

Institute for Public Policy Research



# **REALISING THE NEIGHBOURHOOD NHS**

**DELIVERING A NEW DEAL FOR  
PRIMARY CARE IN ENGLAND**

**Chris Thomas and  
Harry Quilter-Pinner**

February 2020

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# CONTENTS

<b>Summary</b> .....	<b>3</b>
<b>1. Introducing the ‘neighbourhood NHS’</b> .....	<b>5</b>
A new model of primary care.....	11
<b>2. Delivering the ‘neighbourhood NHS’</b> .....	<b>15</b>
Progress to date .....	16
<b>3. A ‘new deal’ for general practice</b> .....	<b>22</b>
1. Create neighbourhood care providers (NCPs) to deliver the ‘neighbourhood NHS’.....	22
2. Offer all general practitioners the right to NHS employment.....	25
3. Reform new GP roles to create career progression, time to care and realistic workloads.....	28
4. A radical transformation of the primary care infrastructure .....	34
<b>References</b> .....	<b>36</b>

## ABOUT THIS PAPER

This paper fulfils IPPR's objective to advance physical health, by providing new evidence and ideas to improve the provision of primary and community care.

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# SUMMARY

**General practice is the ‘jewel in the crown’ of the NHS.** For most of us the GP is our first point of contact when we are unwell, the gatekeeper to treatment we might need and the only healthcare professional we build an ongoing relationship with over our lifetime ‘from cradle to grave’. A strong primary care sector – including teams of nurses, pharmacists, mental health specialists and allied professionals – has been shown to deliver better health outcomes, a decrease in utilisation of hospitals and emergency departments (Macinko 2003) as well as slower growth in health care spending (Kringos et al 2013).

**But, in England, general practice also needs fundamental change.** This is evidenced by four main factors.

- **Quality:** Quality in primary care remains stable with 95 per cent rated good or outstanding by CQC and high ratings in the GP Patient Survey. But these overarching quality metrics hide significant variation in the quality of care for specific conditions (for example diabetes and cancer diagnosis) that need to be addressed.
- **Access:** Access in primary care is poor. New polling conducted for IPPR shows that 36 per cent of people in England waited more than a week for an appointment, and 3 per cent were not able to book an appointment at all, the last time they needed one. Furthermore, access is even slower if you have been diagnosed with a long-term condition.
- **Demographics:** The country’s population is growing, ageing, and living with more complicated health needs. Notably, people are growing older but are living more of their life in ill-health. Their illnesses are increasingly chronic rather than acute, including diabetes, mental illness, frailty and dementia. This shift in the disease burden demands a fundamentally different model of care.
- **Workforce:** The workload of GPs has been increasing as a result of increased bureaucracy, growing patient complexity and increases in medical knowledge. Across the sector there is evidence of increased stress, burnout and mental ill-health in the profession. This is leading to a GP shortage and a workforce crisis.

**There is a growing consensus that a shift towards primary care at scale - what we call the ‘neighbourhood NHS’ - is the solution to these problems.** Most primary care is still delivered by GPs in small independent practices. While this has some advantages, it also limits the scope of care general practice is able to provide. The alternative is primary care at scale (between 50,000 and 100,000 people). Under this model, as a result of economies of scale, it is cost effective to invest in longer opening hours, diagnostics and treatment in the community, and a wider team of healthcare professionals to support the GP in delivering integrated care. There is growing evidence this delivers higher quality care as well as improving access and relieving workforce pressures on the GP.

**Recent government reform initiatives have made some progress in delivering on this vision.** The NHS *Five Year Forward View* set out a vision for greater collaboration between general practices, as well as with community health services, hospitals and social care. This has been further developed in the NHS *Long-Term Plan* which announced the intention to formalise these new arrangements in the form of primary care networks (PCNs) (NHS England 2019). These are new groupings of local general practices that are a mechanism for sharing staff and collaborating while maintaining the independence of individual practices. There are now 1,300 PCNs in England with more than 99 per cent of local GP practices signed up to the initiative. On the face of it this would appear to be an impressive record.

**But the evidence suggests that there is much further to go.** While partnerships between practices might be common, they are not particularly deep. A recent study found that the proportion of general practices “working closely at scale for the purposes of core general practice, with shared strategy and risk” to be less than 5 per cent (Forbes et al 2019). This means many people (around 50 per cent (ibid)) are served by primary care services that have not fully developed the scale of their organisation and service delivery, with many more lagging even further behind. This is concerning. There is evidence that single organisations – or tighter partnerships – may be preferable to networks for the delivery of coordinated care (Sheaff et al 2015). This suggests PCNs need to quickly move beyond loose networks or federations towards single integrated organisations.

**The biggest barrier to delivering the ‘neighbourhood NHS’ in England is the partnership model and the GMS contract.** GPs are primarily funded through core national contracts called the GMS for delivery of essential services (see figure 2.6). GMS funding is made up of the global sum (capitated payments) based on the age and gender of patients and other factors. Partners fund their costs through this and keep any excess as profits. These contracts therefore create what we call the ‘inverse pay law’: those GPs that are the most efficient and deliver the most basic care keep the most profit. This limits the incentive for GPs to innovate and expand provision. Recent initiatives to overcome these incentives, such as PCNs which provide additional funding to federations, are a step in the right direction but ultimately protect a failing model.

**We need a ‘new deal’ for general practice to overcome these challenges.** We argue this should be made up of four main components across England.

- **Create neighbourhood care providers (NCPs) to deliver the ‘neighbourhood NHS’.** A ‘new deal’ for general practice would recognise that the best way to work together as a team is to work together *in* a single team. We recommend that PCNs should move away from loose federations and instead practices should come together in new integrated trusts to provide primary, community and mental health care in a local area. They should also deliver relevant social care and public health services, in order to really fulfil the possibility of population health.
- **Offer all GPs the right to NHS employment.** Senior general practitioners (both partners and salaried employees) should be recruited into management roles within the new NCPs (on similar salary levels to a current GP partner) alongside other non-clinical senior managers. All newly qualified GPs should also be offered a salaried role within the NHS. This builds on the existing trends away from the partnership model and is popular with the public: our polling shows that four times as many people support GPs being employed by the NHS than as partners.
- **Reform new GP roles to create career progression, time to care and realistic workload.** Workload should be reduced by moving away from a nine-session week towards seven clinical sessions per week for full time staff. The time freed up by this should be used for career development, respite and developing other specialisms such as management, academia or specific types of care (including end of life care and mental health). Finally, GPs should be given time to care by moving to 15-minute sessions for people with long-term conditions. More action will be needed to promote automation, team based primary care and patient self-management in order to reduce demand for new GPs as a result of these changes.
- **A radical transformation of the primary care infrastructure.** The primary care estate is often privately owned by GPs and unfit for purpose as a result of underinvestment. This is a barrier to delivering the ‘neighbourhood NHS’. The government should commit to funding and building 1,300 new primary care hubs (one per PCN) and invest in new technology. This should be funded by state borrowing – and would be cheaper than existing funding mechanisms such as PFI.

# 1. INTRODUCING THE 'NEIGHBOURHOOD NHS'

## THE CASE FOR CHANGE

General practice (GP) is often considered the 'jewel in the crown' of the NHS, bridging the gap between self-care and hospital specialist care. It fulfils a range of vital functions including prevention and screening, assessment of symptoms, diagnosis, triage and onward referral, care co-ordination, treatment of episodic illness and provision of palliative care. For most of us, the GP is our first point of contact when we are unwell; the gatekeeper to the treatment we need and the only healthcare professional we build an ongoing relationship with over our lifetime 'from cradle to grave'.

GPs are part of a wider part of our healthcare system known as primary care. These community-based teams might also include other healthcare professionals such as nurses, pharmacists and mental health professionals. Effective primary care has been shown to deliver better health outcomes, a decrease in utilisation of hospitals and emergency departments (Macinko 2003) as well as slower growth in health care spending (Kringos et al 2013). However, there is growing evidence that primary care in England needs fundamental change.

Four factors are worth investigating in depth: quality; access; workforce; and demographics.

### Quality

Quality in primary care remains stable. In 2019, 95 per cent of GP practices were considered good or outstanding, with only 1 per cent rated inadequate according to the Care Quality Commission (CQC 2019). Meanwhile, the 'Quality and Outcomes Framework' (QOF) provides a composite measure of quality in primary care. Previous IPPR research has shown that primary care improved quality 2.7 percentage points on this measure between 2010/11 and 2016/17 (Darzi et al 2018a). Since then, the average practice achievement score has risen further - from 539.2 to 559 - signifying continued quality improvements (NHS Digital 2019b).

Patients report highly positive experiences of primary care. In the GP Patient Survey (GPPS), service users are asked to report their experience of general practice (NHS England and Ipsos Mori 2019). In 2019, 84 per cent reported a good experience, a small increase on 2018 (83 per cent). However, there are undoubtedly still improvements to be made. Compared to other countries the NHS underperforms in terms of cancer survival rates, partly as a result of a failure to diagnose cancers early. Whilst, for other patients treated by the primary care system, such as those with diabetes or mental ill-health, quality may be similar or better than other countries but still requires improvement (Darzi et al 2018a).

These national scores can, however, mask avoidable variation in care quality. For example, diabetes care is delivered almost exclusively in primary care, making it a strong indicator of quality. Yet, evidence of avoidable variation in diabetes care and treatment has been regularly reported. Best practise treatment for diabetes includes nine key elements according to NICE guidance. In the best performing areas of the country, just 47.9 per cent of people get all nine of these things, while

in the worst performing areas it's just 5.4 per cent (Rightcare et al 2012). Similar variation can be seen in cancer screening statistics. A large study (669,220 patients) of 'fast-track' or 'two-week wait' GP referrals for suspected cancer showed variation by both tumour site and patient socio-demographic factors (Zhou et al 2018). This demonstrates that whilst quality metrics largely paint a positive picture, there is still much work to be done.

### Access

Primary care is struggling to provide adequate levels of service access. New polling commissioned by IPPR shows that 36 per cent of people in England waited longer than a week for an appointment, the last time they needed one. Waiting times were longer for women and shorter for people in the highest social grades. Furthermore, 3 per cent of people were not able to book an appointment at all. Extrapolated out, this indicates an estimated 1.7 million people in England are unable to book a GP appointment when they need one.<sup>1</sup>

The GP Patient Survey (GPSS) – the NHS' own large-scale polling of patients using GP services – highlights problems with access that line up with IPPR's polling. For example, the most recent data showed:

- just under two-thirds of patients were satisfied with appointment times available to them
- just under half (48 per cent) of patients were able to see their preferred GP most of the time (NHS England and Ipsos Mori 2019).

Though a redevelopment of the GPSS prevents comparison of exact results between before 2017 and after 2018, this does seem to show a trend continuing from earlier years.

**TABLE 1.1: GP APPOINTMENTS ARE BECOMING LESS CONVENIENT FOR PEOPLE**

**Responses (%) to the question: "How convenient was the appointment you were able to get?"**

Year	Entirely or fairly convenient	Not very convenient	Unable to get any appointment
2017	81	7	12
2016	82	7	11
2015	82	7	11
2014	82	7	11
2013	83	7	11
2012	85	6	9

Source: Authors' analysis of NHS England and Ipsos Mori 2019

<sup>1</sup> 59,607,191 registered primary care patients in England as of January 2019 (NHS Digital 2019a).



**TABLE 1.2: PEOPLE ARE SEEING THEIR PREFERRED GP LESS OFTEN**

Responses (%) to the question: "How often do you see the GP you prefer?"

Year	Mostly	Not Mostly
2017	56	44
2016	58	41
2015	60	40
2014	60	39
2013	63	37
2012	65	34

Source: Authors' analysis of NHS England and Ipsos Mori 2019

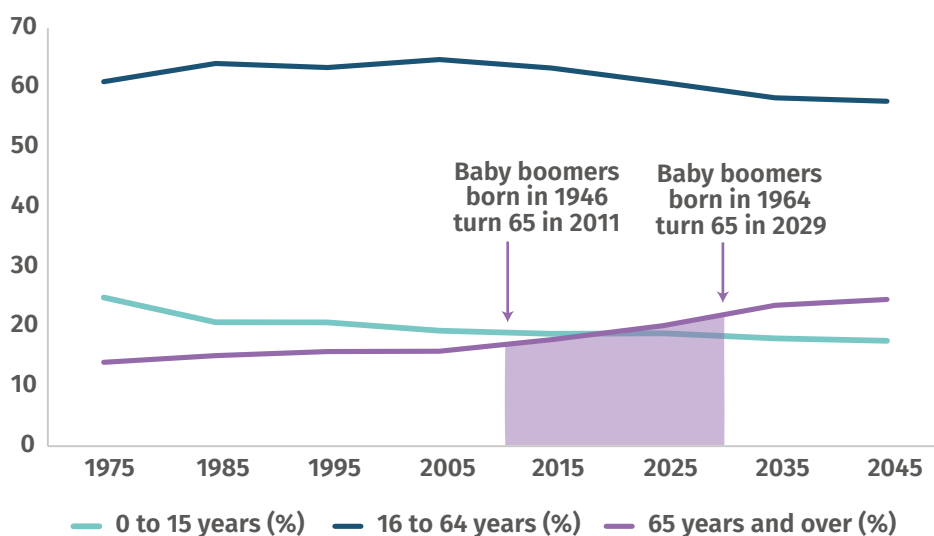
Furthermore, access to a GP is actually slower for those with a pre-existing diagnosis. Of all those living with a long-term condition (n = 1,018), 43 per cent faced a waiting time of more than a week. This was consistent across those with physical and mental health conditions and represents an average wait time that is statistically significantly higher than the English and UK average.

**Changing demographics**

The UK has an ageing, more complex and growing population. This is set to continue in the decades to come. By 2030 the UK will become the largest – and most diverse – country in Europe (Darzi et al 2018a). The number of people over 65 will increase by 33 per cent – compared to a mere 2 per cent increase in the number of working age adults – while the number of over 85s will nearly double over the same time period (ibid) (figure 1.1). This is a sign of success which should be celebrated, but it is also a significant challenge for the NHS.

**FIGURE 1.1: AN AGEING POPULATION WILL DRIVE A RISING TIDE OF CHRONIC ILLNESS**

Increase in the share of people over the age of 65, UK, 1975–2045

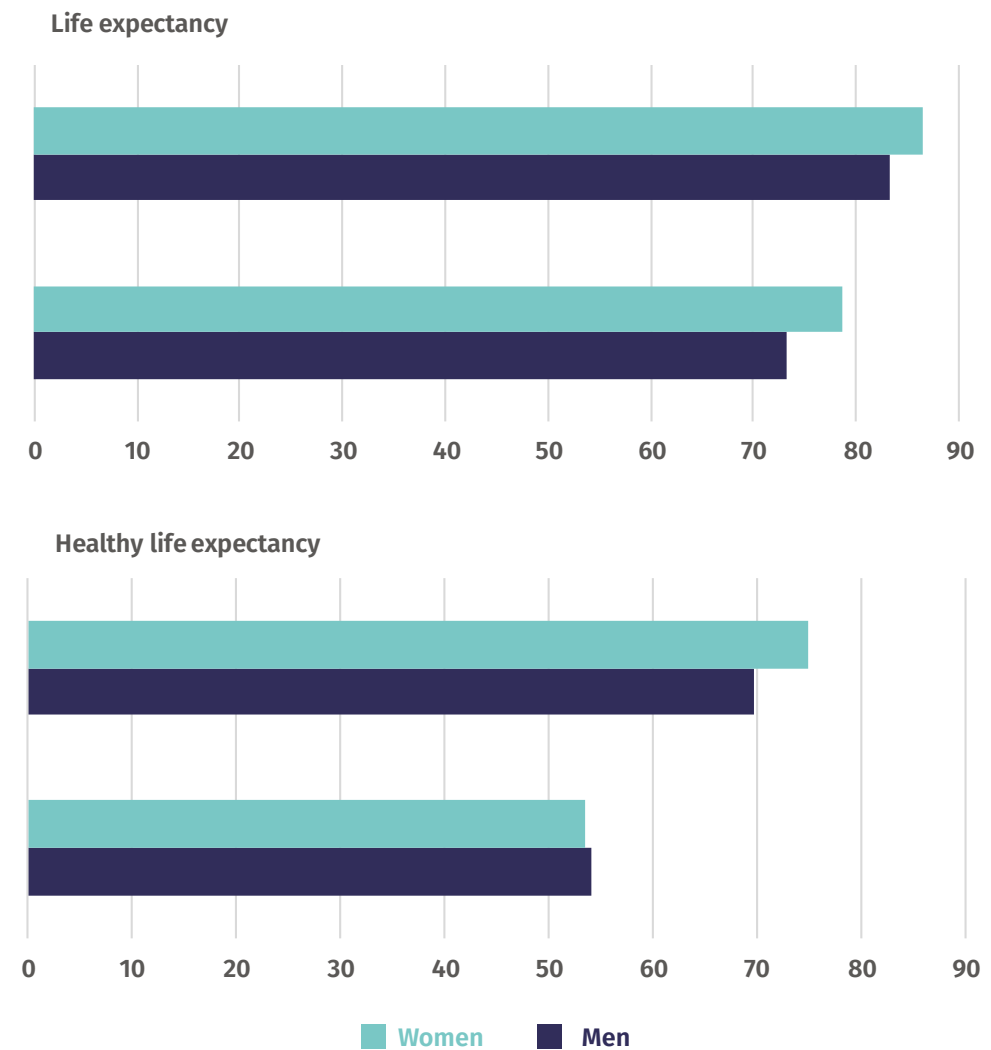


Source: Reproduced from Darzi et al 2018a

Notably, people are growing older but are living more of their life in ill health (see figure 1.2). Their illnesses are increasingly chronic rather than acute, including diabetes, mental illness, frailty and dementia. This shift in the disease burden demands a fundamentally different model of care to that which we have had in the past (ibid). Prevention of illness through driving healthy behaviours becomes vital, as does helping people to manage their conditions themselves in the community. Effective primary and community care can help make this vision a reality, but it is often not set up in the best way to succeed.

**FIGURE 1.2: THERE IS A SIGNIFICANT GAP BETWEEN LIFE EXPECTANCY AND HEALTHY-LIFE EXPECTANCY IN THE UK**

Comparison of UK life expectancy and healthy life expectancy in local authorities (2015–17)



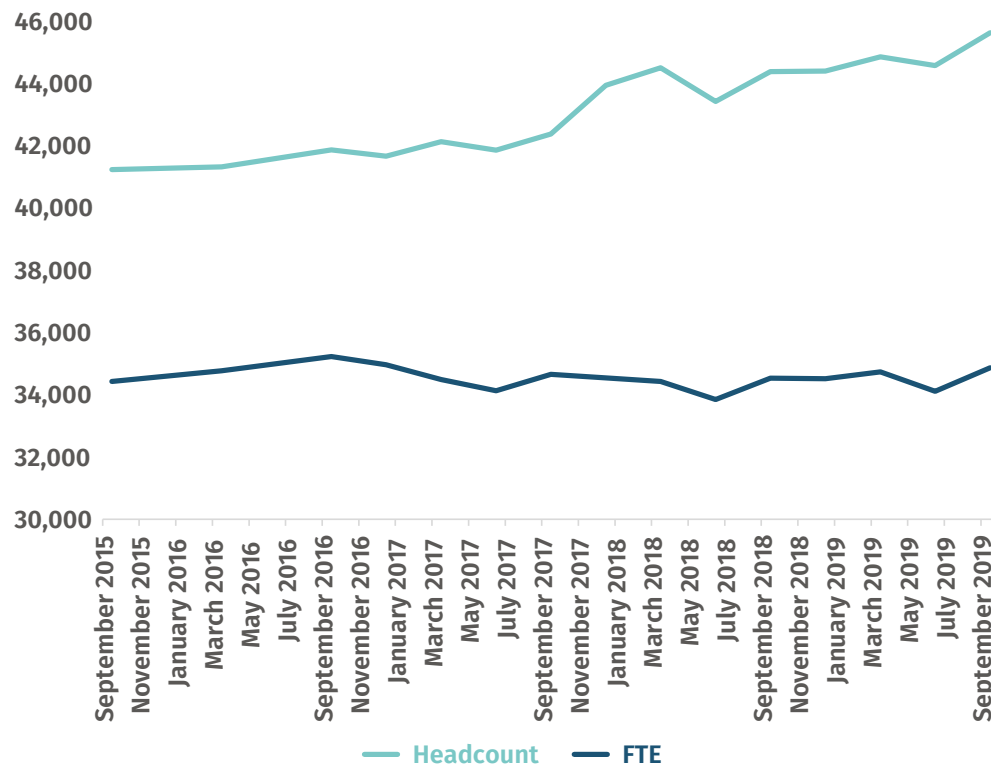
Source: ONS 2018

### Underlying workforce pressures

Underpinning these trends in quality, access and demographic change is a workforce crisis. The most recent NHS figures show that, despite a government commitment to raise FTE GP numbers, staff numbers have remained static. As Nuffield Trust have recently shown, this means the number of GPs per 100,000 people is now at its lowest since 2003 (Palmer 2019).

**FIGURE 1.3: GP NUMBERS HAVE STAGNATED**

GP numbers as headcount and FTE, September 2015–September 2019 (all GPs)



Source: Authors' analysis of NHS Digital 2019d

This stagnation in GP numbers is driven by a drop in the average 'FTE' (full-time equivalent) work each GP is doing. The average GP has dropped their hours from 0.84 FTE to 0.76 FTE – though this is likely as much an indicator of the unfeasible increase in the amount work represented by each GP 'session', both clinical and non-clinical, which is making full-time work unsustainable for many

This is the equivalent of losing over 3,000 full-time staff (around 7 per cent of the workforce). The move to part-time work (or to lower levels of clinical work) is likely to represent an attempt by GPs to control their workload and work-life balance (GMC 2019). This is likely driven, at least in part, by the increase in workload, stress and pressure on an individual GP.

**TABLE 1.4: THERE HAS BEEN A SUBSTANTIAL DROP IN THE AVERAGE FTE A GP DOES**  
**Average FTE of a single GP 2015–2019 (all GPs)**

Date	Average FTE of a single GP
September 2015	0.84
March 2016	0.84
September 2016	0.84
December 2016	0.84
March 2017	0.82
June 2017	0.82
September 2017	0.82
December 2017	0.79
March 2018	0.77
June 2018	0.78
September 2018	0.78
December 2018	0.78
March 2019	0.77
June 2019	0.77
September 2019	0.76

Source: Author’s analysis of NHS Digital 2019d

Simultaneously the workload of general practitioners is rising, driven by three key trends.

- **Increased bureaucracy.** Since the NHS’ formation, GP work has always required balancing the management of patients with the management of a business (their practice). However, the demands these place on the time of the GP workforce is increasing. A survey by the NHS Alliance and Primary Care Foundation found that the key causes of administrative burden were getting paid, processing information with hospitals, keeping up to date with changes, reporting demands and helping patients navigate the NHS (Primary Care Foundation and NHS Alliance 2015). IPPR’s qualitative work indicated this was a pressing concern for GPs working across the country (see box 3.3).
- **Growing complexity.** An ageing population brings with it added complexity. The most obvious is the rise of multiple conditions – with one in four adults in the UK now living with more than one condition (Stafford 2018). These patients are likely to have more symptoms and to require more time than a GP can deliver in a system that broadly limits consultations to 10 minutes. But it is not just about ageing. Many people are now facing more complex health needs, increasing the case mix of general practice. Rises in common mental health disorders amongst are a case in point, with young people experiencing more common mental health disorders (EPI 2018) and older people facing systematic under-treatment for conditions like depression (Mental Health Foundation 2016).
- **Growing knowledge.** Medical knowledge has increased substantially over seven decades. This has allowed us to split the human into smaller and smaller units of measurement. In the acute sector, this has meant more specialisations, to account for the knowledge needed. Yet, no such quarter can be given to general practitioners in keeping up with advances and innovations. The need to keep up with medical knowledge provides a workload burden to general practitioners, even as it enables them to provide better or more efficient care to their patients.

## A NEW MODEL OF PRIMARY CARE

These trends, combined with changing expectations amongst patients, demand a shift in the way we do primary care in this country. Patients increasingly demand that care is preventative, joined up, accessible and personal (see box 1.1). Furthermore, having grown up in the age of the internet, artificial intelligence and big data they will not stand for an analogue health and care service. Already, the way in which people interact with their businesses, entertainment, work and friends has changed beyond all recognition. They will expect this transformation to change their health care as well.

### BOX 1.1: WHAT DO PATIENTS WANT FROM PRIMARY CARE?

In IPPR's Lord Darzi Review of Health and Care (Darzi et al 2018b), we set out four principles for health and care reform for the future based on what we know patients are looking for from the NHS. These must also underpin future primary care reform.

#### Care must become more preventative

This means intervening earlier to prevent ill health rather than waiting for people to get ill. It will require a shift from a paternalistic model of care where doctors are experts and patients are recipients to one where both work together to co-produce care plans that are led by the patient in the community. NHS and social care staff will need to 'make every contact count' in shaping people's behaviours and utilise all the best practice preventative interventions available to them, including new science and technology, as well as peer support groups and social prescribing.

#### Care must become more joined up

This means treating the whole person rather than individual medical symptoms. Support for physical, mental and social health must be fully joined up, and the divide between people's health and social care must also be closed. Services will need to be provided in the community where possible. People will still want a single point of contact, but this must be complemented with support from a wide range of professionals – including community nurses, social workers, community-based mental health teams as well as wider public services and the voluntary sector – with technology used to communicate and work together to meet the care needs of each individual.

#### Care must become more accessible

This means delivering care at the right time and in the right place. This is partly about reversing the increases in waiting times seen in the last decade. But it's also about changing where and how care is delivered. People with low intensity (one-off) needs will increasingly receive care remotely using new technologies (telehealth or telecare) or in person, using easy access hubs which open out of hours to suit the needs of the patient.

#### Care must become more personal

This means tailoring care to needs of the individual. It's about giving patients choice over what care they receive and where they receive it. It requires health and care staff to work with each patient – treating them as an individual – to co-produce a care plan which speaks to their needs and wants. It means ensuring the health and care service is professional but also relational. New developments such as genomic sequencing will also be a huge step towards personalisation. A universal service should be there for everyone, but not the same for everyone.

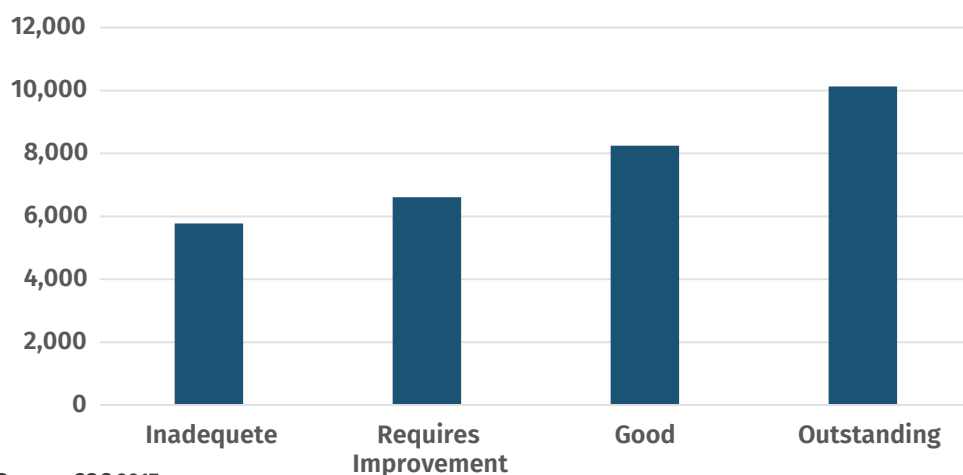
Given this, our current model is no longer fit for purpose: it is not set up to react to these shifts and meet the expectations of the next generation. The majority of primary care is still delivered by small independent practices of GPs (with some nursing and admin support) in a ‘cottage industry’ model (usually a small group of GP partners with nurses and some admin support in a privately-owned practice). This is a legacy of the creation of the NHS which saw general practitioners remain as independent contractors (small partnership businesses) rather than face nationalisation like many hospitals did.

Historically this model has been a core strength of the NHS. Small practices have allowed GPs to build strong relationships with patients and the local community, delivering much valued continuity of care. Furthermore, their independent status has allowed GPs to manage their own work environment and innovate with patient care without having to tackle the NHS bureaucracy. These benefits are not to be underestimated, but the evidence is clear that this model of primary care is increasingly unfit for purpose.

Small scale independent general practice limits the type of care the primary care system is able to offer. This system is often unable to offer quick and seamless access to the wider primary care team (eg mental health support, pharmacy etc). It largely confines care to inflexible and short appointment slots, only available from Monday to Friday within normal working hours. And, it limits the ability of primary care to invest in the modern buildings and new technologies needed to offer telephone, email, skype based care or diagnostics/treatment in the community.

**FIGURE 1.4: BIGGER IS BETTER IN PRIMARY CARE**

Average list size and CQC quality ratings



Source: CQC 2017

Instead, we will need to shift to primary care at scale. Only across larger populations of patients - as a result of economies of scale - is it cost effective to invest in longer opening hours; diagnostics and treatment in the community, and a wider team of healthcare professionals to deliver integrated care (Rosen 2016). This is supported by growing evidence base behind primary care at scale. For example, the CQC points to a clear correlation between size and CQC ratings (see figure 1.4) (CQC 2017), while others have found links with hospital admissions as well (IFS 2014). It is also easier for crucial community partnerships to form between larger organisations – like work between Voluntary and Community Sector (VCS) organisations and primary care, partnerships between social care and general practice, and partnerships between secondary and primary care.

**FIGURE 1.5: A UNIVERSAL HEALTHCARE SYSTEM SHOULD BE THERE FOR EVERYONE BUT NOT THE SAME FOR EVERYONE**

**Patient segmentation model designed and used in north-west London**

Age	'Mostly' healthy (rest of the population)	One or more physical or mental long term conditions	Cancer	Serious and enduring mental illness	Learning disability	Severe physical disability	Advanced dementia, Alzheimer's, etc	Socially excluded groups
0-12	1. 'Mostly' healthy children	5. Children and young people with one or more LTCs or cancer		9. Children with intensive continuing care needs			N/A	15. Homeless individuals and/or families (including children, young people, adults and older people), often with alcohol and drug dependencies
13-17	2. 'Mostly' healthy young people			10. Young people with intensive continuing care needs				
18-64	3. 'Mostly' healthy adults	6. Adults with one or more long term conditions	8. Adults and older people with cancer	11. Adults and older people with SEMI	12. Adults and older people with learning disabilities	13. Adults and older people with physical disabilities	14. Adults and older people with advanced dementia and Alzheimer's	
65+	4. 'Mostly' healthy older people	7. Older people with one or more long term conditions						

Source: North West London Integrated Care 2015

There is a growing consensus about the key characteristics of the 'neighbourhood NHS'. Firstly, as set out above, it is underpinned by a recognition that to deliver more preventative, joined up, accessible and personal care, primary care institutions should be overseeing a larger patient population. Experts have argued that new 'neighbourhood NHS' organisations should be set up around real places – neighbourhoods – to serve between 50,000 and 100,000 people each (Addicot and Ham 2014). Currently the average 'list size' for general practice is around 9,000.

Secondly, these new organisations should take a whole-person population health approach. This means segmenting the population into groups with broadly similar needs (eg those with long-term conditions) and then bringing together all parts of the health and care system around them to deliver joined up and preventative care. The groupings that we propose are based on the work by the 'Whole Systems Integrated Care' programme in north-west London for adults (see figure 1.5) (North West London Integrated Care 2015).

And, thirdly, we argue that while the GP may remain the focal point of primary care, these new 'neighbourhood NHS' systems should be team based. Each organisation should bring together a wide array of professionals and approaches including mental health, community health, pharmacy, social care and public health, as well as elements of acute care (eg diagnostics and minor surgery). This will help to relieve pressure on the GP, reduce demand on the acute sector and offer more joined up and accessible care to the patient. This should involve close work with the wider community – including schools, local government, the third sector and public health specialists – to ensure holistic, joined-up care.

The UK government has started to drive forward this vision (see next chapter). But this transformation is incomplete. Pressing forward with the delivery of the ‘neighbourhood NHS’ is crucial to securing the vision of the NHS Long-Term Plan and, ultimately, the future of the NHS (NHS England 2019). In this context, this paper sets out new evidence (see box 1.2 for methodology) that helps us to understand the progress made in driving this vision forward, the barriers to further progress and the policy levers available in looking to overcome them.

### BOX 1.2: METHODOLOGY

This research presents the results of qualitative and both primary and secondary quantitative analysis on the state of primary care in England. Qualitatively, IPPR carried out 15 semi-structured interviews with young GPs relatively near the start of their career (trainees, through to those with approximately 10-years’ experience). The GPs had a range of roles, and interviews were held with GPs across the whole of the country, and with GPs working in registrar, locum, salaried and partner roles.

The reason for focusing on early-career GPs was twofold. Firstly, they are underrepresented in primary care research – which disproportionately focuses on older GPs, who are more likely to be partners. Second, because younger GPs are best placed to provide insight on stagnation in recruitment in general practice, and on what GPs look for when entering the career or applying for new roles.

IPPR also ran polls to ensure a diverse range of views on the future of general practice in England could be established. Separate polls gauged the views of:

- **the general public:** Savanta ComRes were commissioned to poll 4,042 adults living in England, Wales and Scotland. A sub-section of 1018 people taking the poll indicated they were living with a longstanding health condition, allowing comparison of the GP experience of those living with and without a long-term diagnosis. All participants were over the age of 18 and the survey was weighted to be representative of Great Britain's population.
- **early-career GPs,** through the first-5 and Next Gen GP networks (n = 33). This survey covered perceptions around workload, around general practice provider models, and around patient access and care quality.
- **senior community health professionals** (n = 10) were consulted through the joint NHS-Confederation and NHS-Providers ‘community network’, on their experiences of working with general practitioners and on the future of integrated care.

This was complimented by secondary analysis of key NHS datasets, namely:

- NHS Digital’s General Practice Workforce collection
- the General Practice Patient Survey
- NHS Digital’s GP Earnings and Expenses Estimates collection.

This combines to provide a comprehensive snapshot of the state of general practice and primary care moving into the new decade. Insight presented in this report is focused on England only, and there may be other priorities for reform across the devolved nations.



## 2. DELIVERING THE 'NEIGHBOURHOOD NHS'

### THE REFORM AGENDA

The challenge for primary care is the journey rather than the ultimate destination. The vision of primary care at scale - the 'neighbourhood NHS' - is not controversial. It has been widely embraced by NHS England and the primary care sector (including the Royal College of GPs) in recent years. This began with the *Five Year Forward View* in 2014 and then the *General Practice Forward View* in 2016 which set out a vision for greater collaboration between general practices, as well as with community health services, hospitals and social care. These documents announced an intention to 'encourage' practices to work together in hubs or networks and began setting out a framework to do this.

This has been developed further following the publication of the *NHS Long-Term Plan* in 2018 which announced the intention to formalise these new arrangements in the form of Primary Care Networks (PCNs). These are new groupings of local general practices that are a mechanism for sharing staff and collaborating while maintaining the independence of individual practices. Each network should cover between 30,000 and 50,000 patients, with around 1,300 PCNs nationally (covering every area). PCNs are not new legal bodies but allow a mechanism for funding to be channelled to groups of practices to deliver shared services at scale.

These new contracts will allow groups of practices to deliver additional services (see table 2.1), as well as extend opening hours. This will be enabled by new funding that will be provided at PCN level to employ additional staff such as clinical pharmacists, social prescribers, physician associates, physiotherapists and community paramedics. Indeed, NHS England has calculated that by 2023/24 a typical network covering 50,000 people will receive up to £1.47 million via the network contract. This is a significant step forward: it formalises partnership working in all areas of the country and ties significant income to participation in this collaboration.

**TABLE 2.1: PCNS WILL DRIVE COLLABORATION ON SEVEN KEY AREAS****PCN service specifications**

Service specification	Introduced from	Examples
Structured Medicines Review and Optimisation	2020/21	Directly tackling over-medication, including inappropriate use of antibiotics Focus on priority groups including the frail elderly
Enhanced Health in Care Homes	2020/21	PCN members expected to support the implementation of vanguard models tested between 2014/15 and 2017/18
Anticipatory Care	2020/21	Practices in PCNs to collaborate to offer more care, and more proactive care to patients at high risk of poor health outcomes
Personalised Care	2020/21	Implementing aspects of the Comprehensive Model of Personalised Care
Supporting Early Cancer Diagnosis	2020/21	Ensuring high and prompt uptake of cancer screening invites
Cardiovascular Disease Prevention and Diagnosis	2021/22	The Testbed Programme will test the most promising approaches to detecting undiagnosed patients, with subsequent roll-out across PCNs
Tackling Neighbourhood Inequalities	2021/22	Approaches will be developed through the Testbed Programme and tailored to meet the specific context of PCN neighbourhoods

Source: Reproduced from Fischer et al 2019

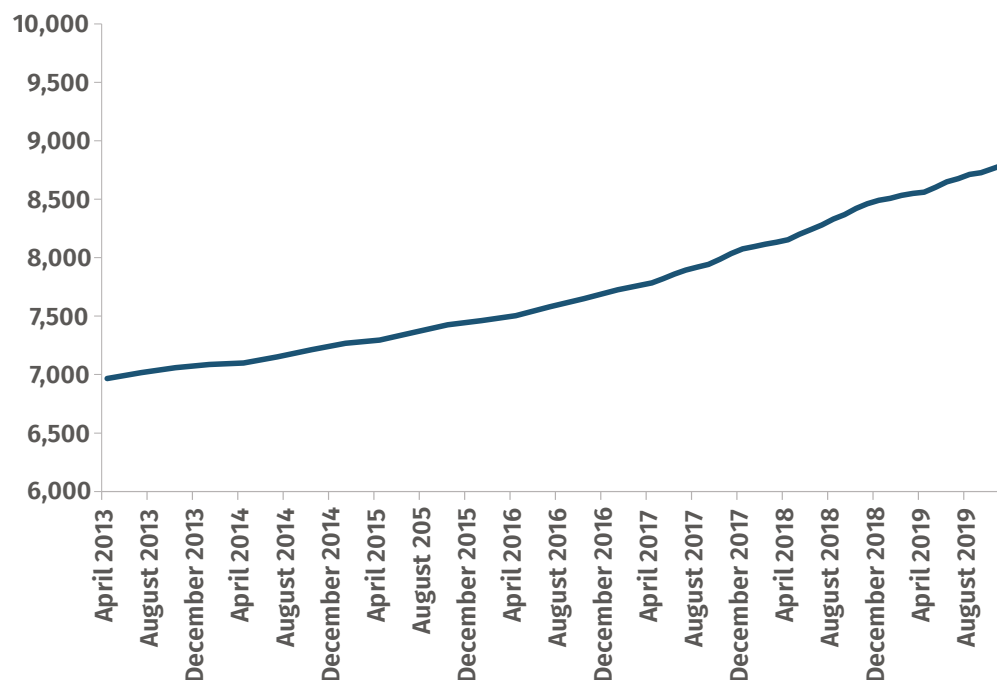
**PROGRESS TO DATE**

These initiatives have begun to deliver change in primary care. The average general practice list size in England has increased from below 7,000 in 2013 to nearly 9,000 in 2019 (see figure 2.1). Furthermore, surveys suggest that the majority of GP practices are collaborating in some form: a survey by the Nuffield Trust found that in 2017 81 percent of practices were part of a formal or informal partnership (Nuffield Trust 2017). Since then NHS England claims that over 99 per cent of practices have signed up to become part of a PCN. On the face of it this would appear to be an impressive record.

However, a deeper investigation reveals that this is an overly flattering assessment of progress. Notably, there is significant evidence that while partnerships between practices might be common, they are not particularly deep. For example, whilst a recent survey by the Nuffield Trust found that over four-fifths of GPs were working with other GPs, they also found that over half were not formalised, one-fifth had hired no non-clinical staff and the majority were loose ‘networks’ or ‘federations’ of independent practices rather than more integrated ‘super-partnerships’ or single integrated organisations (see table 2.2).

**FIGURE 2.1: GP LIST SIZES HAVE INCREASED CONSISTENTLY OVER THE LAST SIX YEARS, AND CONTINUE TO RISE**

Average list size for a GP practice, April 2013–November 2019



Source: Authors' analysis of NHS Digital 2019c

**TABLE 2.2: MOST GP PRACTICES ARE PART OF LOOSE NETWORKS OR FEDERATIONS RATHER THAN INTEGRATED ORGANISATIONS**

Organisation forms of large-scale general practice organisations

Organisational form	Characteristics	Example
<b>Network</b>	No formal ties; practices maintain GP contracts No executive function Share principally intangible objectives	Most of country
<b>Federation</b>	Growing ties; maintain GP contracts but develop legal agreements for shared activity Employ an executive function & some clinical roles Share some organisational goals	PCNs
<b>Super-partnership</b>	Close ties; practices merge GP contracts Employ executive function and management team Shared goals across whole organisation (multiple practices) Pool all/most income and risk	Modality
<b>Multi-site practice organisation</b>	Tight ties; same as above but directors hold all GP contracts in a single organisation	Hurley Group

Source: Reproduced from the Nuffield Trust 2017

These findings are corroborated by a more detailed academic study which found that the proportion of general practices ‘working closely at scale for the purposes of core general practice, with shared strategy and risk’ (eg super-partnership or a multisite organisation) to be less than 5 per cent (Forbes et al 2019). This means the vast majority of people (around 50 per cent according to this study) only have access to primary care delivering much less developed primary care at scale (eg GP federations), whilst the rest lag even further behind (eg a network or no collaboration). This is supported by new polling conducted for this report which finds that the many people with long term conditions are still not benefitting from access to team-based care (see box 2.1).

### BOX 2.1: ACCESS TO TEAM-BASED PRIMARY CARE

Polling produced by Savanta: ComRes for this report supports the conclusion that the majority of people are still not benefitting from primary care at scale. One of the main benefits of the ‘neighbourhood NHS’ is better patient access to team-based primary care and a wider set of innovations that will make community and primary care services more effective for those with chronic conditions. These include social prescriptions, link workers to help navigate the care system, a personalised care plan and personal health budgets. However, our polling showed that access across these remains worryingly low (see table 2.3).

Over half of people living with a long-term condition received no bespoke support from primary care – despite many of the interventions listing being key and long-standing NHS commitments. It is particularly worrying to see around seven in eight people with a chronic condition going without a personalised care plans – a relatively easy and highly impactful intervention. Even the one apparent positive in this table – longer appointment times for people with chronic conditions – must be taken in the context that GPs appointments remain restrained to 10 minutes on average, and practitioners will have to make this time up elsewhere.

**TABLE 2.3: PEOPLE WITH LONG-TERM HEALTH CONDITIONS ARE NOT RECEIVING ACCESS TO IMPORTANT INTERVENTIONS**

**Responses (%) to the question:** “Thinking about any NHS care you may have received in the past 12 months, which, if any, of the following types of support or assistance have you been given?”

Intervention	No health condition (Base)	Physical health condition	Mental Health condition	Disability	Other chronic condition
A longer appointment to discuss your issue, diagnosis or condition	12	31	29	32	28
A personalised care plan	5	15	12	13	21
Access to additional technology	6	9	9	9	9
Formal education or training about your health condition or lifestyle	4	5	4	5	7
A social prescription	3	3	5	5	3
Support from a link worker	3	5	4	4	3
Access to a peer support network	2	4	7	4	3
Access to a personalised health budget	2	2	3	4	0
None of the above	74	56	53	55	49

Source: Authors’ analysis of Savanta ComRes polling of 4,024 people

However, people with long-term conditions do have better access to primary and community professionals who are not GPs (see table 2.4). The findings suggest team-based primary care may be becoming more accessible (though we do not know whether these professionals are in the same organisation or federation). Moreover, access is largely better for medical services whilst access to services delivered in the community, by the voluntary sector or by local government do not show the same difference. This indicates that we are some way off delivering multi-professional, ‘hub’ based integrated care to people at scale.

**TABLE 2.4: PEOPLE WITH LONG TERM CONDITIONS HAVE BETTER ACCESS TO NON-GP HEALTH AND ALLIED HEALTH PROFESSIONALS**

**Responses (%) to the question:** “During the past 12 months, which, if any, of the following staff members or services have you been seen by or used through your GP practice?”

Professional	Long-term condition	No long-term condition
General practitioner (GP)	75	57
Pharmacist	43	24
NHS dentist	29	22
Primary care nurse	24	14
Allied health professionals, such as speech and language therapists, osteopaths, art therapists or physios	13	5
Sexual health or family planning services	4	5
Welfare advice services	3	2
Social care advice or services	3	2
Public health support, such as stop smoking services	2	2
Housing advice or services	2	1
None of the above	10	23
Don't know	2	2

Source: Authors’ analysis of Savanta ComRes polling of 4,024 people

### BOX 2.2: GP PERCEPTIONS OF PROGRESS ON DELIVERING PRIMARY CARE AT SCALE

In IPPR’s poll of, and qualitative interviews with, general practitioners, there was strong agreement that the vision of integrated and community care – as in the Long-Term Plan, and underpinning the introduction of Primary Care Networks – was the right one with some recognising that progress was being made.

**“Working within these primary care networks, you are able to look at things more at scale. Like homelessness, or childhood obesity, or substance abuse. I think the future has to be much larger than your practice.”**

A salaried GP working in London

**“[My area] has had an integrated care service for a while now, where three practices work together...and the experience is very good. We’re more proactive with our frail patients with patients with recurrent conditions...I feel the patient experience is better and like you’re less likely to be turned away.”**

A salaried GP working in South East England

But many others felt that change was fairly limited or lacked depth:

***“I don’t think we’ve ever been further away from integration. With public health, mental health, social care. It feels like there’s just an enormous gulf. We get invited last minute to meetings, but don’t have time to go.”***

A salaried GP working in London

***“PCNs are a red herring. There’s no staff. And the PCNs dictate to you which allied health professionals you can employ... so they said we could have a pharmacist...but we don’t need a pharmacist really, what we need is a mental health worker, and yet we’re not allowed to employ that through the network.”***

A partner GP working in South West England

This is concerning. There is evidence that single organisations – or tighter partnerships – may be preferable to networks for the delivery of coordinated care (Sheaff et al 2015). In particular, a number of factors can be identified as requirements of high-quality primary care at scale which are not always present amongst looser partnerships (ibid; Ghorob and Bodenheimer 2015; Hochman 2015), including:

- being in the same location
- shared strategies, incentives and cultures
- a stable organisational structure and shared governance
- defined roles and workflow
- data integration and good communication.

However, the inability of national policymakers to drive closer integration is unsurprising, not just because it is a fundamentally challenging task, but because of the approach they have taken. For too long national policy has relied on volunteerism (eg practices having the freedom to choose not to work in larger partnerships) and the protection of the independent partnership model (see information box). Indeed, the perceived strength of the *Five Year Forward View* and *NHS Long-Term Plan* (including PCNs) was that they could enable primary care at scale without requiring the closure of smaller practices.

But this approach has an inherent flaw. Except in a few exceptional circumstances, where strong relationships and passionate clinicians overcome the obstacles to delivering close integration despite maintaining separate organisations, a ‘network’ or ‘federation’ model locks in loose partnership working and fragmentation in primary care (see box 2.3). In recent years, national reformers have claimed to be agnostic to the governance model local partnerships develop in order to deliver integrated care (eg putting function over form). But this is not true: policymakers have in fact bent over backwards to protect the partnership model in primary care at the expense of delivering truly integrated primary care at scale. This must now change.

### BOX 2.3: PARTNERSHIP, GMS AND PRIMARY CARE AT SCALE

Historically GPs have been local businesses managed by one GP partner with some minimal non-clinical support. These partnerships were contracted to the NHS under the terms of a national contract (GMS) since the inception of the NHS, reflecting the deal struck between the British Medical Association (BMA) and the post-war Labour government under which GPs should not become salaried employees of the state. Since then there has been a shift towards larger practices (see figure 2.1), many of which have taken on multiple managing partners and also salaried employees. As discussed, there has also been a move to loose federations of practices delivering services across larger populations.

However, as set out in this chapter progress has been slow. This is partly because the logic and incentives of the partnership model work against the push for primary care at scale. GPs are primarily funded through core national contracts called the GMS for delivery of essential services (see table 2.5). GMS funding is made up of the global sum (capitated payments) based on the age and gender of patients and other factors. Partners fund their costs through this and keep any excess as profits. These contracts therefore create what we call the ‘inverse pay law’: those GPs that are the most efficient and deliver the most basic care keep the most profit. This limits the incentive for general practitioners to innovate and expand provision.

Policymakers have looked to overcome these incentives by creating new and alternative funding streams for improving quality, providing additional services and working together through partnerships. An important innovation in 2004 was the Quality and Outcomes Framework (QOF) under which a proportion of pay is linked to the quality of care they deliver to patients. Another is the expansion of PMS contracts which are negotiated locally and may include funding for a wider range of services (eg some community services and services that would usually be provided in hospitals). PCNs are an extension of this logic but across multiple organisations.

However, all these arrangements are ultimately imperfect workarounds that fail to address the underlying problem. As long as we have many independent practices built around the GMS contract, the incentive will always be to protect organisational boundaries (to maintain smaller organisations) and therefore form only loose federations. Whilst approaches such as PCNs may make these loose federations more widespread and, in some cases, may incentivise more complete partnerships overtime, these will likely remain the exception rather than the norm.

TABLE 2.5: CONTRACTUAL MODELS FOR GENERAL PRACTICE

General medical services	Personal medical services	Alternative provider medical services
Nationally negotiated between the BMA and Department of Health	Locally negotiated	Locally negotiated. Can be held by the widest group of ‘alternative or independent providers
Stipulates essential services	Stipulates essential services	No requirement for essential services
Contract managed by area team of NHS England (previously primary care trusts - PCTs)	Contract managed by LAT (previously PCTs)	Contract managed by LAT (previously PCTs)
Held by 55% of practices in 2012	Held by 40% of practices in 2012	Held by 2.2% of practices in 2012

Source: Reproduced from Addicot and Ham 2014

### 3.

## A 'NEW DEAL' FOR GENERAL PRACTICE

Delivering the 'neighbourhood NHS' is crucial to realising the vision of the *NHS Long-Term Plan*. Without primary care at scale, joined-up, accessible, preventative and personal care is simply not obtainable. For too long, policymakers have worked around the existing organisational structures of the NHS in attempting to realise this vision. But the evidence set out in the previous chapter suggests that progress has been slow and, perhaps more importantly, shallow. We need a new approach - a 'new deal' for general practice and primary care - to push forward at pace towards the 'neighbourhood NHS'. This chapter sets out four key tenets of this new approach.

#### 1. CREATE NEIGHBOURHOOD CARE PROVIDERS (NCPS) TO DELIVER THE 'NEIGHBOURHOOD NHS'

A 'new deal' for general practice would recognise that the best way to work together as a team is to work together *in* a single team. The best way to deliver integrated care for patients is for it to be delivered from an integrated primary care hub. The best way to align strategies, cultures and incentives is to have one strategy, one leadership team and one set of incentives within a single organisation. And, the best way to share information is to collect it once on a single system. This can only be achieved if we are brave and take a more radical shift in policy in primary care than we have so far.

To this end, we propose that over time PCNs should move away from loose 'federations' or 'networks' towards new neighbourhood care providers (NCPs) across every local area, on the same geographic footings of PCNs - or of several PCNs, where they are smaller. These trusts could either be newly created or could be formed by existing community trusts, more advanced PCNs or multi-speciality community providers (MCPs). Over time these NCPs should take on the contracts for primary, mental health and community care. They could also deliver social care and public health in order to really fulfil the possibility of population health.

#### BOX 3.1: INTEGRATING IN COMMUNITIES

The Vanguard<sup>2</sup> process has seen several models for delivering more integrated care at the community level develop over the last few years. In early years, these have focused on building effective partnerships, developing vision and governance, testing delivery processes and ensuring processes for using resources.

There have been several approaches to restructuring general practice, including direct management of general practice by trusts, community interest groups and the creation of new organisations. Our conversations suggested that primary care was often restructured to deal with a specific

2 Early adopters of new care models, originally formed through the Five Year Forward View, published October 2014.



challenge – with recruitment or financial sustainability – but that they could all deliver significant benefits.

### Multi-speciality care provision in Tower Hamlets

Tower Hamlets formed a GP Care Group in late 2013 as a federation. They have taken joint responsibility for providing services to the local population. Thirty-six GP practices are involved in the collaboration, covering more than 300,000 people. The aim of the process was to ensure the GPs of Tower Hamlets could speak with one voice.

The scale of the care partnership has allowed Tower Hamlets to become a multi-speciality care provider, delivering a number of public health and community services. This includes health visiting, a school health and wellbeing service and social prescribing services.

Crucially, the scale and highly networked nature of Tower Hamlets GP Care Group has allowed general practice to ‘lead the way’ in the NHS. They are, for example, the lead manager in an alliance with Barts Health and East London NHS Foundation Trust (ELFT). This collaboration involves delivering community services across the population.

There are substantial benefits to genuinely GP led, cross-organisation care. GPs are experts in local health and care needs so are well placed to provide this leadership on population health. However, they are often too small scale to take this role in practice, in the way England’s care system is currently organised. Tower Hamlets GP Care Group provides insight to how that could change as PCNs develop – as long as that process leads to genuine integration of local practices into ‘one voice’.

### Creating a new ‘single organisation’ in Yeovil

Faced with the prospect of a number of struggling practices near the point of handing back their contracts, Yeovil Foundation Trust began directly running several GP practices several years ago. Operationally, they do this through a limited company – Symphony Healthcare Services Ltd (SHS) – which is solely owned by the trust. The trust holds GMS and PMS contracts through nominated ‘nominal partners’, and general practitioners are indemnified through the trust.

The model has had a significant impact on the integration of care in the area. The trust quickly identified that working across local government, the acute sector, general practice and other care providers would. Having employed GPs directly, they were able to encourage this, and to design work contracts around this cross-setting work.

It has also had a significant impact on the stability of GP services. Since taking over, no GP has been forced to hand back their contract in the area. This bucks a wider local trend. At the same time care have improved – with emergency admissions in the area down 1.5 per cent. Nationally, the trend has in fact been for increased emergency admissions.

Equally, it has managed to take steps towards maintaining the autonomy of general practice – for example, the innovative introduction of an ‘employed GP partner role’, and by maintaining clinical leadership within the practice (though clinical leads are not necessary GPs).

SHS provides a way to deliver primary care at scale – by allocating resources and staff time effectively, having much more coordinated workforce planning sessions, and by providing the space for cross-setting learning and lesson sharing. In doing so, it provides a model that – while not without challenges – has begun to deliver the results hoped for from the PCNs, several years in advance.

### Trust-led general practice in Southern Health

The Willow Group was formed by Southern Health Trust and operates out of Gosport. It emerged, among other reasons, due to pressure on recruiting a sustainable number GPs, into an area with traditionally high levels of deprivation.

The group began with four practices forming a partnership in April 2017. The group is run by three managing partners, with all general practitioners employed by the trust on salaried terms, and the leasehold to each property (with a private landlord/CHP). However, the group has been able to keep incentives often associated with partnership – through a shared profit scheme where GPs do private work, and by providing a share of surplus in the practice if achieved (financial deficit since forming has meant this has not yet happened in practice).

There have been substantial benefits. Retention has improved. The group has been able to move to 15-minute appointments. Work across sector has picked up, with GPs able to collaborate more intimately with community and acute sector colleagues. This is despite less than three years' work in this model.

Challenges emerge where the NHS proves inflexible to the kind of creativity being shown. For instance, the GMS contract does not make allowances for Agenda for Change,<sup>3</sup> and standard NHS pay scales mean salaries far beyond what would be normal in an independent practice. While good for staff, and likely more equitable overall, this makes it very difficult to maintain a surplus.

Gosport has two PCNs, one of which covers the Willow Group. The experience has been eased by a head start on culture change, and a leadership with a birds' eye view on cost-benefit, workforce needs and finances. This offers an advantage in terms of using the PCN to achieve genuine shared-savings and collaboration.

### Delivery of GP services in St Helens

St Helens & Knowsley NHS Trust had the opportunity to deliver on an interim basis and then tender and subsequently win the bid to deliver a GP practice in one of their boroughs. The previous providers operated under a GMS contract and delivered the service from a purpose-built facility within the hospital, delivering both a traditional and virtual GP practice. The trust now provides the service under an alternative provider medical services (APMS) contract from the same location and have merged the two practices into one.

On taking over, the trust were required to develop the practice from the ground up with staff, equipment and a communications plan to advertise the new service. Since then, the trust has been able to lead a process of recruitment and now has a practice manager, advanced nurse practitioners, practice nurses, a health care assistant and administrative support in place; in addition it also works in partnership with the local authority and CCG to provide the services of a midwife, social prescriber and first contact practitioner.

Exposure to a different type of culture has also presented as a challenge. General practice has often been more competition driven than the rest of the NHS; making collaborative working a long-term project and aspiration. A lack of understanding between acute, primary and community

3 Agenda for Change is the national pay system for most NHS staff.

staff has also been a real area of focus; as so often in the NHS. However, working through this has provided tangible benefits – such as the area’s leadership having a far deeper understanding of the sectors that make up a wider health and care system.

The trust has since been approached by other organisations interested in the benefits it can provide when working collaboratively, which include:

- instantly lower risk, particularly property management risks
- a comprehensive back office support function
- cost efficiencies from working at scale
- cross-organisation leadership and working relationships.

However, discussions have slowed down as primary care networks develop. This provides an example, in a single practice, of how the benefits that the centre hopes to spread across the country, through the PCN push, can be achieved through formal, cross-setting collaboration.

**Policy recommendation:** By 2023/24, all PCNs should be transformed into neighbourhood care providers (NCPs) with the local contracts for primary care, community care, mental health care. NCPs should also look to take on contracts for social care and public health where appropriate.

## 2. OFFER ALL GENERAL PRACTITIONERS THE RIGHT TO NHS EMPLOYMENT

All general practitioners in the NHS in England should be given a right to NHS employment. Senior general practitioners (both partners and salaried employees) should be recruited into management roles within the new NCPs (on similar salary levels to a current GP partner) alongside other non-clinical senior managers. All newly qualified GPs should also be offered a salaried role within the NHS. In the short-term GPs should have the right to refuse this offer (eg to maintain their partnership model) but over time policymakers should consider ending the right of partnerships to create new or replace existing partnership roles.

This may seem radical. But it is in fact starting to happen already. The partnership model is in decline with the number of partners reducing year-on-year. Even in the short time since the *Five Year Forward View* was published, salaried GPs have increased by 3,000, and now make up nearly a third of all GPs, whilst partners have decreased in numbers by a similar amount (see figure 3.1) though it is worth noting that locum GPs have been growing at an even faster pace (see box 3.2). If these trends continue at their current pace, salaried GPs will become the majority by 2026.<sup>4</sup>

In this context, our proposed policy of a ‘right to employment’ for GPs in England is going with the grain of current trends and the interests of newer generations of GPs. It would simply speed this process up and ensure that salaried GPs are contracted directly to new organisations which are better set up to deliver primary care at scale. This move is not controversial amongst the public: our polling shows that four times as many people support GPs being employed by the NHS than as partners (see table 3.1). It shouldn’t be controversial with staff either: all other NHS professionals, from nurses through to clinicians, are directly employed as part of the NHS. It is therefore time to welcome GPs into the NHS family as well.

<sup>4</sup> By headcount, if trends since 2015 continue forward linearly.

**TABLE 3.1: THE PUBLIC SUPPORT GPs BEING EMPLOYED BY THE PUBLIC SECTOR, RATHER THAN RUNNING PRIVATE SECTOR BUSINESSES**

**Responses (%) to the question:** “Please read the following information carefully before answering the question. Most general practitioners (GPs) are independent contractors (private sector). Many GPs run businesses – ie GP practices – as partners and are then contracted by the NHS to deliver patient services. Some say GPs working as independent contractors can increase productivity and cost-efficiency reduce bureaucracy and give GPs more freedom over what they provide. Others say that it can increase workloads, individual liability for GPs, and waiting times for people and patients. Or simply that the government, rather than independent contractors (private sector), should provide all NHS services. An alternative is for GPs to be employed as official and salaried NHS staff, like many other NHS doctors, rather than independent contracts (private sector) provider services to the NHS. Please select the statement below that best represents your view.”

Answer	Respondents in England
NET: agree GPs should be independent contractors (private sector) providing services to the NHS	16
Strongly agree GPs should be independent contractors (private sector) providing services to the NHS	4
Tend to agree GPs should be independent contractors (private sector) providing services to the NHS	12
Tend to agree GPs should be official and salaried NHS staff	37
Strongly agree GPs should be official and salaried NHS staff	32
NET: agree GPs should be official and salaried NHS Staff	68
Don't know	16

Source: Authors’ analysis of Savanta ComRes polling of 3,445 people in England

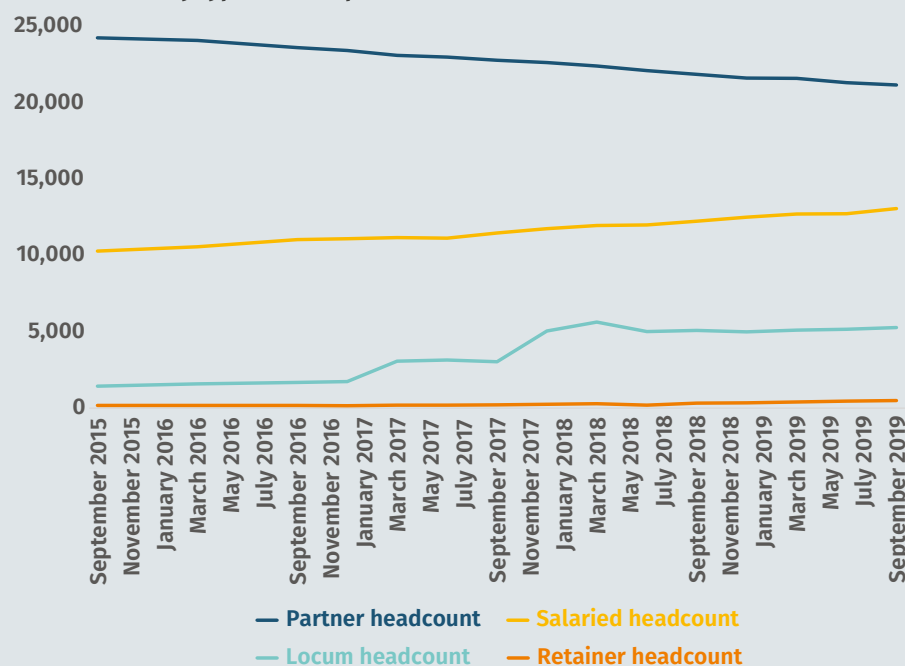
**Policy recommendation:** All existing and new GPs operating in England should be given a ‘right to NHS employment’ as part of new NCPs. In the short-term GPs should have the right to refuse this but over time policy makers should consider ending the right of practices to create new or replace existing partnership roles.

### BOX 3.2: 'VOTING WITH THEIR FEET': THE RISE OF LOCUMS

That the current model of general practice is unsustainable is clear from the kinds of careers GPs are prioritising. The most obvious trend is the rise in locum work. Locum work currently provides a highly attractive offer. The pay is excellent, the paperwork demands are slight and the hours can be tailored and are entirely flexible. In sum, it is reminiscent of the more balanced GP roles of the mid-19th century – and avoids the modern stress that has made the role untenable for many. It has led to an almost three times rise in the number of locums over just the last five years.

FIGURE 3.1: PARTNERSHIP HAS DECLINED WHILE SALARIED AND LOCUM WORK HAS THRIVED OVER THE LAST FIVE YEARS

GP headcount by type of GP September 2015 onwards



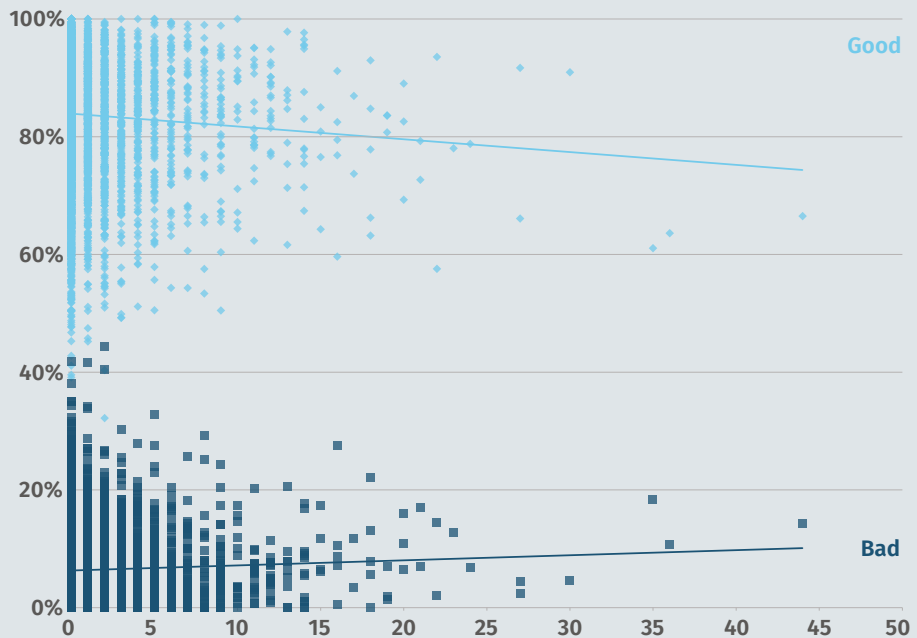
Source: Authors' analysis of NHS Digital 2019d

There has always been a need for locums in the health system – to fill gaps and ensure continued patient care when others are off sick or have not yet been recruited. But there is growing evidence that the locum model is being misused, with professionals using it as a way of managing the increasing workload and pressure put on salaried and partner GPs. Without change, it is possible that locum model could become the most common form of GP contract. This would be the equivalent of permanently staffing a school with supply teachers – it is neither cost effective nor optimal for quality.

Indeed, a rapid review of job adverts listed by the RCGP in December imply – even before agency fees, bonuses and incentives are taken into account – the general practice locum bill stands at around £200 million per year. Further, there is evidence that practices with higher usage of locums deliver worse care. Our research tentatively points to a correlation between patient reported outcomes (GP Patient Survey) and the number of locums in a practice (see figure 3.2). This makes sense: patients value continuity of care and a strong relationship with their GP, neither of which are easily obtained with temporary staff.

**FIGURE 3.2: HIGHER LOCUM NUMBERS IS CORRELATED TO LOWER PATIENT SATISFACTION IN GENERAL PRACTICE**

**Satisfaction score (GP Patient Survey) by number of locums (all locum types) for all GP practices in England**



Source: Authors' analysis of NHS England and Ipsos Mori 2019 and NHS Digital 2019d

GPs shouldn't be blamed for increasingly choosing to locum instead of taking salaried roles. Instead, this is the result of the inability of policymakers to address the workforce crisis in primary care which means salaried roles remain unattractive in terms of workload, stress and progression. This suggests that there is an urgent need to invest in the salaried model in order to make it a desirable alternative to both the partnership but also the locum model. Failure to do this could perpetuate this shift towards a model based on locum GPs which could end up costing the NHS more money whilst delivering worse outcomes for patients.

### 3. REFORM NEW GP ROLES TO CREATE CAREER PROGRESSION, TIME TO CARE AND REALISTIC WORKLOADS

There is a recruitment crisis in primary care. Despite efforts to increase the number of GPs over recent years, England is at its lowest level per 100,000 people since 2003 (Palmer 2019). This has come at the same time as growing patient need and a reform agenda that is aiming to shift more care out of the acute sector and into the community. This crisis is partly a result of increased part time working as GPs choose to reduce their hours. But it's also because there is a retention crisis in the sector: nearly half of GPs in a recent survey said they had brought forward their plans to leave the sector (Owen et al 2018).

There are multiple causes of this recruitment crisis. A major factor is high stress as a result of the workload (ibid). This is reflected in our qualitative work which shows that the majority of GPs believe workload is risking patient safety (see figure 3.3). Another is that GPs increasingly want more flexibility (eg a portfolio career which

may involve commissioning, research or working in another sector) and more work-life balance (see information box). Finally, there are concerns over the health of GPs as a result of stress and overwork: a survey of 1,000 GPs found that two in five have a mental health problem (Mind 2018).

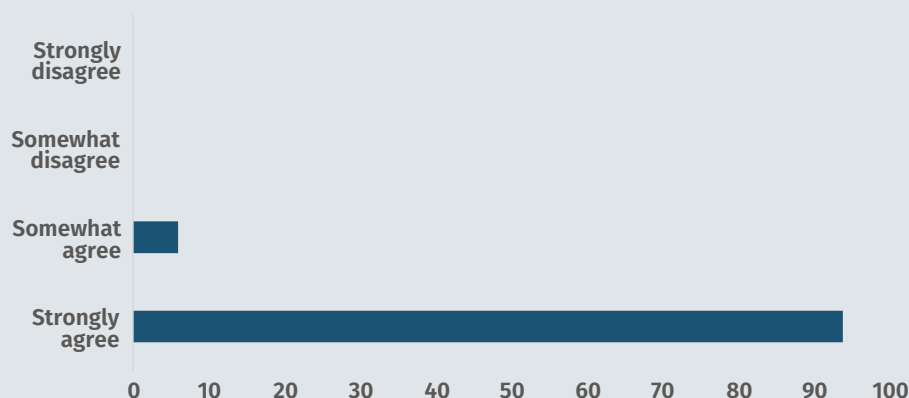
Many of these trends are also driving the shift away from the partnership model towards salaried (or locum) roles. Staff often value the increased flexibility these models give them to take on more varied roles alongside general practice, to work part time therefore making time for work-life balance, and to focus on clinical work rather than management. In particular, being a partner often includes a significant administrative burden and financial risks which GPs are often neither trained to cope with, nor passionate about. These trends frame our call for a move towards welcoming GPs into the NHS family.

### BOX 3.3: THE GP WORKFORCE CRISIS – QUALITATIVE EVIDENCE

The workload in general practice has never been low but it is clearly increasing. IPPR polled GPs before each qualitative interview (n = 33). They all indicated a perception that workload is harming quality and putting patient safety at risk.

FIGURE 3.3: GP WORKLOAD IS INCREASING CONCERNS OVER PATIENT SAFETY

**Responses (%) to the question:** “On a scale of 1 [strongly agree] to 4 [strongly disagree], what are your views on the statement: ‘the workload in general practice is increasing to an extent that I fear it impacts patient outcomes, care quality of safety’”



Source: Authors’ analysis of IPPR poll of early career general practitioners

This is being driven by GP shortages but also by growing complexity.

*“I normally see people who have multiple conditions, huge complexity and who need multiple appointments that I just don’t have. I probably need to increase my appointment to 15 minutes, but that’s all in my own time. It’s impossible to do a 10-minute appointment. I maybe manage that once every 15 patients.”*

A portfolio GP working in the Midlands

This was described as having given GPs entering the system risk significant burnout, which reflects how much more stressful and complex general practice has become:



***“I think what’s happened is the working day has got more stressful, if you do the job we do every day, you’d get quite burnt-out, so you see GPs doing six sessions because that’s all they can manage...I’d say that’s why salaried GPs and why six clinical sessions have become very popular.”***

A salaried GP working in the Midlands

Flexibility was a recurring theme throughout the qualitative component of this research. It was not only a priority for GPs when thinking about the roles they would and would not take, but a key reason for many avoiding the partnership model of working.

***“I couldn’t think of anything worse than sitting in a consulting room for the next 35 years... I’ve got enough paperwork without a commercial loan, there’s too much risk too and it’s not indemnifiable risk, it’s property risk if you’re the last man standing. After training, I just didn’t want to negotiate my pay, my holiday and so on – I wanted flexibility”***

A GP from South East England

Many felt very conscious of the threat of burn-out in trying to meet the kind of standards set by government for full-time GP work. Particularly, the idea any GP could sustainably work nine sessions per week was considered unrealistic at best:

***“Most GPs are really passionate about their job...but I don’t think working in the way government want us to is sustainable.”***

A young GP in the Midlands

***“My friends, even the ones who weren’t married and had kids, didn’t want to work four long days... seven sessions is the top you can do.”***

A young GP from South East England

It was felt that variety was the antidote to ensuring the role of general practitioner remained sustainable in the future.

***“Limiting workload would be better in terms of retention and GP wellbeing – 25 patients a day and a limited number of other things. Otherwise, GPs are making the most ridiculous number of decisions per day. You can’t just keep adding if you want the quality to remain high. A portfolio career could be a solution. I really genuinely believe variety is the spice of life.”***

A young GP from South East England

There were concerns that GP wellbeing was being put at risk – particularly by high levels of workload. Some thought that affirmative action could be taken – to help the system focus on the health and mental health of its workforce.

***“I think we need to do a lot more on emotional wellbeing. I think the next step is on retention and working with young GPs and making them want to stay...we need a lot on wellbeing, on mentoring on how we can best support them. It should be built within the local workplace culture.”***

Salaried GP from the South of England



But designing these new roles to manage some of these challenges as part of newly created NCPs will be crucial. This means that the offer must be immediately attractive to general practitioners and tackle the problems they describe experiencing.

**Changing populations:** The population in England will grow by an estimated 1.5 million in the next five years. Most of that growth will be among over-60s, who have higher risk of developing a long-term condition. It is likely this will increase the need for general practitioners (see figure 3.4).

**Workload:** We need to be realistic about how many people GPs can see in a week without burning out. Getting better work-life balance for GPs must be a priority. We need to move away from a nine-session week (which works out to far more than 37.5 hours indicated by government) - and which is dominated by clinical sessions. Full-time work should be defined as eight sessions, of which a maximum of six sessions should be clinical. This may seem extravagant in the context of GP shortages, but overwork is a false economy: it is driving GPs to reduce hours or leave the profession.

**Career progression and variety:** The time created by this change (above) should be used for career development, respite and developing other specialisms. These could include the following.

- **A GP director** with responsibility for leading new NCPs including staff management and overseeing the strategy.
- **An academic GP** creating links between NCPs and leading academic organisations in order to understand and implement best practice.
- **A link GP** with roles split between primary and community care and other parts of the sector, including acute care and public health.
- **A commissioning GP** with time working on designing care pathways and commissioning provision.
- **A specialist GP** working in a specific part of the system including end of life care or mental health.

**Time to care:** The growing complexity of patients - notably, those with multiple long-term conditions - require GPs to have the option of moving to longer appointments for those with multiple long-term conditions. Currently, the average appointment is approximately 10 minutes (Davies 2016), where basing workforce planning off a 15-minute appointment would relieve significant strain. This is the best thing for both patients (who need more support) and for staff (who need time to care). This can also be achieved by moving towards team-based care, with patients who do not need to see a GP receiving support from another professional.

The BMA have previously argued that this could be achieved by reducing the average number of appointments per GP to 23 a day (BMA 2016) – a reduction in line with international safety standards (McCarthy 2016). Evidence indicates the current average is 41.5 appointments per day (Gregory 2018).

If recruitment were the only method available to adapt to each of these changes up to an extra 37,000 GPs would be needed before - with still more needed on top of this to improve access (see table 3.2). This is simply not achievable in any realistic timetable.

**TABLE 3.2: IT IS NOT REALISTIC TO ONLY USE RECRUITMENT TO SOLVE PROBLEMS IN GENERAL PRACTICE**

Change	Estimated GP requirement (headcount, fully qualified)
Maintaining access as the population increases	7,000
Decreasing full-time GP clinical sessions to seven	19,200
Increasing appointment time average to 15 minutes	8,600
Total GPs in 2024/25	69,400
Total Increase (from 2019 numbers)	34,800

Source: Authors' analysis of NHS Digital 2019d

Instead we must combine recruitment with wider levers to drive increases in productivity that can both improve access for patients and workload challenges for GPs. NHS Alliance have previously shown that 27 per cent of GP appointments are avoidable – showing the scale of the opportunity (Primary Care Foundation and NHS Alliance 2015). Automation also has significant potential to ease pressure (see table 3.3) by reducing workload (particularly administration). Elsewhere, we should invest in the wider primary care team (eg social prescribers, nurses, pharmacists etc) and invest in patient empowerment to support people to manage their health better in the community. This is yet another reason why primary care at scale is the only option: these changes are only achievable if we embrace a new model of primary care.

**Policy recommendation:** Increase government targets on GP numbers in England in order to increase ‘time to care’ by moving to 15-minute appointments for patients with long-term conditions and reduce workload by reducing the number of sessions defined as ‘full time’.

**Policy recommendation:** Prioritise investment and action as part of the NHS People Plan to scale up the use of automation, team based primary care and patient self-management in order to reduce demand for new GPs in England.

### **BOX 3.4: GOVERNMENT PROMISES AREN'T SUFFICIENT TO SAVE PRIMARY CARE**

The Conservative manifesto committed to 6,000 extra GPs by 2024/25. The commitment is to 6,000 extra 'full-time equivalent GPs', meaning headcount will need to increase by closer to 8,000 GPs. The government has also confirmed that the 6,000 figure includes 3,000 trainee GPs, who will not be qualified by the end of the parliament.

Leaving aside doubts about whether the commitment can be achieved – a similar commitment was missed by some way between 2015 and 2020 – there are doubts whether this will keep up with rising demand. The population of the UK is ageing; meaning needs are growing more complicated. This may mean a higher GP to population ratio is necessary in years to come (Palmer 2019). In the same period, the population of England is projected to grow by more than 1.5 million people (ONS 2019).

In 2019, Nuffield Trust released analysis showing the historic change in GP numbers (permanent, fully qualified) as a proportion of the population in England. Their research showed a significant drop in fully qualified GP numbers between 2010 and 2018, relative to the population. Repeating the analysis, and using it to forecast the Conservative manifesto pledge, gives some much-needed context.

First, it shows that – should the pledge be delivered in full – that England's GP to population ratio would return to approximately 2009 levels by the end of the parliament. However, as shown in figure 3.4, this is little more than a return to pre-austerity GP staffing levels. As with pledges on police numbers, it does not constitute a significant uplift on the numbers lost.

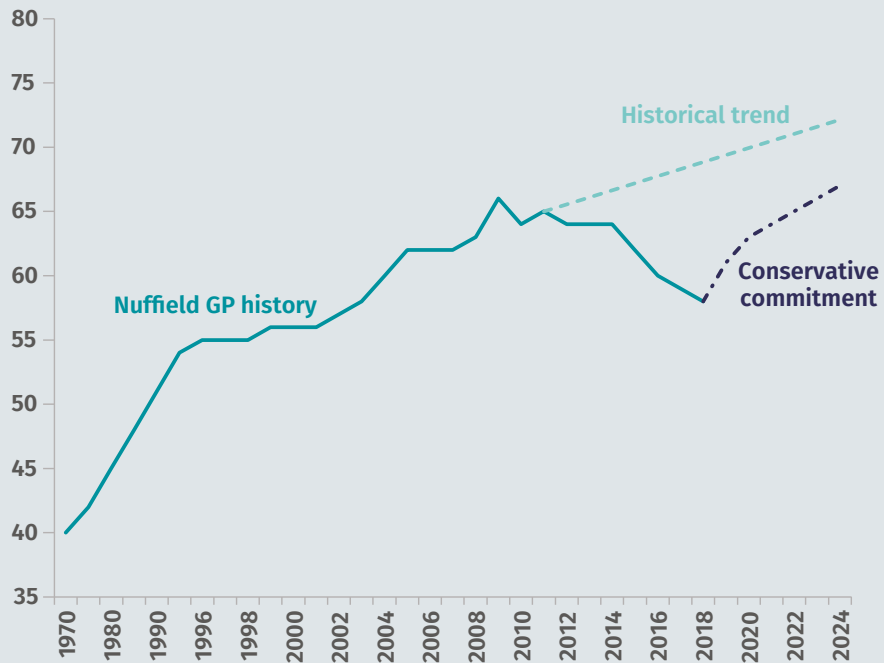
Exploring the historical trend makes this point clearer. Should GP growth (relative to the population) have continued at the average rate between 1970 and 2010, the number of fully qualified GPs per 100,000 people in the population would have been 72 by 2024/5. Under Conservative plans it will be 67. That represents a shortfall of more than 3,000 qualified GPs (headcount).<sup>5</sup>

It is possible that this will be closed as the 3,000 trainee GPs qualify between 2025 and 2030, however the trends creating the shortfall, such as complexity and population growth, will also continue through that period. For instance, if the 3,000 trainee GPs subsequently entered the workforce between 2025 and 2030 (and ignoring the time it takes other GPs to support their training), then the shortfall would still increase due to demographic change. The best conclusion is that government plans will struggle to keep up with England's population growth, leaving GPs vulnerable to workforce rises. More promising may be the commitment to 26,000 other primary care staff, however the evidence is unclear what impact other primary care staff have on GP demand and workload.

5 Methodological note: Projections of GP numbers relative to the population should note a slight change in methodology from 2019 onwards. For historic data, population is estimated through patients registered at a GP practice. This choice allows inclusion of a greater amount of historic data. For projections of GP numbers relative to the population, ONS estimates of England's future population are used (future projections of registered patients are not available). As the NHS has more registered patients than the population of England, this has the effect of inflating the estimated number of GPs relative to the population between from 2019 onwards. The government's pledge on fully qualified GPs is converted from FTE to headcount using 2019 workforce data.

**FIGURE 3.4: PLANS FROM THE CONSERVATIVE MANIFESTO WOULD NOT KEEP UP WITH THE PRE-2010 GP TREND**

Comparison of historical trends in fully qualified GP numbers (headcount) per 100,000 people in England, with Conservative Party manifesto commitment



Source: Authors' analysis of Palmer 2019, ONS 2019 and NHS Digital 2019d

#### 4. A RADICAL TRANSFORMATION OF THE PRIMARY CARE INFRASTRUCTURE

Primary care infrastructure is a major barrier to delivering the 'neighbourhood NHS'. Four in 10 GPs consider their practice not fit for purpose while 70 per cent regard their premises as too small to deliver more services (BMA 2014). This makes realising the vision of integrated team-based care impossible. Many do not have the investment in technology that is needed to drive 21st century primary care such as remote care and digital administration limiting the potential of automation (see table 3.3). This is unsurprising: many are working from terraced houses and bungalows which simply cannot offer the integrated, community-based care.

The partnership model is at the heart of this crisis. This is because partnership in most cases creates a link between the property market and care, with senior GPs owning and managing the primary care estate. This has contributed to underinvestment in the sector with partners unable or reluctant to take on the financial risk of investing in the primary care estate and the NHS rightly unwilling to make big investments in what is essentially private property. Even where investment has been made this has usually come through PFI initiatives which do not offer value for money (Reform 2018).

The NHS has rightly proposed that practices be moved to 1,500 purpose built 'super hubs' across the country. This is the right vision: it is a pre-requisite of delivering the 'neighbourhood NHS'. But the means of achieving this is unclear. The government has made some additional capital funding available for this ambition but given the overall NHS maintenance backlog and capital needs of the acute sector it is unlikely to be enough. We therefore recommend that the government provides funding for at least one new hub per PCN, delivered as a strategic transformation fund and prioritised by levels of need. It is difficult to

give a comprehensive estimate of cost, given variation between areas. Case studies suggest variation between around £3.3 million in Wales (McColgan 2017) and £17 million in London (Bower 2019). The most comprehensive analysis of upgrading premises was Primary Health Properties plc and others suggestion that 750 new centres could be funded at a cost of £3.3 billion (Primary Health Properties et al 2017). Translated that would be just over £0.5 billion public capital investment, annually over 10 years, for 1,300 medical centres.

As part of providing an attractive offer for existing GPs to join the NHS family, through new consultant roles linked to their NCPs, government should commit to a radical upgrade of infrastructure. On the one hand, this must mean much higher quality use of technology. This can help support integration – through achieving interoperability. It can also help to save time – by automating administrative parts of the role and letting staff work on what they joined the career to do.

**TABLE 3.3: THE WHOLE NHS COULD BENEFIT FROM AUTOMATION, INCLUDING GENERAL PRACTICE STAFF**

Job role	Potential time freed up for care and value-added activities (%)	Value (£m) of time released
HCHS doctors	23	1,563
Nurses and health visitors	29	2,605
Midwives	11	80
Ambulance staff	35	196
Scientific, therapeutic and technical staff	25	1,193
Support to clinical staff	57	3,433
NHS Infrastructure support	30	1,567
GPs	31	962
GP Support including patient care and non-clinical	53	880
		Total: 12,479

Source: Reproduced from Darzi et al 2018a

**Policy recommendation:** The government can borrow at record low levels. It should use this power to fund up to £0.5 billion of capital annually, into realising the hub model in England's primary care estate over the next 10 years, to build 1,500 new primary care hubs and invest in new technology. These should be state-owned and state funded.

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