SHEFFIELD
LMC

RESPONSE TO THE GP PARTNERSHIP REVIEW INTERIM REPORT

We welcomed the opportunity for Sheffield GPs to meet Dr Nigel Watson on 22 October 2018 and, following the discussion, have formalised our responses.

We consider that the themes outlined correspond to the pressures felt in the primary care system in Sheffield. Whilst recognising there will be constraints in terms of what the GP Partnership Review can recommend, we do consider that recommendations could be strengthened.

Main concerns discussed:

1. <u>The role of GPs in the local healthcare system</u>

   The rhetoric from NHS England (NHSE) around Integrated Care Partnership contracts (formerly Multispecialty Community Providers and Accountable Care Organisations) is at odds with strengthening the GP partnership model, and the latter needs to be emphasised more. As there has been a lack of long-term investment levers to develop Primary Care Networks (PCNs), their development is slow and patchy. A lack of investment into back-fill to allow GPs to take on more management roles in PCNs and a lack of investment in GP management training (compare with Scottish Contract or ILM5 for practice managers) leads to slow progress.

   The aim to attract more allied professionals to support GPs is to be lauded, but District Nurse levels have halved in many areas. Across South Yorkshire there are 277 practice nurses over 55. The expansion of this workforce needs to be rapid, run by primary care organisations (not secondary care outreach) and driven by need identified by provider organisations.

   New initiatives should not transfer risk to practices, eg the Practice pharmacist scheme that gradually transfers financial risk to practices.

   Continuity of care for long term conditions reduces hospital admissions and is best delivered by small units.

2. <u>The Registered list</u>

   Preservation of the registered patient list, preserving the GP partnership as the prima facia model should be emphasised.

3. Reducing the risk on practices and partnerships

   The work on limited liability partnerships (LLPs) and other models is informative, but our discussion highlighted the fact that intense individual negotiations have to take place with NHSE to secure just one backstop agreement on last-man standing and leases to ensure a practice will survive. This intensity is unsustainable and needs to be formalised into a backstop policy. Lack of transparency with NHS Property Services (NHSPS) and Community Health Partnerships (CHP) contracts creates distrust in property ownership or leases and these are NHS owned organisations!

4. Attracting doctors into general practice

   The pressure on practices to have doors open 0800 hrs to 1830 hrs, plus extended hours, plus evening and weekend appointments, yet the training contract is based on a hospital training contract and does not reflect how general practice operates. The complexity of primary care now leads to doctors completing their schemes with a significant gulf to independent practice - hence your findings of GP trainee intentions 1 and 10 years post completion.

   This requires significant investment in mentorship by senior GPs to support all early years GPs in developing into our future workforce. The preceptorship model is useful but requires extension in time and to all GPs completing their training. This would attract more doctors into general practice and start to create a career structure that could also be developed to start including training hospital doctors in risk management, palliative care and all the things we do well!

5. Status and morale

   We are all aware of anecdotal evidence of negative comments by hospital doctors towards GPs and GP training. We need to collaborate more with Universities and Training schemes to stamp this out. Integrated Care Systems (ICSs) and Sustainability & Transformation Partnership (STPs) are dominated by secondary care with little or no buy-in to primary care issues. Parity with hospital doctors should not just be about General Medical Council (GMC) registration status, but should also pressurise Universities to recognise Honorary Teaching Contracts for GPs as well as Consultants. Practices training students should be recognised with an Honorary University status.

   The workforce and workload crises will deepen if General Practice is not seen as an attractive environment to work. The Scottish contract recognises many of these issues.

   This is before consideration is given to moving workload from secondary care to primary care. Suggestions locally have been to double fund activity in secondary care to "soften the impact" of loss of services. There would be no plan to invest in primary care to expand the ability to cope with this workload. These sorts of comments show what mentality primary care is up against!

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Chair