deliver community-based care and long-term funding to allow practices to employ those staff.*
- *Funding and support for the running of GP networks, as well as assistance with the process of bidding for, and delivering, primary care contracts.*

Addressing the recruitment and retention crisis

We lack the number of GPs we need to meet the demand for GP services. This decreases patients' ability to get an appointment when they need it, cuts the time doctors can spend with their patients, and increases GPs' workloads – thus contributing to a vicious cycle in which the ability to recruit new GPs and retain existing ones is reduced.
There needs to be a comprehensive strategy to boost the GP workforce. This should include:

- *Measures to improve the image of general practice in medical schools.*
- *Increased resources to grow the number of GP placements for foundation doctors and full funding for returner and retainer schemes.*
- *Introduction of an equitable and fair tariff for GP practice undergraduate placements so that all practices across the country can participate.*

Bridging the primary care funding gap

General practice provides excellent value for money. It costs on average only £131.45 to provide each patient with a comprehensive, unlimited service each year.

But, as Simon Stevens, the Chief Executive of NHS England, has recognised, there has been a systematic under-investment in general practice for at least a decade.

To redress this under-investment, and ensure the full benefits of other changes outlined in this report are realised, there needs to be a sustained, year-on-year increase in the proportion of NHS funding going to general practice on a recurrent, equitable basis for practices.

Four out of **10 GP practices** felt their current premises were not suitable to deliver services to patients

Modernising premises and infrastructure

Overcrowded and antiquated premises have no role to play in the delivery of modern, high-quality primary care. The BMA's premises survey in 2014 found that four out of 10 GP practices felt their current premises were not suitable to deliver services to patients, while nearly 70 per cent felt they did not allow for the provision of additional services.

Ensuring doctors can work in a surgery that allows them to deliver the best for their patients will require:

- *A long-term commitment to an infrastructure fund beyond the current timescale, with a comprehensive longer-term premises strategy.*
- *Offering more premises through the NHS or a third party to meet the needs of GPs who do not want to own practice premises.*

Realising the potential benefits of IT and other technology

New technology has the potential to improve patient care and help deliver a more integrated service and seven-day urgent care provision.

The following steps can help best utilise new technology:

- *Support for practices to ensure they have the necessary time to investigate, plan for and implement new technological developments.*
- *Financial support for practices for major investment in new technology.*
- *The full transfer of electronic health records between different practices to reduce or eliminate the need for paper records.*
- *Appropriate access to patients' electronic records in urgent care situations and other health and care settings.*

Alongside this strategy, steps need to be taken to help GPs better manage their workload:

- *Greater and sustained funding for general practice, with a payment system that delivers new resources for increased workload in community settings*
- *An enlarged infrastructure of general practice, with improved premises and community-based estate and facilities.*
- *Measures to empower patients to manage their own care better through a government-backed national self-care strategy and encouraging commissioners and practices to promote self-care.*
- *Measures to manage demand and stem the shift of inappropriate and unresourced workload onto GPs*

Not all GPs wish to work as independent contractors. In our survey, sessional GPs ranked their partner colleagues being overworked as the second most important factor in their reason for being a sessional GP. To tackle the recruitment and retention crisis it is, therefore, important that different employment models for GPs are available. The use of different contracting models can place greater, more clearly defined, limits on GPs' workload and thus leave them with more time to deliver the care that patients need.

It is now time to move beyond headline-grabbing political initiatives, constant tinkering with the GP contract in order to introduce transitory targets and incessant micro-management from Whitehall. If general practice is to take the road toward a responsive, safe and sustainable future, hard choices, additional investment and innovative solutions will be required. This report outlines how we can move towards this new future for general practice.

1. What patients want

High-quality care, continuity of care, timely access to care.

Our deliberative events with patients found what every GP instinctively knows: that patients want high-quality care, provided by a familiar team of GPs who know their medical history, and they want to be able to receive that care in a timely fashion when they need it.

Of course, beneath these priorities are subtle differences. As doctors see every day in their surgeries, there is nothing homogenous about the patients for whom they care. The priorities of elderly people, busy young professionals, and parents with young children vary.

Our groups consistently found that one of the main priorities for patients, especially those who were elderly or had long-term conditions, was continuity of care. These patients value GPs knowing their medical history. That doesn't necessarily mean seeing the same GP every time, but it does mean an appointment with a doctor who is part of a single and familiar team. This desire is one shared by GPs. Eighty per cent of the GPs responding to our survey said they greatly valued continuity of care for patients. For younger patients or those with small children, rapid access to care was the priority. However, at every stage of their life, patients consistently ranked being able to see a GP within a short timeframe in their top three priorities.

Patients' voices: priorities for general practice

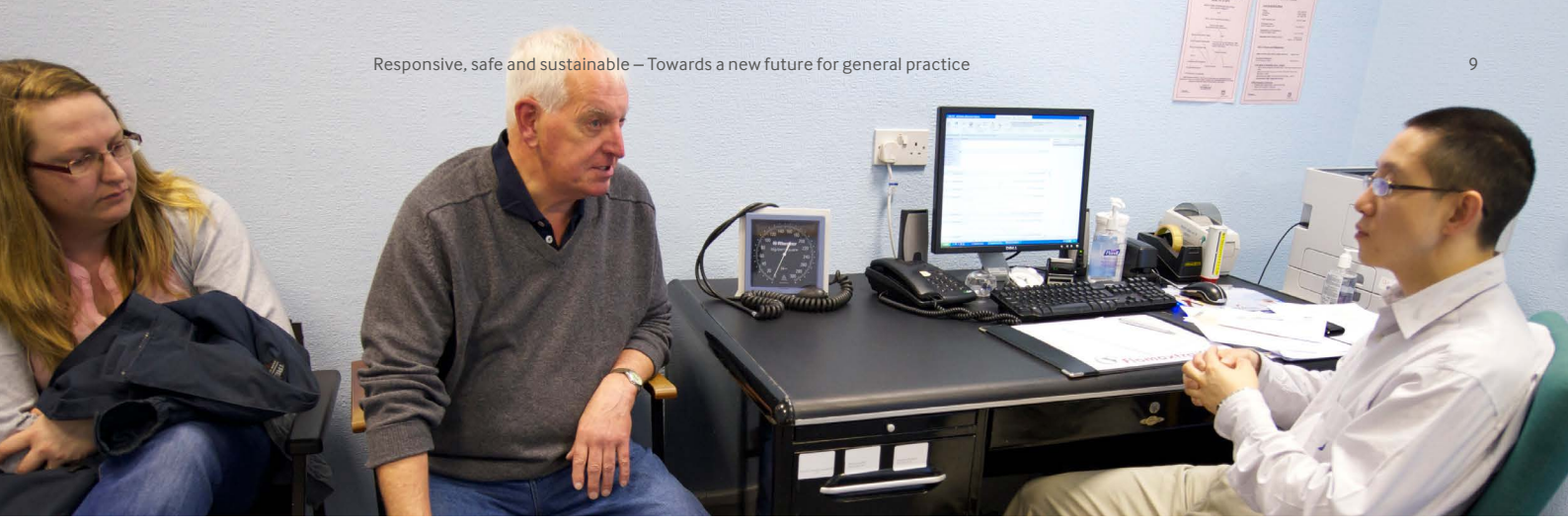
'I've got a long-term condition so [the] priority for me is seeing the team of doctors I'm used to seeing because they understand my complaint... I can wait a week because it's not going to change too much.'

The ideal is seeing the same doctor every time, but this isn't perhaps practicable. What was important for us was your doctor knowing your history, so then having at least a regular team, around three or four.'

'We can communicate clearly. I can tell my doctor exactly what I'm going through and my symptoms. My doctor can have time to tell me treatment options and explain it clearly to me.'

'Most of the time I use my GP is for my children. I'm only ringing if there is a problem, so to see them quickly is [the most] important [thing for me].'

Eighty per cent of the GPs responding to our survey said they greatly valued continuity of care for patients



Nonetheless, all patients want to see a doctor who has time to care and can provide a consultation of appropriate length. Again, this priority is one shared by GPs. In our survey, 70 per cent of GPs ranked longer consultation times as one of the three most important factors that could help them better deliver the essentials of general practice. Having insufficient time with patients was also ranked in the top three factors that most negatively impact on their personal commitment to a career in general practice. The need for longer appointment times is particularly important, given that GPs often are seeing patients with diagnostic uncertainty and often with undifferentiated illnesses which may be dynamic and evolve.

Patients recognise that – with the current pressures GPs are under – there are trade-offs: the longer consultation times both they and GPs desire could result in even longer waits for an appointment. Patients also understand the pressures general practice faces and the resultant consequences. In our events, they acknowledged that it was their GP's workload which was to blame for the difficulties they experienced in getting an appointment. Although frustrated by this, patients also understood that current pressures could have consequences for the standard of care they received. This is a concern of which doctors are fully aware: in our survey, workload emerged as one of the main barriers that prevented GPs from providing the quality of care that patients need and want. Ninety-three per cent of GPs said their workload has negatively impacted on the quality of care given to patients. Workload was also the strongest factor that negatively impacted on GPs' personal commitment to general practice.

Some have suggested that improving access to care requires a seven-day routine service across the NHS. Since the election there have been further government announcements about this,[3] most recently Jeremy Hunt's pledge of a 'new deal for general practice'.[4] As yet, there is no clear detail about how the government intends to deliver a seven-day routine service in general practice or across the NHS. However, our consultation suggested scepticism on the part of patients about these proposals. It found that patients did not particularly value the idea of being able to get a routine appointment throughout the weekend. This indicates a recognition on the part of patients of the reality of the workforce capacity constraints in general practice and the difference between speed and convenience of access. This, together with the initial evaluation of the Prime Minister's Challenge Fund pilots, suggests that while patients value being able to see a GP in the evening or over a weekend when they have an urgent clinical condition, there is less demand for routine GP appointments throughout the weekend.

GPs very much felt that weekend opening for routine appointments was neither clinically necessary nor was it good value for money or the best use for scarce NHS resources. In addition, urgent care is provided by GPs day and night on every day of the year, either through their practices or via out-of-hours (OOH) organisations covering their practice area. Just as practices have been coping with an increased workload with reduced resources, GP OOH organisations have had similar pressures. We have previously made recommendations to make improvements to the current fragmented urgent care service, reducing

3 David Cameron, PM on Plans for a Seven-Day NHS, (18 May 2015) available at https://www.gov.uk/government/speeches/pm-on-plans-for-a-seven-day-nhs
4 Jeremy Hunt, New Deal for General Practice, (19 June 2015) available at https://www.gov.uk/government/speeches/new-deal-for-general-practice
5 BMA, *Developing General Practice Today: Providing Healthcare Solutions for the Future, November 2013,* available at http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-vision/improving-urgent-and-ooh-care

the confusion many patients have about how and where to access the service and enhancing self-management. It is imperative that improving the GP OOH urgent care service takes priority over using limited new funding for expanding weekend routine services.

However, many GPs wanted all practices to offer at least one extended hours session per week, recognising the need to offer appointments for all of their patients within the resources available. How practices might work in different ways to achieve better access will be examined in more detail later in this report. However, it would be wrong to assume that, without significantly more GPs, working differently could in itself deliver significantly greater access for patients.

So how might patients' priorities best be delivered? Both patients and GPs believe that the core principles of general practice should be retained.

Retaining the core principles of general practice

At our deliberative events, patients wanted to see a continuation of GP-led primary healthcare and rejected the non-GP run models with which they were presented. A number of key themes emerged as patients discussed some different practice models:

- A strong desire for GPs to remain in the community.
- A great attachment to the 'personal touch' offered by GP surgeries.
- A great deal of respect for, and faith in, GPs' ability to run services and concern that other parties would not display the same level of dedication or retain the same ethos.

The patient groups were also resistant to large shifts from the current model. Nonetheless, there was also a recognition of the need to balance access with continuity of care. This led to an acceptance that larger practices (of up to 10 GPs) are beneficial and a scepticism about the long-term viability of very small practices.

Patients rejected the idea of practices run by commercial companies, which were viewed as being motivated purely by profit. Patients felt that this would result in deteriorating standards as companies cut corners to reduce costs. By contrast, although patients recognised that GP-led practices had to make a profit, the GPs who ran them were seen as motivated by a concern for their patients and a passion for their profession. Another important distinction that was valued by patients was that the GPs who ran the practice were likely to be doctors they knew and directly received treatment from as opposed to a company-run practice, where the management is much more likely to be faceless and remote.

Patients also firmly rejected the idea of their GP surgery being based within a hospital. Many felt that travelling to a hospital would be difficult and inconvenient. There was concern that the experience of seeing the doctor would become akin to going for a hospital appointment and that hospitals would not run surgeries as effectively as GPs do.

Patients' voices: retaining the core principles of general practice

'Putting GP surgeries in hospitals is a no no. Most people don't like going to hospitals. They are very impersonal. They are too big. Not serviced by the local community like with a GP which is round the corner.'

'I don't think there should be a profit-making motive in healthcare. I think there would be a massive conflict of interest, there would be pressure on the commercial enterprise to make money for their shareholders.'

Moreover, patients were also not convinced of the supposed benefits of arranging services in this way. They did not believe, for example, that services being under one roof would speed up the referral process between different parts of the health service.

Our GP survey also indicated that when asked about their preferred model for the future, only a tiny number of doctors – one per cent – picked hospital-led organisations delivering GP, hospital, community and mental health services. Similarly, there was overwhelming support in the GP survey for GPs taking the lead in running services, and the retention of an independent contractor status. Eighty-two per cent of GPs supported the continuation of the option of independent contractor status. Support decreased as surveyed GPs got younger, although this is because younger GPs were more likely to be unsure about whether they supported independent contractor status rather than definite support for alternative options.

Patients empowered to care for themselves

Patients know that responsibility for their care does not rest with doctors alone. At our events, patients felt more should be done to promote self-care and recognised that the inappropriate use of services is a major contributor to the pressures on general practice.

Doctors share a similar outlook. When asked in our survey what would best help them deliver the essentials of general practice, appropriate self-care by patients was ranked in the top five priorities by GPs.

The Self Care Forum provides a number of positive case studies, highlighting initiatives used by practices and commissioners to promote self-care.[6]

Empowering patients to look after themselves: what needs to be done?

Some patients do not feel capable currently of taking responsibility for their own care. We believe the following steps could help empower them to do so:

- Launch a government-backed national self-care strategy, in conjunction with patient groups and the BMA, to help more people understand how to look after their own health and free up GPs to look after those patients with the greatest need, in particular the most sick and vulnerable.
- Encourage practices to promote self-care. This could range from online resources and patient materials to telephone triaging and different appointment systems - to ensure that patients feel more confident about managing their own care at home when appropriate.
- Commissioners designing care pathways which ensure that patients do not see their GP practice as their first call in all circumstances. Clinical Commissioning Groups (CCGs) have a large role to play in signposting patients to the place where they can get the most appropriate care.

6 The Self Care Forum case studies are available at http://www.selfcareforum.org/resources/case-studies/

Improving urgent care

Urgent care is provided by GPs day and night on every day of the year, either through their practices or via out-of-hours (OOH) organisations covering their practice area.

Just as practices have been coping with an increased workload with reduced resources, GP OOH organisations have had similar pressures.

Improvements can be made to optimise access to appropriate urgent care in and out-of-hours and enhancing self-management.

This could be achieved by:

- CCGs commissioning integrated models of OOH care, bringing together community nursing, social care, walk-in centres, pharmacies, OOH general practice organisations, NHS 111 services, minor injury units, ambulance services and hospital emergency services.
- Using Prime Minister's Challenge Fund money to support urgent care service development rather than creating a parallel routine care weekend service.
- High-quality telephone triage for urgent care as a first point of contact, led by clinicians – not solely by computer algorithms – to enable patients to access the most appropriate service, enhance self-care and management, as well as reducing unnecessary referrals to GP practices.
- Taking Accident & Emergency minor attendances out of PbR (Payment by Results) and tariff arrangements and giving CCGs the responsibility and the budget for commissioning an integrated community and hospital service for unscheduled care.
- Ensuring consistent health and wellbeing messages to patients through better co-ordination of information materials provided by different parts of the NHS.
- Establishing a minimum clinical staff to population ratio for OOH organisations.
- Enabling patients and clinicians working in OOH settings to access their electronic health record.

2. Principles for the future

Listening to what patients and GPs have told us, the GPC has developed a set of key principles which we believe should guide how primary care is delivered over the next decade.

We recognise that there is no one solution and that there are a range of options that could best meet local care needs. But we believe that these principles can help ensure both that the fundamental characteristics of general practice which patients value are retained in any new ways of working and make primary care an attractive career option for the future doctors we so desperately need.

Our key principles:

- Ensure patients have access to a local GP practice run by a healthcare team they know and trust.
- Reduce GP workload to a safe level in order to deliver quality care.
- Resources should match where care is delivered.
- Retain and value the skills of the GP as a specialist generalist, enabling them to provide a holistic approach to care for all their patients.
- Build health and social care teams around each practice.
- Support practices to work in collaboration with one another and other local health and social care providers for the benefit of the whole population in that area.
- Empower patients as partners in their care, giving them greater confidence to undertake more self-care.

NHS England's five year vision: moving care into the community

NHS England's *Five Year Forward View* (5YFV) sets out a wide-reaching vision for the NHS. At its heart is breaking down the barriers between different parts of the health service and delivering more care outside of hospitals. Key to this is the development of new models of care, which aim to redefine the relationship between primary, secondary and community care. The 5YFV proposes two main models of care: Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS), as well as new ways to support patients in nursing and residential homes:

Multispecialty community providers
This approach is based on a registered list of patients and would allow GPs to scale up operations. Outpatient and walk-in care would shift out of hospital settings as groupings of GP practices offer a wider range of care and work more collaboratively with other health professionals, such as hospital doctors and nurses. One way of delivering this vision would be enabling extended group practices, such as through GP-led federations and networks. MCPs might also run some aspects of non-urgent secondary care, for instance, local community hospitals. Over time MCPs may also take responsibility for a delegated, capitated budget for its registered list of patients, possibly including some social care monies.

Primary and Acute Care Systems
The central feature of PACS is an organisation that delivers list-based GP and hospital services together with community and mental health services. These organisations could develop in one of two ways: a mature MCP could run its main district hospital or hospitals might be permitted to run or open GP surgeries with registered lists.

There is scope for very significant variation within each of these two models as well as considerable overlap between them. The 5YFV reflects a movement which is already underway as a diverse range of integrated models emerge led by CCGs, hospital trusts, community trusts and, in some cases, by large GP practices or GP-provider organisations.

At the same time, the 5YFV describes a 'new deal for general practice', with expanded funding for the primary care infrastructure, more GPs and stabilisation of core general practice funding over the next two years. This proposal is a recognition that the increased demand for GP services has not been matched by a corresponding increase in funding for general practice or by a big enough increase in the number of GPs. It is now recognised that investment in general practice has gone down and the share of NHS funding allocated to general practice has reduced from 10.6 per cent in 2005/6 to 8.2 per cent in 2013/14.[7]

An integral part of the 5YFV, and government policy before its publication, is the idea of moving care into the community and therefore closer to patients, which in turn has implications both for the way in which GPs provide services to patients and the demand for their services. With CCGs taking control of an increasing proportion of the NHS budget, the 5YFV notes that this would enable a shift in investment from acute to primary and community care.

The plans in the 5YFV need full ownership and engagement by staff in the NHS, and to be accompanied by a commitment that the whole service is part of the move for greater integration and better care for patients.

7 Thomas Powell and Elizabeth Blow, *General Practice in England*, House of Commons Library Briefing Paper 07194 (22 June 2015) available at http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7194

3. Putting principles into practice

New models of care are needed which both reflect the needs of local communities and the challenges of the future.

The practices of the future may look very different from those both GPs and patients have become used to and, as the many GPs who are at the forefront of driving through these changes recognise, this will require new ways of working. In some areas, GPs are already working as part of larger structures, like GP networks, working more collaboratively with other parts of the health service and under different contracting arrangements. GPs are at the heart of these new ways of working, driving these changes through for the benefit of patients. The key test that any new ways of working must pass is that they adhere to those core principles of general practice which both patients and doctors value.

As noted above, our GP survey showed very clear support for the option of independent contractor status for GPs. There are very good reasons for maintaining and building on this status. By giving GPs a stake in the running of general practice, it provides them with a connection to the local community and thus helps ensure the continuity of care which both patients and doctors believe is so important.

However, the current crisis facing general practice means that consideration must be given as to whether other options could operate alongside this model, giving GPs alternative ways in which they could work. The importance of such alternatives is clear from the fact that while most sessional GPs support the option of independent contractor status – and 73 per cent of sessional GPs aged 30 or under said they envisaged looking for a partnership at some point – almost two-thirds of sessional GPs as a whole do not envisage seeking a partnership in the future. The current traditional model of small independent practices will need, therefore, to develop to provide other options for those GPs who would prefer to work in an employed or freelance arrangement. Regardless of the model used, GPs who wish to work in this way should be protected by a salaried GP model contract, with terms at least as good as the model contract currently in place.[8]

GPs and commissioners should use the inherent flexibilities of the independent contractor status to develop new models of working and so give doctors more options regarding the way they would like to work. The models of working set out in this report demonstrate how flexible the independent contractor status can be, while still retaining the essential elements of general practice.

Building on the strengths of general practice: Moving towards a collaborative care model

To work effectively in the future, the independent contractor model of general practice needs to develop and evolve. The core strengths and successes of general practice need to be built upon, in particular: the connection with a local community which enables GPs to be strong advocates for their patients; the involvement of community and secondary care clinicians in an integrated collaborative model of working; and a model of working that enables innovation and efficient working. General practice should also be at the heart of a stable care system – one that is attractive to doctors considering a career in general practice.

The building blocks of this collaborative model are larger practices working closely with bigger teams built around each practice. These larger practices form networks, which, in turn, work

8 Details of the salaried GPs model contract are available at http://bma.org.uk/practical-support-at-work/contracts/gp-contracts-and-funding/sessional-gps.

with other health and social care providers in the locality to integrate care. These building blocks do not necessarily and consequently lead into one another. They can lead to the development of other models of care, and operate in isolation to the benefit of patients.

Patients' voices: new ways of working

'If there are only two GPs and they've been doing it for twenty years, and they are perhaps retiring soon, how is this surgery going to keep going? It doesn't seem sustainable.'

'I think the smaller practice model is something that would work better in a rural area but for me it would be a little bit too small and I can see how the pressures would get to [them].'

'It [a GP practice with 10 doctors] is very similar to the one I've got at the moment and it works, I can see the doctor fairly quickly and it's local.'

'As a parent I would feel more comfortable with this model [a GP practice with 10 doctors] than [a GP practice with two doctors] there is more on offer, more chances of seeing different GPs.'

There is some consistency between the features of this model and the findings from our patient events. Of five possible models considered by patients at our events, the model of a large GP-run practice was by far the most popular, with patients less keen on both smaller (two partner) and bigger (more than 10 partner) GP-run models. Such a model meets the wishes of patients for services to remain in the community and be run by GPs. Patients viewed it as striking the right balance between convenience and continuity of care, as well as recognising its potential to offer extra services. Although larger practices mean that patients may not always see the same individual GP, our deliberative events indicated that patients accepted that this model offers speedier access to a familiar and trusted local practice team. And, given that patients found it difficult to envisage, and were hostile to, some of the more radical changes which were suggested, a significant benefit of this model is that it is evolutionary.

Our GP survey indicates that this is also the model which GPs prefer. When asked which model would be the best way to develop general practice in their local area, more than half (52 per cent) of GPs state that practices working in networks or federations which, in turn, work more collaboratively with other healthcare professionals (for instance, consultants and nurses) would be their preferred model for the future. Furthermore, for those who prefer a different contractual arrangement, the option of being an employed GP is part of the model. The proportion of independent contractor and employed GPs could vary from practice to practice and change over time.

The maintenance of the independent contractor status is part of this model. It is therefore worth noting that independent contractor status does not necessarily equate to ownership of and buying into a practice. Indeed, it is possible that increasing opportunities for GPs to become partners without this financial responsibility will encourage younger GPs to become partners, with all of the benefits to the health service that this entails.

Larger practices

Irrespective of all other arrangements, the average practice is getting bigger. The size of a practice will reflect the size of the community it serves, but, other than in remote and rural areas, practices should be large enough to offer a full range of services and have a large enough workforce to be able to deliver these services in a sustainable way. Services can then be built around the needs of the local population. In some cases smaller practices will need to work collaboratively with others.

The practice should be based on a partnership structure with the opportunity for salaried GP employment. Becoming a partner is not confined to doctors. Instead, others working in the practice, such as a practice manager or nurse, can become partners. Crucially, however, whether partners or not, GPs should be empowered to take decisions and act as independent advocates for patients.

Teams within and around the practice

A larger practice provides the opportunity to employ a greater range of staff – practice nurses, healthcare assistants, phlebotomists, pharmacists, a full range of administrative staff and a high-calibre practice manager – to meet the needs of patients. A directly-commissioned community team, including district nurses, community matron, health visitor, midwife and social worker, could also work with a practice. Their working arrangements and targets would be aligned to those of the practice.

Allowing patients to have access to these services through their GP practice means they could get a wider range of care closer to home in a familiar environment. With a more stable healthcare team, this could deliver more of what patients told us they wanted: to see professionals who know their medical history. Such practices could also offer a more positive future career path to attract much-needed new staff into primary care. Moreover, larger practices would allow GPs to better manage their workload by delegating work as appropriate to others in the team.

Building teams within and around the practice: what needs to be done?

We believe the following steps could help practice teams realise their full potential:

- Invest in training additional staff for general practice and community-based services, including healthcare assistants, practice and community nurses, care co-ordinators, pharmacists and patient advocates, to help GPs manage current and future workload pressures and provide greater support for administrative tasks and diagnostics.
- Provide long-term funding from local commissioners and NHS England to allow practices to take on these additional staff.
- Build teams around each practice and within each network, with practices closely collaborating with these enhanced teams for the benefit of patients.
- Take action to promote a culture change within the wider NHS, leading to a greater focus on, and valuing of, community-based delivery of care.

Development of GP networks

Practices should also come together to create GP networks. Their goal should be the promotion of high-quality general practice and improved patient care. Networks should support their member practices to manage workload and provide services by sharing good practice, functions, support staff and services. This economy of scale will help preserve and protect viable GP contracts, thus helping to ensure local communities and patients have access to GP care.

Networks are well placed to integrate existing community and nursing-based teams with general practice. This may not be achievable at practice level, but even small networks of practices are more easily able to employ such teams. Sharing team members between different practices in the network provides the potential to cut costs for each practice involved. Crucially, however, by having members of practice teams alternate between different practices within a network during any given week, patients will be able to get the services they need at their nearest practice.

GP networks are already emerging across England. Just over one-third of GPs in our survey say their practice has joined a network or federation. Among the top three reasons given for doing so are to provide GPs with more influence on local healthcare delivery (40 per cent) and to help ensure the long-term security of the practice by being part of a larger structure (39 per cent).

Despite the enthusiasm for working in this way, and the fact that some networks are now well developed enough that they are forming companies, not all practices are convinced of the benefits. The lack of specific new funding to support the management and running costs of these new organisations is limiting their development and thus the potential benefits for patients and doctors. There are also other possible deterrents. Some GPs fear becoming disempowered, managed remotely by others, or that networks will lead to the creation of more layers of bureaucracy and take them away from direct patient care. Despite these barriers, it is clear that working in some form of network or collaboration is key to both the sustainability of practices and the better management of GPs' workloads.

Creating GP networks: what needs to be done?

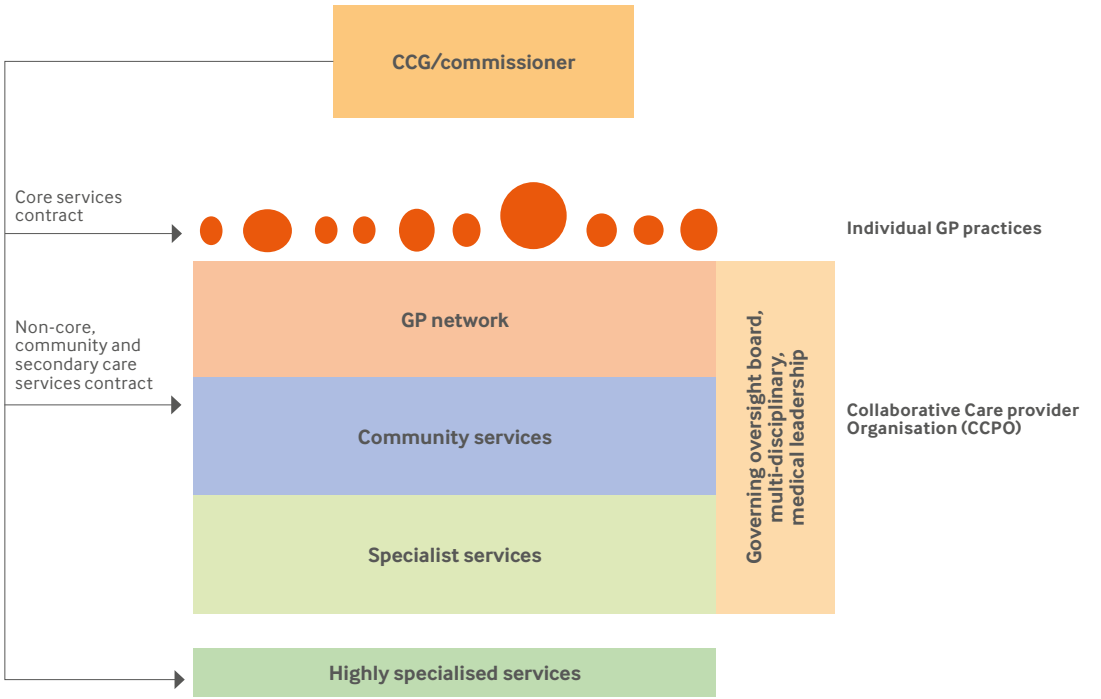
The BMA has already produced considerable guidance on networks. We believe the following steps could help to realise their full potential:

- Support practices to create provider organisations or GP networks with clearly defined funding to both ensure GP clinical time is not lost and cover the running costs of the organisation.
- Provide project management support to all networks from the early stages of their development.
- Offer education and training to network leaders.
- Provide support around bidding for and delivering primary care contracts.

9 BMA, *General Practice and Integration: Becoming Architects of New Care Models in England,* April 2015, available at http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-current-issues/general-practice-and-integration

Development of a collaborative care model

Practices in a network can work within a wider structure of local healthcare provision along the lines suggested in the 5YFV. In *General practice and integration: Becoming architects of new care models in England*[9] we described one possible model which incorporates GP networks: the Collaborative Care Provider Organisation (CCPO).



In this model CCGs hold core contracts with individual practices, providing a foundation for this model of care.

A local GP network has a role in supporting the delivery of services by, for instance, providing support staff to practices and providing additional primary care services – such as enhanced services, extended hours, more specialised diagnostic work and some outpatient services – across a larger area. The size of the network also helps to make premises development and ownership more sustainable thanks to its greater support and scope.

Practices working together, for example through a network, then have a central part in the formation and management of a larger healthcare organisation, the CCPO.

A positive aspect of this model is that collaboration and integration are enhanced as the CCPO focuses on the provision of services to a local population rather than competing with other organisations to provide services; the current tariff system is replaced by a payment system that supports collaboration between providers; and greater collaborative working with hospital specialists and other professionals is encouraged.

At its core, this model is about retaining the GP voice and local accountability within a defined community. While it in one sense benefits from being 'big' – based on larger practices working in networks, and then in collaboration with other parts of the health service – the vast majority of general practice work would continue, as now, to take place at practice level and be delivered by a recognisable practice team. Patients would still identify with practices as being 'theirs', based in the local community.

Super-practice model

As an alternative, instead of practices collaborating with one another in a network and then being the unit for collaboration with other parts of the health service, the super-practice model involves one big GP practice within an area, covering a very large patient population (potentially over 100,000). A number of such practices are starting to develop around England.

While formally one practice, it operates from a number of different sites within an area. Patients would usually receive most of their care from a team of clinicians working in a single practice but over time, the practice may offer different services in specific sites to which patients would travel when necessary. The practice staff is also more likely to move between the different sites and the practice may centralise certain functions, such as a single point of access for telephone contact.

Super-practices can either be run by a small number of partners with the organisation then employing a large number of staff, including salaried GPs and probably community staff, or it may have a wider partnership base, with a small group elected or appointed from within the partners to take on a managing executive role. In some of the emerging super-practices, although not all, the majority of GPs within the practice are employed. Some specialists can also be employed, with others sub-contracted. Super-practices can collaborate with other similar-size NHS organisations within an area but may also compete with them too.

This model could offer many of the features of general practice which patients at our events viewed positively. For example, they are GP-led and, therefore, arguably consistent with the desire of patients for GPs to remain in the community, offering the 'personal touch' that patients want. However, this would depend on the teams within each premises site of the super-practice remaining stable over a longer period of time. It could also be argued that because this model involves one large practice within an area, with a 'top-down' approach in terms of staffing, it could become more remote from patients than other models.

As this is a single organisation, it is likely that this model provides a stronger management structure than a network of independent practices and could ensure consistency of standards across the different practice facilities. It may also allow for a greater career structure within the practice, with GPs and others taking on new responsibilities and perhaps moving around the sites within the organisation as their roles change or develop. In addition, as one united provider, on a par with other NHS or social care providers in the area, it is likely to be treated as a truly equal partner.

The super-practice may, just as with the GP network of independent practices, collaborate with other providers in an area to form an MCP. However, as the 5YFV makes clear, it may be that as the super-practice gets bigger it employs a wide enough range of clinicians to be an MCP, thus meaning it does not need to collaborate with any other provider. Ultimately, the organisation could grow big enough to take on the management of the local hospital.

In some of the emerging super-practices, although not all, the majority of GPs within the practice would be employed. The pros and cons of this for GPs are discussed under the 'employed model' section later on in this report.

But it is not simply new structures such as GP networks and super-practices which will characterise the future shape of general practice. New technology and the modernisation of premises will have essential roles to play, too.

New means of communication: information technology

The patients in our deliberative groups were positive about having new ways of communicating with their doctors. New technology can play an important role in improving patient care and potentially facilitate the development of new models of care and closer working with other providers to deliver a more integrated service. However, as our GP survey showed, while doctors were positive about the use of telephone consultations – a large majority of GPs (86 per cent) agree that they are an effective way of consulting with patients when appropriate – there were also reservations about the use of email and video consultations among GPs, reflecting concerns about the clinical limitations of the technology, possible confidentiality issues and the impact on workload.

Beyond consultations, practices around the country have demonstrated considerable innovation in the use of technology to help them deliver high-quality patient care and more effective ways of working. In line with recommendations from the GPC many practices are now offering patients online appointment booking, ordering of repeat prescriptions and access to their records.

A number of suppliers have developed systems which allow healthcare professionals across different organisations to directly access detailed information from patient records. The sharing of their records can facilitate better care when patients require urgent medical attention, such as in A&E or out-of-hours organisations. Such sharing, which must always meet high standards of confidentiality including informed patient choice, can also help integrate services and support seven-day urgent care provision.

Utilising new technology: what needs to be done?

New technology can play an important role in improving patient care and potentially facilitate the development of new models of care and closer working with other providers to deliver a more integrated service. We believe the following steps can help to realise its full the potential:

- Support practices to ensure they have the necessary time to investigate, plan for and implement new technological developments.
- Provide ongoing assistance to practices to maintain, update and review technological developments.
- Help patients to use web tools and other systems and other health and social care services, which will also enhance health literacy and self care.
- Provide clearly defined financial support to practices for major investment in new technology, including ensuring practices have the necessary bandwidth.
- Share good examples widely to help practices learn from the experience and expertise of others, and to avoid unnecessary duplication of effort.
- Ensure full transfer of electronic health records between different practices to reduce or eliminate the need for paper records.
- Enable appropriate access to patients' electronic records in urgent care situations and other health and care settings. Sharing and access to patient records has to be carefully planned and done in a way that has confidence of patients and doctors.
- Expand mobile technology to enable GPs to access patients' records when away from the surgery e.g. for patients that are housebound.

Surgeries designed to care: investing in premises and infrastructure

Even the most dedicated GPs and their teams cannot deliver the best care for their patients in antiquated, cramped and overcrowded premises which have been starved of investment. In the worst instances too many GPs sharing too few consulting rooms limits the number of patients who can be seen, increasing the wait for an appointment. In others, wheelchair access is inadequate, patient confidentiality is potentially compromised and the ability to deliver even basic general practice services is threatened. As the GPC has highlighted for a number of years, investment in GP and community-based premises is crucial if we are to see more services provided in the community.

Last year, the BMA's premises survey revealed the scale of the challenge: four out of 10 GP practices felt that their current premises were not adequate to deliver services to patients; almost seven out of 10 GPs felt their premises were too small to deliver extra or additional services to patients; and just over half of practices had seen no investment or refurbishment in the past 10 years.[10]

BMA campaigning,[11] coupled with our GP contract agreement with NHS England, in 2014 led to the creation of a four-year, £1bn Primary Care Infrastructure Fund from which over 1,000 English GP practices will benefit in its first year. However, we still need a comprehensive premises strategy covering long-term funding and ownership models, particularly in the light of the changes that will inevitably happen in the organisation of care. In particular, to take account of the growing numbers of GPs who prefer not to have the commitment of owning premises, more needs to be done to provide premises either through the NHS or a third party.

It is also notable that in our GP survey, three quarters (75 per cent) of GPs said they would like to work in a GP premises with access to local primary care hubs providing diagnostics, extended care in the community and out of hospital services, compared to 14 per cent who say they would not. In addition, three-quarters (74 per cent) of GPs say they would like to work in primary care premises with other community based staff and services, while 14 per cent say they would not. This demonstrates that investment is required in the primary care estate as well as GP premises themselves.

Building modern premises and infrastructure: what needs to be done?

Modern, high-quality care requires modern, high-quality practices and infrastructure. We believe the following steps could help to achieve this:

- Provide a long-term commitment to an infrastructure fund beyond the current timescale, with a comprehensive longer-term premises strategy to ensure that general practice and the wider primary care teams can deliver the changes that will be necessary.
- Offer more premises through the NHS or a third party to meet the needs of GPs who do not want to own practice premises.
- Co-location of other healthcare professionals in the same buildings as GPs, working as a wider primary healthcare team.
- Developing local primary care hubs that practices can access for diagnostics, extended care in the community and out of hospital services.

10 BMA, *Premises Survey results,* (2014) available at http://bma.org.uk/working-for-change/your-gp-cares/premises-survey-results

11 For example in *Developing General Practice Today: Providing Healthcare Solutions for the Future, November 2013* available at http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-vision/

Bridging the funding gap: investment in primary care

While it is important to explore different ways of working, there are some other fundamental issues that need to be addressed to ensure that primary care and general practice can survive and thrive in the future.

General practice provides excellent value for money. An analysis of Health and Social Care Information Centre (HSCIC) figures carried out by *Pulse* magazine confirmed that England's 8,000 practices cost only £6bn in 2013/14 with the cost per patient in a General Medical Service (GMS) practice an average of only £131.45 per year for a comprehensive, unlimited service.[12]

Investment in primary care has gone down significantly in recent years and recent small increases have not addressed the resulting shortfalls.[13] At the same time, the demands on general practice have increased and the workload of GPs has risen. General practice is now acknowledged to be buckling under the strain.[14]

In response, the Government has already signalled its intention in the 5YFV to increase investment in general practice. NHS England has also said it aims to ensure that: 'the overall level of total funding growth for primary care is in line with that provided for other local services' – though it is unclear exactly what this means.[15] Moreover, the requirement to produce a further £22bn efficiency savings in the NHS cannot be achieved by transferring yet more work into primary care, which is already at capacity.

Recent government initiatives such as the Prime Minister's Challenge Fund, the Better Care Fund, and funding for 'vanguard' new models of care sites, have provided welcome, albeit limited, additional funding. But this non-recurrent investment does not resolve long-term problems in primary care. In fact, there is evidence that it could be making the situation worse as there is a tendency for those who already have resources to be successful in bidding for more, thus perpetuating unfairness. Indeed, the HSCIC figures revealed significant variations in funding per patient, with Personal Medical Service (PMS) practices receiving an average of £140.62, and APMS (Alternative Provider Medical Service) practices £192.85.

GPs are prepared to play their part in terms of delivering the changes that are clearly needed but the Government must be prepared to ensure long-term, fair and sustainable funding for the benefit of patients.

Investing in primary care: what needs to be done?

Investment in primary care has gone down significantly in recent years and recent small increases have not addressed the resulting shortfalls. We believe the following steps are needed to address this:

- Provide a sustained, year-on-year increase in NHS funding to general practice.
- Ensure this funding increase is available in the long-term on a recurrent, equitable basis for practices, allowing all patients to benefit.
- Uphold principles of equity and sustainability for all practices and patients, and CCGs to be held to account for their use of funding in terms of the benefits to patients or reductions in pressures elsewhere in the system.

12 Chris Sloggett, *Why General Practice is Such Good Value for Money,* Pulse, (6 March 2015) available at http://www.pulsetoday.co.uk/your-practice/practice-topics/practice-income/why-general-practice-is-such-good-value-for-money/20009384.article#.VZpWWEYlcYA

13 Health and Social Care Information Centre, *Investment in General Practice, 2009-10 to 2013-14, England, Wales, Northern Ireland and Scotland,* (2014) available at http://www.hscic.gov.uk/catalogue/PUB14900

14 Jeremy Hunt speech New Deal for General Practice, 19 June 2015, available at https://www.gov.uk/government/speeches/new-deal-for-general-practice

15 NHS England, *Five Year Forward View,* (2014) available at http://www.england.nhs.uk/ourwork/futurenhs/

4. Recruiting and retaining GPs: what next?

Falling investment and rising demand has increased GPs' workload, sparking a recruitment and retention crisis.

Increasing numbers of practices are unable to recruit GPs, particularly in certain areas, with this having a knock-on effect both on the workload of GPs within these practices and, crucially, on patient care.

More GPs are needed in order to meet the demand for GP services from patients. This was highlighted in 2014's Health Education England Taskforce report[16] and the Centre for Workforce Intelligence GP in-depth review.[17] During the recent general election campaign, all of the main political parties pledged to increase GP numbers. Since the election the Government has reaffirmed its commitment, most recently in Jeremy Hunt's New Deal for General Practice speech,[18] although subsequently he has said that 5,000 additional GPs was a maximum figure to be aspired to and would take longer to reach than had earlier been suggested.[19]

At the same time, the popularity of general practice as a specialty for future doctors has reduced, with applications to GP specialty training from foundation year doctors not meeting the targets set by Health Education England.[20]

The potential future scale of the recruitment and retention crisis was clearly illustrated by our GP survey. It found that:

- Thirty-four per cent of GPs are hoping to retire from general practice in the next five years. Significantly, 36 per cent of GPs aged 50-54 – who currently make up 16 per cent of the GP workforce[21] – hope to retire in the next five years.
- Twenty-eight per cent of GPs who are currently working full-time are hoping to move to working part-time in the next five years.
- Nine per cent of GPs are hoping to move abroad in the next five years. This includes 19 per cent of current GP trainees.
- Just under half of GPs (47 per cent) would recommend a career as a GP to an undergraduate or doctor in training, but one-third (35 per cent) would not do so.

The recruitment and retention crisis should be addressed on a number of levels. There needs to be a comprehensive strategy to boost the GP workforce; to reduce doctors' workload; to provide new models of working for GPs who would rather not take on the responsibility of managing, or becoming a partner in, a practice; and, through a consolidated contract, to define the 'core' services which GPs are expected to deliver to their patients.

16 Health Education England GP Taskforce Report, July 2014, available at http://hee.nhs.uk/2014/07/22/gp-taskforce-report/
17 Centre for Workforce Intelligence GP In-Depth Review, July 14, available at http://www.cfwi.org.uk/our-work/medical-and-dental-workforce-reviews/medical-specialties/gp-in-depth-review
18 Jeremy Hunt, New Deal for General Practice, 19 June 2015, available at https://www.gov.uk/government/speeches/new-deal-for-general-practice
19 As reported in many media outlets on 24 June 2015, including GP Magazine http://www.gponline.com/jeremy-hunt-softens-pledge-recruit-5000-new-gps/article/1353174
20 As reported in BMA News, August 2015, http://bma.org.uk/news-views-analysis/news/2015/august/training-stats-make-mockery-of--5000-extra-gps-pledge
21 BMA's 2014 Medical Workforce Briefing, May 2015, available at http://bma.org.uk/working-for-change/policy-and-lobbying/training-and-workforce

GP Locums: Essential to the GP workforce

As with salaried GPs, the number of locum GPs in the workforce has been growing at a fast rate. Although the numbers of locum GPs in the workforce are not officially counted, we know that a significant proportion of the GP workforce work as locums.

GP locums fulfil an invaluable role in the GP workforce, ensuring that services are still provided to patients when there are gaps in the service – for example, through illness, maternity or problems for practices in recruiting salaried GPs or partners. This will continue to be the case in the future, regardless of the model of working used, and as with GPs of all contractual status, locums should be at the forefront of driving through changes to ways of working for the benefit of patients.

As locum GPs fulfil such an important role, it is nonsensical that there is no official measure of the number of locum GPs in the workforce and we call upon the government to resolve this as soon as possible.

Boosting the GP workforce: what needs to be done?

More GPs are needed in order to meet the demand for GP services from patients. We have agreed a 10 point GP workforce plan with NHS England, Health Education England and the RCGP,[22] intended to kickstart initiatives and funding to improve recruitment and retention within the GP workforce. This needs to be the start of a sustained programme of meaningful initiatives and funding for the GP workforce.

We believe the following steps could help to address the gap between the number of GPs we have and the number we need:

- Improve the image of general practice in medical schools. The visibility of GPs in medical schools should be increased by increasing the number of senior academic GPs teaching, mentoring and acting as role models to medical students. Universities need to be incentivised and encouraged to expand the number of academic GPs to bring them in line with the number of academics in the consultant workforce. Applications to general practice have varied by medical school. Research should be carried out to establish why this is and develop best practice in all medical schools.
- Significantly increased resources to grow the number of GP placements for foundation doctors. Many foundation doctors do not currently gain experience of general practice making it less likely that they will choose a career as a GP.
- Fully fund GP returner and retainer schemes in order to retain GPs who have already qualified within the workforce. A national induction and refresher scheme has been implemented as part of the 10 point workforce plan.[23] While this is a welcome first step, it is likely that more funding will be needed for the scheme in order to fund further places and provide an adequate bursary for participants.
- Introduce an equitable and fair tariff for GP practice undergraduate placements – the funding for which currently varies across the country – to ensure that practices take on undergraduates for these placements.
- Be aware of what GPs find attractive about general practice. Working as a generalist was seen as the most attractive feature of general practice. This underlines the importance of emphasising the broad and holistic character of general practice and suggests that a move away from this, thus removing GPs from the frontline of general patient care, would be damaging to recruitment and retention. Developing relationships with patients over time was also rated highly. This indicates that any shift away from the current list-based model of general practice and of practices embedded in a defined community would also endanger recruitment and retention.
- Implement a sustained increase in resources to general practice to match demand for GP services. This would both address the acknowledged underfunding over the last decade and anticipate the increased activity required in the community in the coming years.
- GP training to include leadership, management, commissioning and business training, reflecting the need for these skills as a qualified GP. This is likely to mean a fourth year of GP training.
- Easier access to academic general practice as a career, reflecting the benefits that a well-resourced and flourishing academic general practice can bring to patient care.
- Reduce GP workload to make the job more attractive to prospective GPs and retain current GPs in the workforce.

22 Details of the 10 point workforce plan are available at http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-current-issues/workforce-10-point-plan
23 Details of the scheme are available at http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-current-issues/workforce-10-point-plan/new-induction-and-refresher-programme

Increasing commitment to general practice: managing GP workload

The results of our survey suggest that any strategy to address the recruitment and retention problems affecting general practice will fail without a reduction in GP workload. It is the main factor currently discouraging doctors from entering general practice, and weakening the attachment of those already in the profession. In our survey, workload was seen by GPs as by far the biggest factor detracting from their commitment to general practice: 71 per cent of GPs ranked it in the top four factors lessening their commitment, 37 per cent of GPs felt that their current workload is unmanageable and 84 per cent of GPs experienced a significant amount of stress.

There are a number of factors increasing GPs' workload. A growing population of older people with more complex health needs, combined with greater expectations on general practice, means that demand and consequently workload are escalating. This has been exacerbated by the different payment systems operating in general practice and hospitals, which have increased the shift of work from secondary to primary care in addition to government policy of moving care into the community. Much of this work is not resourced. The number and complexity of patients in residential and nursing homes has added to the increase in doctors' workloads.

Our deliberative events with patients showed they were concerned about how GPs' workloads were affecting their practices. For example, participants reported finding it more difficult to get a GP appointment and noted that GPs appear to have less time to spend with their patients. Patients felt this lack of time had consequences for the standards of their care. As suggested previously, doctors agree, with the GP survey showing 93 per cent saying that their workload negatively impacts on the quality of care given to patients.

Quality first: managing workload to deliver safe patient care

The GPC's guidance, *Quality First: Managing Workload to Deliver Safe Patient Care,* was developed to empower GPs by encouraging them to focus on their main priority of providing core, high-quality services to their patients.[24] A range of initiatives was covered in this report: new ways of working; appropriate patient self-care; making better use of the practice team; and working collaboratively with other practices at scale. We hope that this approach of being clearer about what practices should be expected to deliver contributes to a changed philosophy, one which prevents resources being taken away from patients who really need them.

24 BMA, *Quality First: Managing Workload to Deliver Safe Patient Care, January 2015,* available at http://bma.org.uk/practical-support-at-work/gp-practices/quality-first

Managing GP workload: what needs to be done?

GP workload is currently at unsustainable levels and has a negative impact on the quality of care given to patients. We believe the following steps could help to reduce doctors' workload and improve patient care:

- Commit to increased and sustained funding for general practice to address the historic underinvestment and to prepare for the future increased needs of patients.
- Expand not only the GP workforce but also those who work with, and support, GPs to create an enhanced team of healthcare professionals both within and around the practice.
- Enlarge the infrastructure of general practice, with improved premises, community-based estate and facilities, and optimise the use of new technologies.
- Reform NHS payment systems to ensure that work done in general practice and the community is fully resourced.
- Empower patients to manage their own care better.
- Reduce bureaucracy and over-regulation.
- Focus on new models of care for patients in nursing homes as suggested in the 5YFV, which also have the potential to improve care to this vulnerable group of people.
- Implement recommendations in *Quality First: Managing Workload to Deliver Safe Patient Care* which are designed to give GPs greater control over their practice workload.

Employed model for GPs

One potential route to recruit and retain more GPs is ensuring that there is a range of options available to doctors in terms of their employment status. As we have seen, the vast majority of GPs are supportive of the independent contractor status, with many wishing to remain, or become in the future, partners in a practice. But this model does not suit all current or aspiring GPs. It is important, therefore, to explore alternative options: an employed model and one where GPs act as primary care consultants.

It is arguable that being employees of, rather than partners in, a practice could resolve the current biggest problem for GPs: that of an unmanageable workload. As partners, GPs are both contractors delivering a local primary care service and health professionals caring for patients. Consequently, the boundaries between funding, income and workload are blurred. Moving to an employed model could allow GPs to have a greater focus on clinical work, rather than the business side of running a practice, and give them more control over their work.

As employees, GPs receive a salary linked to a clear set of responsibilities. Under an employed model, the challenges that being a partner presents such as practice income not keeping pace with rising costs, and the responsibilities of being a property owner or leaseholder, employing staff and being a provider of healthcare services (for example, having to manage the Care Quality Commission registration process) could be lessened.

The findings of our GP survey indicated that an employed model might be an attractive option for some doctors – encouraging new entrants into the profession and others who are thinking of leaving to stay. Sessional GPs ranked their partner colleagues being overworked as the second most important factor in their reasons for being a sessional GP, while the related factor of having a good work-life balance was ranked as the most important factor. GP partners were also more likely than sessional GPs to feel that their current workload is unmanageable.

But, while moving to an employed model could reduce some of the workload GPs face, it is important that when considering such a radical change even within a local area, doctors' preferences about which model they would prefer to work under remain paramount.

It is evident from the GP survey that even those who are not partners support the option of independent contractor status being maintained. However, younger GPs are less supportive of maintaining the option than older GPs, with almost three quarters (74 per cent) of those who have been GPs for five years or less being supportive of maintaining the option.

Almost two thirds of sessional GPs do not envisage looking for a GP partnership at all in the future

This figure increases to 85 per cent when only taking into account the view of those who have been GPs for 20 years or more. Sessional GPs were less supportive (but still fairly strongly supportive) of the option than contractor GPs, with 68 per cent of salaried GPs and 70 per cent of locum GPs supporting the option, in contrast to the 88 per cent of contractor GPs who support the option. However, it is also noteworthy that almost two thirds of sessional GPs do not envisage looking for a GP partnership at all in the future.

When GPs were asked in our survey which factors are most attractive about general practice, the two highest-rated factors were the variety of working as a generalist (picked by 80 per cent), and being able to develop relationships with patients over time (76 per cent). Each of these factors could be delivered under an employed model, and these findings emphasise the importance of a strong degree of autonomy being maintained under such a model. However, it is arguable that working as a contractor provides a greater degree of variety than other models, and that because contractors tend to stay within practices for a longer period of time they have a greater opportunity to develop long-term relationships with patients.

What impact would such a model have upon patients? By both reducing the amount of time that GPs have to spend on the managerial aspects of general practice and reducing workload, an employed model could give doctors more time to spend with their patients, thus potentially increasing the amount of time available for consultations and reducing appointment waiting times. However, meeting these patient priorities very much depends on other factors such as the number of GPs in the system and the way in which an employed GP model is structured. Ensuring that enough GPs want to work under such a model is particularly important.

In terms of continuity of care, it is possible that a salaried model would not perform as well as the independent contractor model where GPs have more of a stake in the way that health services are provided, a greater connection with the local community, and stay longer within individual practices. However, it is also possible that, if there is a shift to a salaried model, this may result in salaried GPs being the norm in a particular area. This could potentially decrease turnover thus providing continuity of care.

The key to successful recruitment under an employed model is to make the job of being a GP attractive and rewarding, so that GPs commit for the long term as most hospital consultants currently do. A proper career structure for salaried

GPs should, therefore, be developed. There is a risk that, unless they achieve a comparable status and remuneration to hospital consultants, not enough doctors will find becoming a salaried GP attractive, thus endangering the potential benefits to patients of this model. Protecting the terms and conditions of salaried GPs under a salaried GP model contract, with terms at least as good as those of the model contract currently in place, would also be crucial to ensuring this model attracts enough GPs to be sustainable. The value of portfolio working and variety, as another way to encourage people to stay in practice, also needs to be recognised.

GPs as primary care consultants

Consideration could also be given to the possibility of GPs being employed on consultant-type contracts working for community trusts, GP-led networks, or MCPs, in a similar way to the manner in which community-based consultants in elderly medicine and community paediatrics are currently often employed. This may help to make clear that GPs, as specialist generalists, were on a par with other consultant specialists within the NHS. It would provide GPs with a clear career structure and protect their terms and conditions in line with hospital colleagues. As a result, these changes may help with GP recruitment.

An alternative would be for GPs to act as what might be termed 'consultants in general practice'

An alternative would be for GPs to act as what might be termed 'consultants in general practice'. This still has at its heart the GP practice (albeit likely to remain smaller in size and scope) and a list of registered patients. However, unlike the current model, GPs would focus only on the work for which they have been trained, working as expert medical generalists providing senior clinical input in the community rather than focusing on the provision of services. This would mean wider teams around the practice providing many of the services currently expected from practices. GPs would employ a small number of staff to run their practice and would provide their medical expertise rather than provide services. They would be an expert resource leading their teams as hospital consultants do. GPs would prioritise complex patients and see patients with undifferentiated problems (where they could not be dealt with by other professionals). GPs would be the senior clinical decision makers leading the community clinical team.

The contract would likely be with the individual GP rather than with the practice, with GPs acting in practices under partnership agreements. Practice lists of patients would continue and be the basis for broader primary health care teams. Most services, such as the management of long-term conditions, child health, immunisation and fulfilment of the Quality and Outcomes Framework (QOF), would be carried out by nurses and other staff employed by networks, health bodies or the community provider, possibly in the same practice premises. The GP, as senior clinician, would have a role in monitoring and developing the quality of these services.

Such a system is currently being proposed in Scotland and an adapted version may also be suitable across the rest of the UK, though there would need to be flexibility to accommodate the current variations in provision of additional services by practices. Different versions of this sort of system are currently in place in other parts of the world and have shown the benefits of the GP as a primary care physician being at the heart of healthcare in the community.[25]

25 American Academy of Family Physicians, *Reducing Hospital Admissions: Small Primary Care Practices Shine in National Study,* (2015) available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226782/

This model would require a completely different kind of contract. It might be possible to retain independent contractor status, with GPs contracted as clinicians but working in a different way. Equally, there could be an employment contract as a variation on an employed model. There would need to be a period of transition to any new system and further work would need to be done to redefine the role of GPs and ensure that funding for practices is stabilised and secured for the future. This system would allow GPs more control over workloads and would ensure that patients who do not require clinical care would be able to access more appropriate, but very much local, services.

The benefits of an employed model – GPs having greater control over their workload and more clarity regarding their duties – could equally apply to this slimmed-down model. It is also possible that this model could lessen some of the employed model's potential disadvantages: providing a sufficient amount of variety and control for GPs over their work and a stake in the way that general practice is run, meaning that it is still possible to develop longer-term relationships with patients. It is, therefore, possible that it could improve GPs' working lives and make general practice more attractive to future doctors. It could, however, also be a stepping stone towards a fully salaried and managed GP service.

GPs acting as primary care consultants could deliver similar benefits to patients as those outlined under the salaried model: GPs would be able to concentrate on clinical care. However, while for GPs some of the risks of running and managing a practice would be removed, it is also possible that this would limit the flexibility GP contractors currently have to lead innovation or to provide additional services when the opportunity arises.

Defining 'core' services: a consistent offer to patients

If we are to achieve the principles outlined at the start of this report, or implement any of the proposed new models of care or innovations described, there will need to be a review of the current GP contract. While there are an increasing number of issues that are discussed at a local level, a key strength of a national GP contract is that it helps to maintain a consistent and equitable 'offer' to patients in terms of access to, and the quality of, essential GP services. This provides, therefore, a foundation upon which other models can be built.

Many changes beneficial to patients have already been brought about with no change to the contract

Many changes beneficial to patients have already been brought about with no change to the contract. However, over the last decade the GP contract has been the main vehicle through which government has attempted to introduce change. Many of those government-driven contract initiatives – for instance, 48-hour access targets, some Quality and Outcomes Framework indicators and many Directed Enhanced Services – have been transitory and devised to meet short- or medium-term political requirements. Annual changes to the contract have not only been unsettling, but the work required to make the necessary adjustments for their implementation has added a further burden on already-stretched practices and contributed to the current low morale among GPs.

The BMA has long argued that GPs should be focused on providing high-quality clinical care. It is not appropriate for general practice to be used to take forward political initiatives that may play well in the media, but do not satisfy the best current medical practice or which result in unintended adverse consequences.

A much longer-term strategy is needed for future contract changes, avoiding unnecessary tinkering with, and micro-management of, smaller elements of the contract and concentrating instead on the core expectations on GPs and practices. In 2004 GPs were promised a contract that was 'high trust, low bureaucracy' but the result has been just the opposite.

This is supported by the 2013 Future of General Practice focus groups[26] run by the BMA which found that it was difficult for practices to plan or develop strategy in an environment of constant political change. The Quality and Outcomes Framework, for example, has been annually renegotiated, thus altering what practices have to do to meet targets. Over half of GPs (55 per cent), according to our survey, back reductions in the size of QOF, while only eight per cent would like to see it increased. Further reductions in the size and scope of QOF, with funding transferred to the global sum to ensure practices have the necessary resources to support the management of patients with long-term conditions, could be a means to achieving a shift towards a greater focus on core expectations, reduction in bureaucracy and providing practices with much-needed stability. Similarly, moving funding away from enhanced services into the global sum would also help cut micromanagement by the centre, leading to more GP-led holistic care in the interests of patients.

A consolidated core contract

One of the supposed benefits of the 2004 GP contract was that the definition of core GP work would be clearly set out through the detailing of essential services. This, unfortunately, has not been the case. What is required of GPs is frequently unclear, with a default expectation that they will pick up new and additional work, however inappropriate, in order to ensure that patient needs are met. Again, this is supported by the findings of our 2013 focus groups which identified a lack of definition of 'core' GP work. Clearly, it is crucial that there are not gaps in care which, at worst, could be damaging to patients. However, as demonstrated by our survey, the negative impact on GPs of having work which is inappropriate and not resourced transferred to them should not be ignored, particularly when general practice workload is creating such problems.

To help resolve this, a clear definition of the core contract is crucial. This should also be linked to the current aim of NHS England to equalise payments to all practices by removing and recycling correction factor (Minimum Practice Income Guarantee – MPIG) payments from GMS practices and reviewing and reducing PMS practice funding.

There is now growing support for a clearer definition of core services.[27] Above all, general practice should not simply be forced to fill the gaps in the health service or, indeed, in social care, at a time when local authorities have undergone significant cuts. Defining core services also allows a process for non-core work to be identified, costed and resourced to reflect any increased workload in general practice.

We believe there should be a move to a long-term, consolidated and stable GP contract. This would provide a core of essential GP services that all practices have to offer to patients on their registered list and thus provide consistency for all patients, a solid foundation upon which to build other services, and a ring-fence to protect GP services in any integrated care model.

27 The following resolution was passed at the 2015 LMC Conference: That conference, recognising the increasing mismatch between workload and available GP and practice workforce, calls on the governments and NHSE to work with the GPC to urgently define
(i) what is and is not included in GP essential services
(ii) what work can be postponed or abandoned if a practice is unable to recruit sufficient staff to deliver all services safely
(iii) what patients and public can and cannot expect from GP service in crisis.

Defining core GP services: what needs to be done?

A clearer definition of core GP services is important for doctors and patients, especially during a time of potential changes to the configuration of general practice. We believe the following steps should be taken to move towards a long-term, consolidated and stable core GP contract:

- Stop further changes to the GP contract arising from short- or longer-term political initiatives without adequate supporting clinical evidence.
- Avoid annual, relatively minor, amendments to the GP contract.
- Implement a consolidated and clear contract, providing a core of essential GP services to all patients on the practice's registered list, without unnecessary bureaucracy and box ticking. This will also involve agreeing and adhering to a clearer definition of the GP core contract.
- Ensure Local Medical Committees play a key role in the development of any local initiatives which may have contractual implications.

Conclusion

In 2013, as we began our consultation on the future of general practice, we stated: 'General practice has always been a sure foundation on which the NHS has been built'.

'With more GPs, spending more time with their patients, working in bigger and more comprehensive teams built around the practice, based in better quality premises and underpinned by a fairer share of NHS resources, general practice can deliver the healthcare solutions for the future. Now more than ever, general practice is offering solutions which will enable the whole NHS to remain sustainable and successful.'[28]

This statement is as true today as it was two years ago, but its call to action is now more urgent.

Our consultation and research has found general practice to be in the midst of a growing crisis in relation to workload pressures, GP recruitment and retention and falling morale. While patients continue to report high levels of satisfaction with their GP services, increasing numbers are having problems getting a timely appointment.[29] With almost all GPs reporting that their unmanageable workload is undermining the quality of care they provide to their patients, immediate steps must be taken to relieve the pressure.

There is an urgency, too, to the need to increase the number of GPs, expand the mix of skills and number of people who work with GPs in practices, as well as to directly commission community teams to work alongside the practice. In addition, there needs to be investment in new technology, which will support teams working more closely together, and improvements to premises to enable enlarged practices to provide more services in the community. Investment in general practice has been shown to help deliver efficiencies elsewhere in the system and must therefore be a priority.

Attracting more GPs and community staff also requires a change in NHS culture, with a far greater focus on promoting the importance of these roles if the health service as a whole is to remain sustainable. There can be no question of extending routine GP services to cover the whole weekend when there are too few GPs to provide the current service. Stretching an already overstretched service more thinly would simply undermine the quality of care to all patients.

Practices need to recognise the importance of both being large enough to meet the needs of their local community and of working in networks with others across a wider area. The current fragmented NHS and social care system, with organisations competing rather than collaborating with one another, does not serve patients well. Built on a solid foundation of a rejuvenated and properly funded general practice, a collaborative care model which brings together GPs, community and hospital specialists as equal partners to work for the benefit of a specific community, provides a golden opportunity to meet the challenges that face us all.

28 *Developing General Practice Today: Providing Healthcare Solutions for the Future, November 2013* available at http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-vision/
29 *NHS England, GP Patient Survey 2014-15,* available at http://www.england.nhs.uk/statistics/2015/07/02/gp-patient-survey-2014-15/

Reforms of the GMS contract have a part to play in ensuring the future for general practice. But this is not the only vehicle for change. Our survey clearly showed strong support for retaining and building upon GPs' independent contractor status. With its inherent flexibility, this status can provide a foundation for different models of care. It is also clear that employed and locum GPs prefer to work in GP-led organisations. However, other contractual options, both those currently available and potential radical new alternatives, also need to be at the forefront of different ways of working.

The BMA is the only organisation that represents and brings together doctors who work in primary, community and secondary care settings. Further the BMA's GPs committee is the only body that represents all GPs across the UK, from partners to sessional GPs and trainees, supported by a national infrastructure of local medical committees. We are, therefore, in a unique position to take this transformation agenda forward. To do so, though, requires the commitment of government, NHS England and all other health and social care bodies to work directly with us, and, above all, to provide the necessary funding to make these new models of care a reality. Not doing so will be to fail our patients and put the future of the NHS at risk.

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Towards a new future for general practice

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