August 2018

Londonwide Local Medical Committees' response to GP Partnership Review

Londonwide Local Medical Committees (Londonwide LMCs) is the clinically led independent voice of general practice in the capital, supporting Local Medical Committees; bodies recognised in statute (NHS Act) which represent the interests of all local GPs and their teams. We aim to secure the future of general practice in London through our work with all partners in the health and social care sector and beyond. We support and represent over 7,000 GPs and over 1,250 practice teams in London through our 27 locally elected committees. We ensure that London's GPs and their practice teams have access to the information and support they need to help them provide the best possible service to their nearly nine million patients.

Londonwide LMCs welcomes this opportunity to respond to the Review on the future of the Partnership model in general practice.

Summary Response:

We sought views from across the London GP network regarding the four main aspects of partnership being considered as part of the Review. Comments received via email are attached at **Annex A**.

A summary of the comments received/ made during a roundtable event organised by Londonwide LMCs as part of the hosted visit of the Review Team can be seen at **Annex B**.

Challenges:

1 - Workforce – challenges expressed around the recruiting of suitable GPs in sufficient numbers to the permanent workforce. As time goes on, older GPs are opting to leave practices to become locums or retire earlier. Also citations of concerns about workload and burnout.

2 - Liability and risk – comments expressed concerns about unwillingness to take on this liability. The risks of being a partner are now being seen as greater than the benefits.

3 - Lack of career progression – some locums and younger GPs have said that they would consider joining a practice as a partner, however not immediately after completion of their training.

4 - Uncertainty about the future – concerns about the younger generation committing to a partnership for the medium to long term citing a number of reasons from the flexibility of locum work to the cost and challenge of buying-into a partnership, and the work it entails.

Solutions:

1 - Proposals for partnerships without the responsibilities of premises ownership should be developed and prioritised;

2 - Multidisciplinary teams – including community, social care, mental health and third sector members - working collaboratively with GP partnerships in local primary care networks (PCNs) of 30-50000 patients, with care co-ordinators would work in a London context since the capital is designed around local neighourhoods and communities. This is highly analogous to the Primary Care Home model which we support.

3 - Primary Care Networks or Homes also provide the critical size for practices to be supported with shared staff at practice level which meet the specific needs of their populations; at this level we believe it is possible for the Treasury to soundly fund developments that benefit the delivery of core services to patients.

4 - Physical infrastructure – in London there needs to be a recognition that space for development is at a huge premium and takes many years to free up. Smaller scale improvements can make a huge difference to existing working environments and should be actively encouraged.

5 - Digital infrastructure – connectivity across practices and networks is arguably more important than physical infrastructure.

6 - Education and training initiatives - we believe, based on evidence garnered from the 1990s Tomlinson Report and special funding, that funding protected time for education, training and career development aligned to the strategic care needs of the populations of practices working in primary care networks will improve morale and attract clinicians into practices.

Londonwide LMCs is eager to work with the London system to explore each of the above.

Additional Points:

Partnership, work/life balance and digital developments

One of the key issues for any GP taking on a substantive role is the ill-defined, ever increasing workload. To help manage workload and deal with the medical complexity, practices should be encouraged to move to significantly longer appointments to match the increasing complexity of consultations. In order to achieve this without reducing access, significant numbers of appointments would need to be virtual appointments and other contacts which currently result in appointments need to be directed to self-care.

For example, a patient calling with a headache may be given a GP appointment for that day by a receptionist/care navigator. An online consultation with this patient would be able to distinguish between a patient who has a headache with red flag symptoms needing urgent/immediate review and a patient who has a tension type headache, that may need a routine review and can be advised on self-management.

We need to consider how we incorporate digital working into core GP business as the benefits will only be realised when there is significant uptake by patients. The potential to use digital platforms for better triage and signposting could result in a reduced number of in-person appointments, with a more appropriate caseload and longer to spend with each patient. These changes, combined with an option of a weekly session of digital consultations from home, would give a GP partner could have a more manageable workload and one that is more rewarding.

In order for the potential of digital health to be realised practices need the infrastructure to provide it, to know how to use it effectively and patients need to want to use it. We should remember that at present online consultation is in its infancy, NHS England is funding the development of online access with a £48m fund between 2017-2020. Online access and consulting could reduce the need for attendance at GP practices and appointments in the long-term. How to apply the technology in ways which actually do this needs to be established by rigorous evaluation, rather just the belief that rolling out more online services will somehow inherently reduce workload.

Patient Online figures show that simple digital services such as managing online appointments, repeat prescriptions and accessing medical records are still not well used in London. Although 99.4% of practices in London offer online appointment booking, less than a third of patients are registered to do so. The practice offer is nearly 100% for repeat prescriptions but the take up is even lower at just over a quarter of patients and only 7% of patients are registered to view their records online (97.3% offered). This is low uptake for a programme that has been running for some years now.

People expect to be able to access more and more services via mobile devices, which suggest there may be demand for online GP services. However there will only be significant uptake if these services meet public expectations of how an online service should work, namely: that they are simple to sign-up for, what users can and cannot expect from the service is clearly outlined, and the quality of service that is promised is consistently delivered. To create a reliable service the NHS needs to fund user research (both patient and clinical), significant IT infrastructure improvements in practices, software development and/or procurement, training and roll-out support.

NHS contracts would need to adapt as well, for example some areas have key performance indicators based on number of appointments per 1000 patients, practices covered by these should not be penalised for online consulting. CCGs would either need to move away from such KPIs or ensure that online consultations are included in any calculation.

The NHS needs to consider that those people with high technological literacy and access to modern mobile devices tend to come from socio-economic groups which already have above average health outcomes. Demand for online access from this cohort may not be proportionate to their actual need for improved access to NHS services, the inverse care law would suggest that the greatest need for improved access actually lies elsewhere in the population.

In order for investment in digital health tools to fit with the values of general practice, such tools must directly reduce health inequalities, or free up resource which can be directed to other methods of care delivery which are proven to do so.

Contacts

For further information about Londonwide LMCs' response to this consultation please contact Dr Michelle Drage, CEO on michelle.drage@lmc.org.uk or Sam Dowling, Director of Communications on sam.dowling@lmc.org.uk.

- End -

ANNEX A - COMMENTS RECEIVED FROM LONDONWIDE LMCs GPs

GP1

I have a very positive experience of being a GP partner (historically part of a 2 partner practice and now a single handed GP supported by 3 salaried GPs). I will list below the challenges, benefits and alternatives for the partnership model as I see them personally.

Challenges
- recruiting new partners is a difficulty (as is recruiting any GP). I think part of the solution is to role model the positives of what GP partners can do. I really value the flexibility and autonomy that being a partner gives me and I can try out new innovative ideas to improve general practice quality, I love being a partner!
- I do not feel we share these positive messages with our younger colleagues enough. I recently spoke at the North East London GP mums group and much of the feedback was that they did not know that partnership could really be a career option for them as they were afraid of the "management responsibility". We need to debunk this myth.

Benefits
- very few other professions give people the amount of autonomy and flexibility in work as being a GP partner lends itself to. GP partners can feel more of a sense of ownership of their patients and their work as its their business. This can be very fulfilling and certainly for me being a GP partner gives me a sense of purpose and continuity with my patients, I feel responsible for providing excellent care to them and will do more to ensure this happens- however I enjoy this and do not feel it's a burden.

Alternatives
- I do not think that having a full salaried workforce is a viable alternative as we may lose sense of ownership and responsibility (something we sadly see in secondary care - the large organisation means that nobody is often sure who has/ will take the responsibility for the patient). I think partners working together in super practices or in some sort of loose federated form is the way forward so we can each have autonomy but provide a universal standard of care and benefit from the economies of scale and reduce the isolation but also keep the autonomy.

GP2

As a GP of over 25 years in partnership, I will retire if I am forced into an employee role. The NHS cannot afford to disenfranchise any GPs who are currently working, this is a serious and significant risk which must be mitigated against. Therefore there cannot be a one size fits all approach. Any review must support a mixed economy – with some providers at scale with more employee GPs and some partnerships.

Factors that are threatening partnerships

1. The pressure to work at scale and to engage with all processes – we simply don't have the personnel to attend every single meeting and keep up the pace. This means decisions are being made about us, without our input. This is not okay. At the very least the LMC must be present at all these meetings to represent our views independently.

2. Buildings issues – negative equity, unfair service charges, dealing with CHP and NHSP both of whom are not fit for purpose, etc etc

3. IT issues – we have an IT infrastructure that is not fit for purpose – both the PCs which have insufficient processing capacity for our needs, and the N3 connection which is inadequate. Poor ongoing support. This means you end up doing things in house yourself (breaking the rules sometimes) or you spend hours on the phone logging the same issues again and again!

4. The workload – over and above the clinical session. Partners have to sort complaints (frequently vexacious which mean lots of work without any meaningful benefit to us – we need to change the culture that all feedback needs reflection and is useful, sometimes it is not – it is the patient offloading on us, or they have mental health issues or a personality disorder – we need help with this!). Partners have to sort employee issues – which again can be very very time consuming if they go wrong. Partners have to sort out financial issues/financial strategy/ financial monitoring. As well as delivering patient care and leading on various clinical areas. All of this means that we put in at least an additional 6-8 hours a week each even as part timers. If we were employees this would be recognised in our 'job plan'. Some partners are earning less than their employee GPs. The removal of seniority should not have been allowed to go ahead, as it compensated for experience, which is incredibly valuable as I can do things quicker than a new inexperienced GP as I have done them before. We need a financial settlement that means that partners can take remuneration for this additional workload and have recognition of this input to the system. If I become an employee I will work to rule, and won't do extra hours without overtime pay. This will cost the system as a whole much much more.

The positives and why I would not give up being a partner

1. Autonomy and control and choice – I can change the system in my practice if I think it is not working, and I can influence more widely. I value this highly – and compared with consultant colleagues I think we have much more control over our working environment, which I would be loath to lose.

2. I am my own boss and accountable largely only to me and my partners and our manager. I could not bear to work for a junior manager who is not a clinician telling me what to do and when.

3. Whilst the challenges above are tiresome a lot of the time, if I have time and capacity, they can also be interesting and make the workload variable – I have learnt enormous amounts about employment law, corporate governance, financial management, buildings management, IG which I would otherwise not know.

GP3

I am currently a GP partner and have been for 17+ years. My observation is that partnerships are but one way of ensuring that the people who run a practice have 'skin in the game'. By this I mean that being in a partnership as a model for working and running a practice, when it works well, 'imposes' the following requirements on those involved:
- the need to find ways to work together (because we are in a 'partnership' and so in it together)
- squarely puts all responsibility in one place - with the partners. If anything goes wrong, partners know whose door people will be knocking on!

This means the partners have an interest - financial, professional, social, for wanting to do their best to make it 'work'. My feeling is that few models of employment or running an organisation create such a shared goal.

Of course I accept that many partnerships go wrong, but then again, many work well.
So any efforts should perhaps be directed at helping partnerships work well as opposed to trying to replace them with a new 'innovative' model. Any model of employment / for running GP practices has to replicate the above. My worry is that when people have no 'skin in the game', that's when things go wrong - inefficiencies, dumping of work, passing of responsibility etc etc.

GP4

With the constant changes that are occurring in the NHS, please note my immediate comment. With GMS, PMS it APMS contracts I propose there should be provision for the experiences Practice Managers to continue running practices whilst partners are retiring or even after retirement of partners. PMs should be allowed to run a practice and nominate future partners. This would protect the practice and the premises fromclosing down for good and beneficial for the partners after their retirement.

GP5

As a locum GP working in Hackney and Camden, I think the main issues that need addressing are the priorities that newer generations of GPs are having to make:

Often leaving university with heavy debts (especially those coming through in the next few years with high tuition fees); Particular to London (unless you are fortunate to have assistance to buy) often paying extortionate rent and living costs whilst trying to save some kind of feeble deposit; Trying to decide what is the best working environment that gives you flexibility and an income that genuinely reflects years in training and that you are a professional person; Witnessing salaried GPs have no pay rise and coming home late in the evening or doing work remotely as so called 'part time' sessions; Having to deal with too many patient contacts in too little time, the expectation that you will squeeze everything else around this and the guilt if you dare question this method of working; Or the guilt of having to cut sessions because you're so miserable and exhausted after one full day of work.

Partnership just seems to be signing up to a 'carte blanche' with CCGs and NHS England, with high risk personal investment emotionally and financially. I have no wish to run a business with ever reducing funds, taking on extra work and having to manage staff and patients. I'm just about getting on my feet in my late 30's and the thought of jeopardising that with agreeing to signing over my life as a partner is terrifying. I may need to leave London if financially unsustainable and my partner is Italian, so we've been in limbo for nearly two years waiting on Brexit.

Partnerships need to modernise as do the whole of GPs working lives. Needs flexibility, regular sabbaticals and breaks to pursue other interests so can refresh and reboot. Need to stop doing 3-4 hour marathon surgeries and the RCGP needs to back GPs up when they say they can't deal with this many patients. Then maybe more people would work full time knowing the day wasn't going to be a constant pressure, they could actually talk to colleges, have a lunch break and sit and do paperwork properly as well as time for own learning and teaching and team building.

GP6

I'm 45 years old and work as a sessional GP. I work 4 sessions a week. For me, the three important factors in my career are sustainability, financial risk, and leadership. These are all interlinked. Some factors are outside our control as GPs, but some most definitely are not.

As a doctor who has been burnt out in the past, I'm aware of the urgent need to control our workload and work within our limits. Something that I find very frustrating within our profession is a learned helplessness that manifests as resistance to making changes that can help with this. In my experience this is usually because some colleagues are afraid of the consequences of setting boundaries with their patients. I also think that the whole "patient centred" culture which is dominant in the profession and certainly the college, ignores the reality of the fact that the doctor is also a human being, and to neglect the doctor's agenda for the sake of the patients has significant adverse effects upon the doctor.

In terms of financial risk, as a potential partner I'm being asked to buy a business that has significant downsides and very limited upside. A business model that involves entering a market which is shrinking, where demand is not linked to increased financial reward, and where there are significant recruitment and sustainability risks is not an attractive one. Frankly I think that most new GP partners only take on partnerships because they are unaware of these risks, and the possible personal consequences of failure.

However, I do feel that both of these factors could be mitigated if a partnership was to work as an effective team. Unfortunately I see very little evidence of this in practice. Too often in partnerships cordiality is valued over discourse, disagreement and resolution. In my opinion this leads to group think and procrastination when it comes to dealing with the serious issues above. This then manifests as a dogmatic approach and learned helplessness towards the difficult problems that I have outlined above.

To be clear, I don't think that these problems are specific to doctors or GPs, they're shared across all forms of business to a greater or lesser extent. However, I do think that there is something about the elitism of the selection process for the profession that tends to lead to emotional fragility. This in turn leads to resistance to change and irrational fear of adverse consequences.

My solutions are radical. Random selection of medical students and trainees for positions. A rejection of the outdated "professionalism" model and replacement with a whole system approach. A more human centred approach to service design and training. Unfortunately these are not quick fixes and are likely to meet with significant resistance at many levels.

On a more immediate level, I think that there is currently far too much focus on the political and financial situation of the NHS. These are circumstances that are outside of our locus of control. Instead of constantly raging against the dying of the light, as a profession we would be far better served by working out what actions to take in order to best adapt to current circumstances. Some ideas would be increased promotion of the importance of the business component in training and professional development and more availability of training about "human factors" and how they impact on ourselves and our colleagues.

GP7

I was a GP Partner in Doncaster for 30 years during most of this time I was in a PMS Practice in a privately owned leasehold building. I left Doncaster and the Practice in 2017 partly due to difficulties with the lease and the PMS review. I have been working sessionally in London but started as a partner in July 2018.

I'm privileged to be a GP it's a lovely job but over the last 10 years it has become harder to sustain partnerships for various reasons.

1. **Financial**. Profitability has gone down. There needs to be a financial benefit to being a partner over being a salaried GP otherwise the whole model will vanish.

2. **Standards**. CQC, GDPR etc all distract from the main work of a GP.

3. **Demand from patients**. It's insatiable. When I started in General Practice the average number of appointments per patient per year was 2.7 it's now 8! Patient must be educated to self care for minor illnesses, chase their own hospital results and take responsibility for their own lifestyle eg weight, exercise, smoking. The default must be to 'go to your GP' it should be 'sort it out yourself'.

4. **Support**. There is no support for GP Practices when they run into problems there is no-one to help. The LMC can advise. CCGs and NHS England hold Practices to account but don't support. If Hospital trusts run into difficulties they are often bailed out financially or funding is found to improve buildings etc.

5. **Estates**. NHSE/CCGs need to have a national programme where every Practice building is reviewed and either made fit for purpose or new buildings provided. Darzi centres were built at vast cost and leased at horrendous rates but this was a waste of money that could've been ploughed into existing General Practice.

I'm sure there are other problems as well but sustaining the current model is better than creating a new system. Commissioners and patients will regret not doing more to help if the current system of General Practice folds.

GP8

Here are my thoughts about the partnership model. I think it is outdated, there are many salaried GPs very committed to practices and working alongside partners who are not earning much (if any) more who are having to shoulder the huge burden. I have been salaried, then a partner, then back to salaried at my practice.

I left partnership as I found the burden and working hours too great alongside my family life. We are a training practice and many of our training doctors are keen to come back to work with us but often in a locum or short term capacity. Young GPs are understandably not keen to make long term commitments.

I think there needs to be a discussion about a 5 year commitment to the NHS on leaving medical school - although students do leave with debt their training is heavily subsidised by

taxpayers and I don't think there should be the option of disappearing to work abroad permanently or in the private sector.

Perhaps medical students should have better continuity with their GP training so attending only one or two practices throughout medical school - this will require excellent practices being involved in training and better renumeration to allow practices to provide quality teaching - undergraduate teaching is one of the first things to go when practices are under pressure. I think this would encourage doctors to see the value of general practice and the benefits of continuity and being part of a team and might encourage better recruitment after they complete their training.

The partnership discussion also needs to look far wider at the health professional team - why should practices mostly be managed by doctors? Many practices I know have PMs and nurses as partners but what about everyone else we work with?

At our practice we have worked in 'circles' for the last few years which has meant dispensing with a top down approach and allowing all practice members to have greater ownership of their work and able to make decisions about patient care and services. Staff satisfaction is extremely good here. I think the future will be about federations, with all members of staff sharing the responsibilities and the rewards of general practice. I do not think that responsibility for premises should be at practice level but should be held by CCGs or care groups.

GP9

It seems astonishingly limited that only practices, partners and registrars have been involved when it is the huge cohort of both salaried and (probably even more) freelance GPs who are the ones who are not taking up partnerships. Unless they are consulted there will just be guessing going on about why we are not taking up partnerships. The idea this is only about young GPs is wrong. Most of the GPs in my sessional GPs peer support group are mid career or later (we do have a few younger doctors) and these are the ones who "should" be taking up partnerships.

Like so many GPs, I am a mid-career sessional GP who finds myself underutilized and under appreciated (other than by patients) in, effectively, the gig economy. I've been a GMS principal in the past and also a principal in a PCT led practice (in Hounslow), also having been salaried and done many years working freelance direct for practices. I am also an appraiser so I get to hear the points of views of doctors working in various different settings.

I have also been a salaried GP until recently. I left when raising concerns about under-staffing and the fact I was regularly doing 50% over my paid hours to keep patients safe because the partners were simply not doing so (eg there were 1000 "tasks" on system one, mostly clinically important which had not been looked at - including at least 50 of mine to

the senior partner about safety issues. This is not an unusual story - my sessional GP group is full of similar stories and I also hear them from my appraisees.

The biggest problem with the partnership model is that the underclass of sessional GPs is exploited and not properly represented. Partners are stressed and over-worked, I accept, but they are the ones in the position to decide how to re-structure their work.

Those of us that moved to sessional work from partnership expected a drop in income. If you decide to lengthen your appointments in order to be able to fit the work in then you may see a drop in income (but you may not because you will be working much more efficiently instead of just firefighting). A partner can decide to get everyone to sort out badly organised notes, or medication review system, or prescribing, or chronic disease management. Sessional GPs have no such control. In the worst practices sesssional GPs actually get shorter appointments!

I've lost count of the times that patient's ask me why I am the only doctor who 1) listened 2) made a diagnosis 3) noticed they were on the wrong drug 4) didn't fob them off etc etc. Patients get a raw deal from doctors who are only interested in the bottom line - don't get me wrong - I know that they HAVE to be or they won't be able to staff their practice but maybe that is the whole problem?

Partners look at locum rates and wrongly extrapolate this to 8 hours a day working and think it looks great. Back in the real world we all know that a 15 patient morning surgery of patients you have never met before in a struggling disorganised practiced with poorly stocked rooms is not going to take 2.5 hours more like 5 after you've done all the letters, handed over, called the patient back because of local referral guidance etc etc and you certainly are not going to be able to fit 3 of these surgeries in a day. Some practices expect a 6 week check or postnatal check in 10 mins when you have never met the mum, and it involves finding the scales. Some practices will not book doubles for patients who need interpreters or incredibly complex multimorbid patients. Trying to do the impossible 30 times a day is good for no one and the main problem with the current model is that the system of payment does not reflect the time needed for the work.

Lengthening appointments across the board is the number one obvious move to reduce work stress for the whole profession. My feeling is that this won't lead to increased demand but I think it is important to start shedding some of the needless politically driven work like health checks for the well and public health work which doesn't need doctors (but needs to be funded - it is not okay to just let councils decide to stop doing this and thus put the onus back on the NHS).

GP10

Partnerships are struggling to recruit not only because of workload / risks etc but also because over the years the terms and conditions of locuming have become so favourable that it makes no sense to become a partner. The pendulum seems to have swung so far in a direction favouring locum work that regular salaried / partnership work has no advantages.

The outcome of any review if it is going to tackle to the impending crises in general practice is to restore the position of making permanent work more favourable over being long term locum. Even if we could get a 50% shift in people who are qualified as GP but are working as locums it would go some way to help general practice and probably as a quicker pace than waiting for international recruits to be trained or more Dr to qualify from medical school.

I would like the review to consider looking at how to disincentivising locuming and conversely incentivise being a salaried Dr / partner.

Two easy wins which would cost no extra money would be:
1) Remove the ability to pension income earned as a locum. I am not aware of any organisation that allows short term contractors entitlement to company pension schemes.
2) NHS are looking at introducing indemnity for practice employed staff / partners; This should be restricted to those who works as salaried

Others thing to consider:
3) Invest in training initiative that can only be obtained if you are in salaried employment or hold a pms/apms/gms contract
4) Look at making being a partner being both financially rewarding as well as having a quality of life . A bit like how city law and accountancy firms have waiting list for partnership rather than the drought general practice is currently experiencing.

Whilst I recognise that the LMC also needs to represent all GPs - all GP need to be looking at the long term sustainability of general practice. If practices start to fold then over the long term locum will also suffer as care will be provided via alternative models that will not be so GP dependant and also their terms and conditions are unlikely to be so favourable going forward.

In term or concerns new Drs have towards buying-in etc, there are already models in place where people do not have to buy in. However the issue arises as salary pressures often necessitate Drs requiring the need to buy-in as salaried dr expectations of salary make it unprofitable to be a partner in view of the risks partners take. It is in these situation that difficulties might arise. Options to consider would be for NHSE to underwrite risks for practices so that practice can take on salaried dr without burdening the obligations to buy in . This is all dependant on NHSE risk appetite versus their desire to provide a sustainable General Practice .

I do think we need to be looking at doing a reset of mindset re expectation of work as a doctor /work life balance etc - I do not recollect anyone ever saying being a doctor was an easy life.

GP11

As a new (less than 1 year) partner, some key issues for me have been:

Sense of significant vulnerability to my family finances if something were to happen to the partnership or there were resignations in quick succession leaving me as an almost last doctor standing. This has led me to question whether I should continue to take the risk longer term. Security of individual finances in that situation (i.e. not being liable for all staff or support thus) is a major factor in deciding not to become a partner for many - if the model is to continue we need new partners and confidence that one's life savings might not be at stake!

I suppose the overwhelming sense is that we have to achieve more loopholes/ goals with less and less time and money so I agree that funded protected partnership admin time would be much welcome - at present it is increasingly done in our own time for those that have it and not by those partners who may have other jobs/ commitments and so balance of work can be an issue.

Drop in income with new contracts is hardly an incentive to become a partner - despite lip service to greater funding our income is going DOWN!!

Frankly the stress and the worry don't really justify the additional profit - as salaried doctors incomes increase and they have their indemnity paid, there is little incentive to take on the additional worry/ burden.

I still think clinical leadership and investment in one's patients/ locality make the model work best for patients, probably.

ANNEX B – LONDON ROUNDTABLE DISCUSSION SUMMARY (30/7/18)

Issues in a nutshell:

- Lack of **flexibility.**
- Risk is now seen as greater than **reward**.
- **Uncertainty** about the future.
- Lack of **resource**.
- Demand is not matched by capacity – **Workload**
- Capacity – **Workforce**
- For **younger GPs** – Lack of career structure and career progression.
- For **older GPs** – fed up with red tape, regulation etc – taking pension early.
- Those in between – **Last person standing.**
- **Locum** more attractive than **salaried GP** more attractive than **Partner**.

What are the main areas of development for the GP Partnership review:

Leadership:

- The concept is good in theory but needs to be developed. Be it at network level or executive level.
- A lesser reliance on GPs is needed. There's a difference between leadership and partnership.
- Holacracy is the answer – eg: the opposite of a pyramid scheme. Instead everyone is responsible for everything, based on local decision making instead of a hierarchy.
- Establishing a clear journey, to a clear destination would make the partnership model more attractive. At the moment there is still a lot of uncertainty in the air.
- We need to work out what the public need and work backwards from that. The public like the traditional model but want to develop it that it helps support GPs.

Joy:

- It's important that we establish what brings joy to patients, then work backwards.
- Having incentives has proved to be a beneficial aid to many developing projects. The GP Partnership Review knows that GPs would like to receive a small reward for joining a partnership.

Young GPs: How to entice them?

- A John Lewis type partnership is admirable.
- Recruitment schemes are the key thing that needs to be harnessed.
- Young GP speciality schemes needs to be established to entice them to join the partnership and stay on board for years.

Demand:

- Managing demand is important i.e. establishing the necessity of treating certain patient ailments.
- The work that's being required needs to garnish or reflect what the patient needs.