



WHAT CAN WE  
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INNOVATIONS  
IN GENERAL  
PRACTICE?



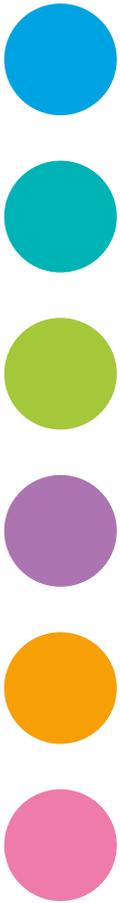
# Exploring innovation in general practice

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# Reception



WHAT CAN WE LEARN FROM INNOVATIONS IN GENERAL PRACTICE?



# Exploring innovation in general practice

## Introduction

Despite current contractual, financial, and capacity constraints, GPs are innovating in different ways to deliver high-quality care and attract and retain staff. This demonstrates that some solutions to the current crisis in general practice already exist but realising them on a larger scale will require far greater investment, contractual flexibility, and political will.

Here we showcase eight GP providers who are innovating with different models: personal lists, working at scale, employee ownership, direct management, and chronic disease-focused care. There is no one-size-fits-all solution, but we hope these examples will start a conversation about what is possible and begin to shape a vision for the future of general practice. It is not the BMA's intention to promote any of these approaches over others, but rather to highlight how GPs are responding to local system pressures.

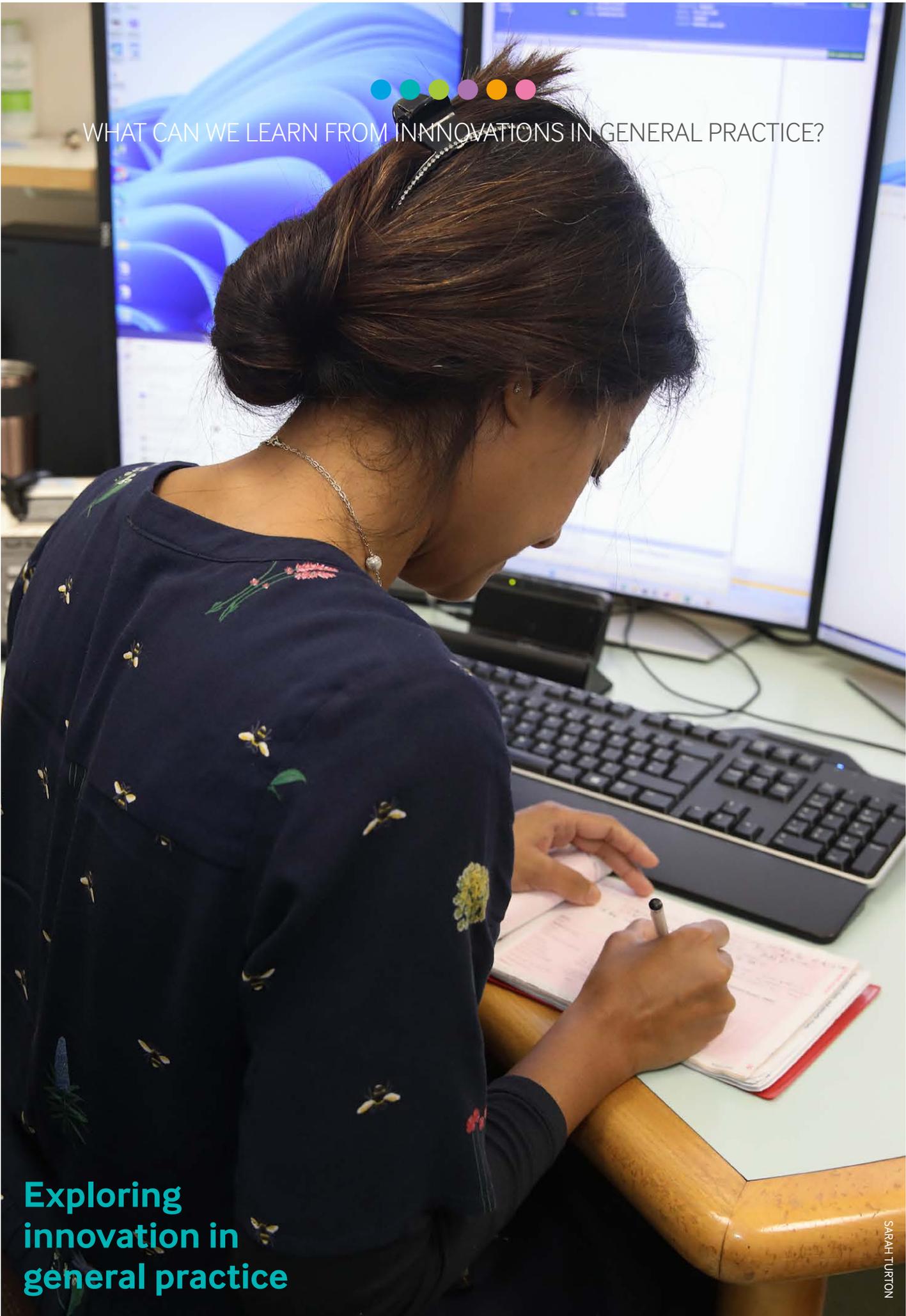
General practice is in crisis as GPs are under increasing and unprecedented strain caused by rising demand, workforce shortages, and burdensome bureaucracy. These pressures are leading to GPs leaving the profession and patients experiencing delays in accessing care. The independent contractor model – the model of provision which has existed since the creation of the National Health Service in 1948, ensuring continuity of care for millions of patients – works and must be preserved. However, it has been fractured in recent years and must be allowed to evolve to accommodate the increased flexibility the modern workforce seeks and to empower GPs to make the decisions and provide the services their patients need to reduce referrals, admissions, morbidity, and [mortality](#).

The BMA GPCE (GPs committee England) begins negotiations in England this autumn. The end of the five-year framework around primary care networks presents an opportunity to pause, consider, and address some of the pressures GPs are facing to start building a foundation for a model of general practice that is sustainable, and serves the needs of patients and GPs alike.

GPs have told us that they want to see a model for general practice that allows for autonomy, prioritises continuity of care, encourages and supports innovation, provides variety in their work, retains close ties to the communities they serve, and is cost-effective. England needs a model for general practice that is inclusive and that reflects and supports the different ways modern GPs work as partners in practices and as salaried employees.



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## Group 1: Practices using personal lists

### Personal list systems are an efficient way of achieving continuity of care

Several studies have demonstrated that personal list systems lead to higher levels of continuity of care than combined list systems (in which GPs provide appointments across all registered patients),<sup>1</sup> and personal lists [have been recommended by the Health and Social Care Select Committee](#).<sup>2</sup> In most cases, a personal list system is created by splitting the practice lists into smaller personal lists, which are allocated to a named GP or small team. The named GP takes overall responsibility for the care of the patients on their list. Patients are normally seen by their named GP unless presenting with a same-day or urgent need.<sup>3</sup> This system is compatible with the GMS contract with minor changes to most practices' methods of operating, as it is a return to the system which was widely used when the GP contract was created.

### Continuity of care is proven to benefit doctors and patients

Continuity of care refers to the ongoing (often decades-long) relationship between a patient and their GP. Continuity of care has a variety of benefits. It increases doctor and patient satisfaction, improves efficiency, ensures that doctors see a fair variety of patients, and can radically improve patient outcomes. This is most recently evidenced in a landmark study conducted in Norway, where the equivalent of GP practices all use a personal list system. The study provides evidence that continuity of care by a regular GP is associated with reduced need for out-of-hours services, acute hospital admissions, and decreased mortality, with the probability of these occurrences reduced by 25-30% if the GP-patient relationship has lasted longer than 15 years.<sup>4</sup> The Norwegian health system is one of the most similar systems globally to the UK independent contractor model. It therefore makes for a sound comparison against the UK system and demonstrates the impact continuity of care in general practice can have on patient outcomes and the wider health service.

### Despite these benefits, continuity has been in decline in general practice

Continuity of care, though once commonplace in English general practice, has been in decline.<sup>5</sup> Though continuity is not at odds with access, the increasing focus on same-day access has generally meant patients are directed to whichever clinician is available at the time, rather than to a named GP. This pressure to see a patient as quickly as possible, irrespective of clinical urgency, also increases workloads as GPs will be seeing patients for the first time, and this reduces the potential time spent on planned and preventative care which underpin continuity.

- 1 Roland M, Mayor V, Morris R. Factors associated with achieving continuity of care in general practice. *J R Coll Gen Pract* 1986;36(284):102-4
- 2 Health and Social Care Select Committee, [The Future of General Practice](#), 20 October 2022.
- 3 Gray, Sidaway-Lee, and Evans, [How to implement and manage personal lists in General Practice: A guide for GPs and Practice Managers](#), 2021.
- 4 Sandvik et al. [Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway](#). *British Journal of General Practice* 2022; 72 (715): e84-e90.
- 5 Tammes et al. [Is continuity of primary care declining in England? Practice-level longitudinal study from 2012 to 2017](#). *British Journal of General Practice* 2021; 71(707).

Though the current GMS contract requires every patient to have a named GP, this does not mean every patient is on an active personal list. If continuity of care is to be supported and encouraged within general practice, personal lists should be supported more widely, potentially through contractual quality improvement incentives.

## Continuity can be easily measured using the SLICC method

Various measures of continuity of care are used in general practice research. One practical method for practices starting a new personal list system is the SLICC (St Leonard's Index of Continuity of Care) method. This method is relatively quick to implement and can be used to measure continuity on a short-term basis.<sup>6</sup> The SLICC method is described in full in the box below.

### SLICC (St Leonard's Index of Continuity of Care) Method:

Data is extracted monthly from the practice database, which holds all necessary and extraneous data including patient arrival time, date, appointment duration, clinician, patient age, sex, and their named doctor at the practice.

#### How to calculate the SLICC score:

1. Collect all GP appointments for all patients on a particular doctor's personal list over a specific period (for example, one month) into a spreadsheet. Include which doctor the appointment was with and which doctor's list the patient is on.
2. Count the appointments that were with the named GP.
3. Divide the number of appointments that were with the named GP by the total number of appointments for the patient group.
4. Show as a percentage. This value reflects the level of continuity achieved by that GP in that period.

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#### Things to consider:

- Patients can choose their personal doctors (for example, sometimes requesting doctors of a specific gender) and occasionally move between GP's lists.
  - This method relies on GPs accurately recording appointments.
  - The benefits of the measure are that it is simple, applicable to short periods of time, takes into account patients who only have one appointment during a given period, and allows comparison between doctors.
  - A value of 0% is possible in months when a GP is on long-term leave.
  - As these audits take place within the practice, the data must be checked at the time of extraction (ensuring appointment types are correct and few are missed out).
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<sup>6</sup> Another common measure of continuity is the UPC (Usual Provider of Care) Index, which measures the proportion of contacts a patient has with the most regularly seen GP during a given time period. Since this method requires several patient visits so the most regularly seen GP can be established, it is less responsive than the SLICC method, which measures continuity against the named GP.



## Example 1: Improving continuity through the use of personal lists

### Horfield Health Centre

**Location:** Bristol

**Number of GP partners:** 9

**Number of salaried GPs:** 7

**Practice list size:** 16,500

**Type of area:** Higher levels of deprivation

Horfield Health Centre is a partner-led practice, which places continuity of care at the heart of service delivery and has been using a personal list system for over 20 years. Every GP has a personal list of patients they are responsible for, though sometimes they will look after someone else's patient when the situation requires it. GPs are also supported by a range of practice nurses and healthcare support staff, who carry out appointments such as cervical screening or taking blood samples.

GP workload is actively managed. For example, lists are regularly reviewed and adjusted for fairness, ensuring all GPs have a similar share of complex patients such as those over 75. The number of appointments per GP is capped for each single half-day duty session and capped for each routine (non-duty) session.<sup>7</sup> There is a strict stop at 6pm to allow for necessary outstanding care until 6.30pm. The practice experiences no issues in recruiting GPs.

### Less than full-time working is not a barrier to achieving continuity

Horfield achieves between 50–60% continuity using the SLICC method. This degree of continuity is achieved by all doctors at the practice, including those who work less than full-time, which demonstrates that part-time work is not a barrier to holding ownership of a personal list. Patients adjust to the working days and hours of their GP but understand that if they need to see a GP urgently outside of these hours, there will be a GP available.

### High levels of continuity can be achieved in areas of deprivation

Horfield Health Centre is in a fairly deprived area, yet it achieves around 50–60% continuity using the SLICC measure. This is remarkable since greater socioeconomic deprivation is associated with lower levels of continuity and a higher need for increased service provision.<sup>8</sup> This is likely due to several factors. For example, there are fewer GPs per head of need-adjusted population in deprived areas than in affluent areas,<sup>9</sup> and there is a higher preference for NHS services which do not require an appointment in deprived areas.<sup>10</sup>

7 Duty doctors picks up unmet demand on a per day basis, compared to non-duty doctors who will mainly have planned appointments, which have been arranged some time in advance.

8 Levene LS et al. [Predicting declines in perceived relationship continuity using practice deprivation scores: a longitudinal study in primary care](#). British Journal of General Practice 2018; 68 (671): e420-e426.

9 The Health Foundation, [Level or not? Comparing general practice in areas of high and low socioeconomic deprivation in England](#), 2020.

10 [Emergency Care](#). In: Curtice J, Clery E, Perry J, Phillips M., Rahim N (ed.) British Social Attitudes: The 36th Report. The National Centre for Social Research; 2019.

## Patient cooperation is essential for success

Personal lists require the cooperation of patients, who may need to wait to see their named GP. At Horfield, appointments are allocated by a specialist team of 15 patient coordinators, led by two coordinators with experience in customer service. This team has worked with patients to help them understand and access the named GP system in a way which works for them, and new members of the team are trained in how to explain the system to patients.

Patient coordination is viewed as a specialist skill at Horfield. Team leaders have completed several courses, and the practice also organises internal training, opportunities to shadow team leaders, feedback sessions and cross-team observations. The team regrets that there is no official qualification or career pathway for patient coordination, which they think would benefit coordinators and help with recruitment.

## Example 2: Improving continuity through the use of personal lists

### Whitley Bay Health Centre

**Location:** Whitley Bay

**Number of GP partners:** 8

**Number of salaried GPs:** none

**Practice list size:** 12,800

**Type of area:** Low levels of deprivation



Whitley Bay Health Centre is a partner-only practice which aims for personalised care and continuity through the use of a personal list system. All partners have a personal list of patients, and there is built-in provision for patients who wish to see a GP of a specific gender. The partners are supported by practice nurses, a healthcare assistant, and a primary healthcare team attached to the surgery, which includes first-contact physiotherapists, mental health workers and pharmacy advisors.

Whitley Bay achieves an average of 85% continuity using the SLICC method. As mentioned above, this method takes into account list demographics, so it allows the practice to ensure personal lists are equitable and all GPs see a fair variety of patients. This helps distribute the burden of more complex patients, but it also makes the role of a GP more interesting as they can care for different types of patients. They note, though, that performing the SLICC calculations manually can be tricky, and think that automated systems would be more efficient, and could potentially be incorporated into GP operating systems.

## Providing continuity of care has helped to reduce workload

List sizes are matched to the number of sessions a GP works. The partners at Whitley Bay have found that continuity of care reduces demand over time: for example, patients who have built trust with a named GP will make fewer unnecessary appointments as they are aware that all their different needs will be addressed in a single appointment, with a GP they know well. They have also found that the clear delineation of responsibilities, which personal lists provide, protects against burnout, as it means partners have extremely clear responsibilities for their patient list and that list alone.

## Personal lists support GPs' special interests

All partners at Whitley Bay have their own special interests, such as joint injections or GP training. These are catered for through built-in provision within personal lists. This means that certain slots are reserved for special interest cases so that if a relevant patient needs to be seen there is space for it (even if that patient is not on the GP's personal list). This allows doctors to provide continuous care while also pursuing their own interests.

## Creating a 'culture of continuity' has helped the practice achieve success

When new patients are registered, they are given a named GP whose work pattern is explained and told that ongoing care will normally be with this GP. When patients call into reception, they first get asked who their doctor is. Then the discussion around availability starts. Patients are encouraged to wait a few days to see their named GP, if necessary unless there is an urgent need. This emphasis on working with patients to understand the process has reduced negative patient behaviour, both towards reception staff and towards clinicians.



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## Group 2: Practices working at scale

### Working at scale: practices and their communities in a network

Working at scale allows different practices to work together, creating efficiencies by providing services across a larger footprint. This can include services which are already provided, but at a larger scale, or new service provision, made possible by having a wider pool of patients.

By offering a wider provision of care, working at scale can also present opportunities to tackle healthcare inequalities and disparities, and can be used to focus provision in areas of significant need. It can also assist with mitigating workload burden, as working at scale can enable practices to potentially draw on a wider pool of staff.

Working at scale can be challenging without adequate support. Though working at scale can offer many benefits, it can be difficult for practices to expand their services. Both financial and system support are currently lacking. For example, many practices currently struggle to invest in new premises or equipment, albeit some have benefitted from charitable support. The current contract also makes it difficult for practices to merge should they wish to do so. Future contracts may offer valuable opportunities to build in appropriate support for enhanced services offered by GP practices, for example through premises provision.

There are different ways to work at scale. Working at scale can take many forms. We have collected case studies where working at scale is driven by GPs, rather than imposed from the top without GP input. These examples include Faversham Medical Practice, Middlewood Partnership, and Herefordshire General Practice.

Working at scale is also inherently possible within the GP contract, both with and without using newer working-at-scale structures. GP federations, for example, are a longstanding example of GPs working at scale and providing services across a larger footprint, while maintaining their positions as leaders and decision-makers within the system.

### Example 3: Improving access to a wider range of services and supporting health service recovery

#### Faversham Medical Practice

**Location:** Faversham

**Number of GP partners:** 6

**Number of salaried GPs:** 5

Practice list size: 14,000

**Type of area:** Lower levels of deprivation



Faversham Medical Practice is a partner-led practice operating at scale in North Kent. The practice was formed in 2014, by the merger of two smaller practices. Since then, it has increased its list size and expanded the range of services it provides by taking over and establishing several community services. In doing so, it has built strong community links, improved access to services, and helped provide continuity of care in the community.

## Faversham's model helps to ease service pressures across the local system

The enhanced services provided by Faversham Medical Practice include minor operations and joint injections, COVID and shingles vaccination clinics, physiotherapy, and orthopaedic clinics. The practice has also partnered with a local hospital trust to support elective care recovery, including the provision of minor hand surgery, haemorrhoid banding, and gynaecology clinics. The practice also provides an X-ray service, which was set up in 2016 through charitable support from the [League of Friends, EKHUFT](#) (East Kent Hospitals University Foundation Trust) and other stakeholders.

As of this year, the practice also started offering an extensive range of eye services in partnership with ophthalmologists. The services include community ophthalmology clinics, such as minor surgery, OCT (optical coherence tomography) imaging and Wet AMD (age-related macular degeneration) injection clinics, as well as cataract surgery. All these services are highly pressured in other parts of the local healthcare system and provision through Faversham Medical Practice is helping with elective care recovery across Kent.

Alongside these services, Faversham Medical Practice also runs a UTC (urgent treatment centre). The practice successfully bid for the 'Faversham MIU (minor injuries unit)', in 2015, when it was under threat of closure. In 2019, the MIU was upgraded to a UTC. The UTC is open from 8am until 8pm seven days a week, including bank holidays.

## Faversham's model promotes autonomy, allows for flexibility, and improves patient care

This model allows for major decisions on healthcare provision in the local area to be taken by partners, as they have taken the initiative to provide the services and thus direct how they are delivered. The model also benefits staff wellbeing and recruitment as GPs know they will have significant autonomy and variation in their day-to-day work. Staff members have flexible working arrangements and receive bonuses which incentivise work. Recruitment at Faversham Medical Practice has benefited from the innovative model of working.

Working at scale allows Faversham Medical Practice to employ a wider range of specialists, which helps the practice run smoothly. For example, the practice has full-time HR management, an IT specialist, a community services manager, a business manager, and a receptionist manager. The practice employs around 65 people in total.

Working at scale has substantially improved care coordination. The practice mainly relies on cloud telephony to triage patients on a first-come, first-served basis, but also has an emergency protocol for urgent cases. The average waiting time for callers is about 2-3 minutes. The practice has a duty doctor in the morning and one in the afternoon, who is responsible for answering calls and seeing patients. The non-duty GPs will see their usual patients.

## Service expansion has been challenging

One of the biggest challenges of expanding services at Faversham has been the availability and condition of premises. There is insufficient suitable space available for clinical work, let alone training. Service charges have increased dramatically in recent years while funding for maintenance and upkeep of premises has been insufficient. The practice emphasised that with greater system support (which could incorporate shared premises provision) it would be possible for general practice to play a significant role in reducing long waiting lists for elective services.

## Example 4: Integrating care through working at scale



### Middlewood Partnership

**Location:** Cheshire

**Number of GP partners:** 14

**Number of salaried GPs:** 14

**Practice list size:** 34,000 (across four practices)

**Type of area:** Primarily rural villages

Middlewood Partnership consists of four practices working in tandem, with a team of 160 staff in total. Building this partnership has been a long-term process, which started in 2015 and required committed leadership. The result is efficient and integrated care, with the partnership equipped to meet increasing patient demand and devoted to improving the health of its community. Integrated 'at scale' services such as the urgent care hub, prescribing team, and specific back-office functions are delivered from one of the four practices. Read more about Middlewood's journey [here](#).

### Middlewood has a single, large staff rota

Middlewood can offer efficient, integrated, and coordinated care in part due to the large pool of staff available. Middlewood's operating model has been built onto and around their primary care network, which means the partnership is able to run shared services with a single staff rota. This has several benefits. For example, because of the larger number of GPs that are on the staff rota, GPs can take a 'one session, one job' approach. They do only one type of job per session, such as prescriptions or care home visits. This allows them to focus on a single task and prioritise patient contact.

This sessional approach also extends to non-GP staff, who can devote a significant amount of time to single-condition clinics, such as asthma and diabetes services. These clinics have also allowed Middlewood to fully utilise the ARRS (Additional Roles Reimbursement Scheme) staff it employs.

### This level of integration can facilitate continuity of care at a very large scale

The practices run an amended version of personal lists, in which patients are allocated a named GP but with a 'micro team' to manage urgent issues. This approach allows for a combination of continuity with the GP and their small multidisciplinary team, developing significant personal relationships and trust, which in turn improves outcomes and experiences for clinicians and patients. However, there is also scope for services at scale, such as specialist clinics, urgent care and visiting.

### Patient triage has been streamlined

Middlewood's at-scale model has also streamlined patient triage by bringing in a single point of access for all patient queries. To further facilitate the process of accessing care, a GP is present in reception assisting with patient triage at all times. Every GP in the practice spends one session per week fulfilling this function. This system has reduced workload as patients are always directed to the correct staff member on first contact, and many issues are dealt with immediately without the need for a GP appointment. Signposting to alternative PCN and community services has also been achieved through this model.

## Merging practices did carry financial, legal, and practical challenges

One of the main challenges in setting up this model was the initial financial investment. The partners note that the merger incurred financial risk, as there were significant legal and accounting costs, and noted that the inflexibility of the current GMS contract made it extremely difficult to merge, despite this being to the benefit of patients.

## The merger resulted in increased financial stability, and flexibility for GPs

The resulting partnership, however, provides more financial stability than many small partnerships. There is now less risk to the partnership from greater flexibility for those GPs who may wish to change their mode of work. Furthermore, the model has enabled savings and efficiencies, meaning more ARRS and clinical staff could be hired, which in turn has helped reduce the workload of GPs.

## Example 5: Leveraging BI (Business Intelligence) at scale to improve patient care and reduce workload

### Herefordshire General Practice (previously Taurus Healthcare Ltd)

**Location:** Herefordshire

**Number of employees:** c.315

Number of patients: 190,000

**Type of area:** Large area, which includes areas with higher as well as lower levels of deprivation



HGP (Herefordshire General Practice) is a GP federation in Herefordshire, which works across the county to directly deliver clinical services and support GP practices and PCNs. It was founded in 2012 through a provider-led initiative.

Every practice is involved in developing strategy via all practice events, where each clinical director of a PCN sits as an executive director on the executive committee and main board. This gives clinical directors clear executive function on behalf of Herefordshire General Practice, even though its constituent practices are still individual businesses. HGP has also appointed specialist non-executive directors to sit on the main board, with HGP employing all PCN staff, including development and operational managers and ARRS ([Additional Roles Reimbursement Scheme](#)) roles.

The clinical services delivered by HGP include direct as well as out-of-hours services; the support it provides includes HR and BI (business intelligence) support. During the last few years, HGP has demonstrated the benefits of BI for general practice, which has helped make available valuable information from a practice perspective, such as ways to reduce demand, as well as manage appointment activity and capacity. This has helped practices understand shifts in workload, as well as patient needs (eg due to winter pressures).

As part of its BI support, and harnessing the support of ARRS staff, HGP has introduced a PHM (population health management) tool. This has aided the team in gathering and providing data centrally, with staff members able to focus on a specific disease area across HGP's wider population. By using GP data this way, the federation has a clearer picture of what the practices' populations look like and can target its services based on what its populations need, for example by offering social prescribing.

HGP was able to prove to its ICB (integrated care board)<sup>11</sup>, with the data collected and analysed by their data team, that an inappropriate workload shift was taking place from secondary care to primary care, especially around fit notes. There has now been an intervention at the hospital trust level to reduce this shift.

The importance of this type of information was amplified during the COVID-19 pandemic, as GPs needed data on who needed vaccines and on the health inequalities in the area. GPs also realised the value of dedicated business support, as their own dashboards did not have as much information and were not reactive enough.



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<sup>11</sup> ICBs (integrated care boards) are a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the ICS (integrated care systems) area. ICSs are partnerships of organisations that come together to plan and deliver joined-up health and care services and to improve the lives of people who live and work in their area.

## 3



## Group 3: Practices owned by employees

### Employee ownership allows GPs to share ownership with their staff

Employee-owned businesses distribute ownership among employees, offering them a share of the business's annual profits, and a say in how it is run. The best-known example of this model is the John Lewis Partnership, but it can also be applied outside the free market. Minehead Medical Centre is the first individual GP practice in the country to run an employee-owned trust.

### The current contract is not set up for employee ownership

Though our case study shows that employee ownership is possible within the current contract, it is not set up to facilitate this: the contract requires at least one partner to hold the contract. Though the partnership model should be supported and protected, increased flexibility within the contract for those who wish to limit liabilities may be desirable.

### Example 6: Sharing leadership in an employee ownership model

#### Minehead Medical Centre

**Location:** Somerset

**Number of GP partners:** 1 (on a legal basis, to legitimately permit holding a GMS contract)

**Number of salaried GPs:** 6, plus a GP registrar

**Practice list size:** 13,000

**Type of area:** Coastal town, on the edge of Exmoor Park (more deprived area)



Minehead Medical Centre runs an employee-owned trust, established in July 2022. In practice, employee ownership at Minehead means that every staff member is effectively treated as a shareholder – with one GP holding a share and the other shares held in a trust on behalf of the employees. Staff members elect representatives to a board which takes managerial and financial decisions on their behalf. This gives GPs and other staff a say in how the practice is run.

The practice shifted to this model because its number of partners was decreasing, which made the future of the practice uncertain. Dr Ford, who now serves as medical director, wanted to ensure the survival of the practice in an underserved area. He was also curious to discover if innovation around the model could draw more GPs to an area which traditionally struggles to recruit clinical and non-clinical staff to GP practices. Since this model was set up only last year, and is the first of its kind, we have no clear sense yet of its impact.

### The 'partnership bonus' is shared among staff

Profits are reinvested into the practice, but all staff members also share in what is traditionally seen as the 'partnership bonus'. It is hoped this will further assist with recruitment and retention of staff in a geographical area where recruitment is difficult, and where it is a significant challenge if even one staff member leaves.

## Through employee ownership, GPs can develop leadership skills without being partners

A key benefit of this model is that it gives staff the opportunity to develop leadership skills while sharing more widely the financial risks among a wider pool of people. Both clinical and non-clinical staff can take up leadership opportunities without having to personally invest in a traditional partnership.

GPs working at Minehead can take up leadership roles and manage clinical services, without having to engage with the business aspects, as decisions are taken by the board and professional managerial staff. The practice hopes that this flexibility may further help with the recruitment and retention of GPs as well as other staff.



ARAH TURTON

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## Group 4: Directly managed, NHS-owned practices

### Direct NHS management can benefit GPs

Direct management allows GP practices to transfer some of the financial and business responsibilities of running a practice to an outside organisation, such as a GP-led external organisation. In addition, it provides the opportunity to access some business functions which GP practices historically do not provide at a significant scale, such as HR. This can free up time for clinical work, reduce financial risk, and enhance patient services – while keeping services within the NHS.

### Direct NHS management is not currently supported

As our case study shows, it is currently difficult for practices to take up or provide direct management. The categories used within the current contract are not suitable for this model, and neither are existing pension arrangements. The contract also requires that GP premises remain partner-owned (or leased), meaning responsibility for premises cannot be outsourced when GPs wish to do so. The next contract should consider improved financial and system support for potential contract changes in areas where this may be desirable.

### Example 7: Freeing up time for clinical care through the use of a salaried model

#### Northumbria Primary Care

**Location:** North Tyneside

**Number of GP partners:** 0

**Number of salaried GPs:** 46 (across nine practices)

**Practice list size:** 60,000

**Type of area:** Mix of urban and rural, mix of deprived and comparatively wealthy areas



NPC (Northumbria Primary Care) is an at-scale, not-for-profit provider of primary care services across a large footprint, covering both urban and rural areas in North Tyneside – a coastal area with historic mining heritage – and Northumberland. The organisation was created in 2015, bringing together several similar-minded GP practices in a bid to improve their resilience and service quality while retaining the individual identity and team composition of every practice.

### The NPC model keeps general practice services not for profit and within the NHS

NPC is a not-for-profit provider. Profits are invested back into the business, which allows for increasing service provision or quality improvement. GP partners actively choose for their practices to join NPC, and as such GPs remain in control of their practices and the services they deliver, and remain active in the governance of the organisation. As part of their agreement with NPC, GP partners theoretically forgo their share of partnership profits but, in return, have their employment terms and conditions aligned to ensure their salary is commensurate with what they would otherwise receive as drawings.

## Financial and business responsibilities are transferred to a leadership team

Practices which are part of NPC transfer monetary and business operation responsibilities to the NPC leadership team, which provides support with business functions such as HR, finance, and communications. NPC operates with an entirely salaried GP workforce, consisting of 'salaried partners' who provide GMS and PMS services to their patients. By joining NPC, partners retain their GMS contract with NHS England but sub-contract the delivery to NPC.

## Leadership team support frees up time for clinical work, improving the working life of GPs

Direct management has several benefits. Once they have joined the partnership, practices can access NPC's various types of management support, which means GPs can predominantly focus on clinical care. GPs who are part of NPC have reported better work/life balance, significantly less stress, and greater enjoyment of their role as a GP. Because staff are better able to organise cover for sick and annual leave, staff report less stress overall, and that service provision is less likely to be cancelled or reduced due to unforeseen circumstances. These benefits aid with recruitment and retention.

## There were financial, legal, and bureaucratic costs involved

The establishment of NPC was not a smooth process. The financial, legal, and bureaucratic costs of setting up NPC have been considerable, as many of the solutions implemented by NPC had not been attempted outside of the independent contractor model of primary care before. For example, it uses pension arrangements and categories which are not suitable for the model adopted by NPC, and it requires that GP premises remain partner-owned – an aspect that GPs who wish to join this model are actively seeking to change. All this, while ensuring clinicians are protected by a robust subcontracting arrangement that focuses on service, delivery, and personal risk mitigation. This model serves as evidence that it can be easier to set up a privately held GP model than one held within the NHS, where ownership of premises is transferred to an NHS provider. Within the current contract, therefore, replicating NPC's model will be difficult.



## Group 5: Chronic disease-focused care

Chronic conditions comprise a significant portion of general practice demand

Long-term conditions or chronic diseases are conditions for which there are currently no cures – such as diabetes – and are managed over a lifetime with medication and other treatments. Patients with long-term conditions require significant support from the NHS, particularly in general practice, where they account for around half of all GP consultations.<sup>12</sup> As people get older, they accumulate more long-term condition complexity and require a greater need for long-term continuity of care.

Direct chronic condition management can lead to significant improvements for practices

Our case study demonstrates that an approach focusing on patients with chronic conditions can allow practices to improve workload and relieve pressures in the long term more effectively. Proactive chronic disease management can lead to reductions in acute demands on the practice, allowing GPs to focus on the quality of appointments and improve safe working in the practice. Implementing and sustaining a chronic condition-focused approach would be facilitated with improved support and funding in the face of worsening pressures.

### Example 8: Improving the quality of care with a focus on chronic disease management

#### Steel City General Practice

**Location:** Sheffield

**Number of GP partners:** 3

**Number of salaried GPs:** 4

**Number of patients:** 13,000

**Type of area:** Suburban, deprived, inner city, and student populations – fifth most deprived decile<sup>13</sup>

Steel City General Practice is a three-site practice operating in Sheffield. It brings together three practices that merged in the last 15 years, catering to a diverse range of demographics, from suburban to deprived inner city and student populations.

In recent years, the practice struggled with increasing workload pressures, which were worsened by the COVID pandemic. In the absence of additional support and funding to deal with increasing demand, these challenges led the practice to consider a new approach that focused on patients with long-term conditions, who make up two-thirds of the patient list. Limited capacity to focus on patients with long-term conditions compounded the acute demand and work burden on the practice. The practice expected that improvements in chronic disease management could lead to decreases in acute patient need and allow the practice to focus on the quality of appointments over quantity.



<sup>12</sup> Department of Health. (2012) *Long-term conditions compendium of Information*, <https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition>

<sup>13</sup> <https://fingertips.phe.org.uk/profile/general-practice/data#page/12/ati/7/are/C88037>

## The practice collected and analysed data to better understand trends in chronic disease conditions

Patients were grouped into cohorts (assessed through a simple questionnaire) and assigned to a specific GP. Identification of high-risk patients was prioritised, with an additional focus on patients with higher needs and higher levels of deprivation.

As part of improving the quality of care, every GP working in the surgery is committed to one quality improvement session per week involving non-patient-facing work. Each GP uses this time to identify a problem and propose how best to resolve it. The practice also dedicates time to exploring technological improvements, such as using SystemOne<sup>14</sup> functionality to develop automated protocols, enhance efficiencies in system protocols, and reduce time spent on administrative tasks.

## Management of long-term conditions allowed the practice to prioritise quality over quantity

Successful management of patients with chronic diseases led to a decrease in the day-to-day demand and the number of patients requiring urgent attention. Consequently, the practice has been able to ensure that all clinicians have a fixed number of appointments per day, with a minimum appointment length of 15 minutes, ensuring a patient's range of needs is addressed in as much detail as possible. Improved quality of care in appointments has yielded long-term benefits. For example, patients are less likely to become frequent returners thereby reducing demand on the practice. This, in turn, facilitates better care for patients with acute needs, which improves outcomes for the entire practice patient population.

As well as improvements in the quality of appointments and the practice's ability to manage demand, both in other clinical areas and same-day demand, the practice observed improvements in the areas below.

- **Patient satisfaction** – particularly with the quality of care received, where patients have more complex matters addressed and resolved.
- **Retention and recruitment of staff, including GP partners and salaried GPs** – since the implementation of the new approach, the practice has not lost a GP due to demand or lack of satisfaction. Previously, the practice could expect to lose GPs due to workload pressures. Staff express feeling rewarded and less burdened, as well as enjoying all aspects of their role. The practice has also experienced a smooth process when recruiting for roles within the practice.
- **The primary care and secondary care interface** – by making complex referrals, the practice has facilitated active collaboration between the practice and consultants, with a consultant chemical pathologist electing to run clinical sessions from within the practice itself.
- **Key GP practice metrics:**
  - 89% of appointments are face-to-face, compared to the national average of 65%.
  - 96% of practice activity is care-related, compared to the national average of 89%, with the practice noting a significant decrease in administrative workload.
  - significant efficiencies in prescribing
  - minimal use of emergency services.
- **Practice capability to conduct quality research** – the practice now has the capacity to conduct international research to further understand how other countries manage certain conditions, such as whether the practice can proactively incorporate new pharmaceutical developments.

<sup>14</sup> SystemOne is a clinical record system used to record patient care (health records) electronically

## There were major challenges with implementing this new way of working

Challenges the practice faced included limited time to conduct initial data collection and analysis, as well as the change management process of moving to a new way of working. Implementing a new way of working requires all staff to 'buy-in' to the philosophy and maintain resilience when faced with challenges, particularly early on. However, a gradual phased approach rather than an immediate change, and clear communication with patients, allowed for a smooth transition to the new way of working. This was further facilitated by having sustained continuity of care.

This new way of working of proactively managing patients with long-term conditions has been implemented in the absence of additional support and funding. However, additional funding would enhance its implementation, particularly at the start by allowing GPs and their teams to redesign processes and reduce difficulties in sustaining this approach in the long term and saving time and system resources in the process.

## Conclusion

The crisis in general practice has placed GPs under growing pressure due to soaring demand and workforce shortages. Despite these challenges, GP providers are pioneering innovative approaches to maintain high-quality care and retain staff. The case studies show the potential within the current model, illustrating how it can evolve and adapt to accommodate the increased flexibility the workforce requires and empower GPs to provide the services their patients need. The BMA is not promoting a single approach over another but rather demonstrating the potential of what can be achieved in the current model, particularly if providers are adequately supported. Enhanced support can further facilitate the exploration and implementation of innovative strategies that can shape a vision for the future of general practice.





# WHAT CAN WE LEARN FROM INNOVATIONS IN GENERAL PRACTICE?

**BMA**

British Medical Association, BMA House, Tavistock Square, London WC1H 9JP  
[bma.org.uk](http://bma.org.uk)

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