Delivering general practice with too few GPs

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With an increasing number of GPs leaving clinical practice or working part time, and many practices unable to fill vacant GP posts, hundreds of thousands of patients are being forced to re-register with another practice after their own practice has closed. Plans to increase GP numbers through pulling more graduates into GP training posts and recruiting internationally are making slow progress.

This briefing presents ideas on how general practice can continue to be provided as the shortage of GPs becomes chronic. It combines findings from a workshop with research evidence and specific examples of innovative practice around the country in order to identify generalisable lessons from current innovators and to outline the ways in which national and local policy can support new ways of delivering general practice.

Key messages

Keep it local. The design and delivery of new forms of general practice should take place at borough and network level so that services can be tailored to local contexts and the needs of practices and local populations.

- Avoid the imposition of detailed national 'blueprints' that dictate numbers of staff and types of services to be offered
- Support funding and policy that allows services to develop in response to evidence of local need

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- Tolerate variations in pace of change and in the ways services are delivered if this reflects local responses to population health needs.

Invest substantially in change. A significant proportion of the £4.5 billion committed to general practice and primary care by 2020/21 should be set aside and sustained over several years to invest in capital and running costs and staff development. Most important will be:

- training for clinicians in new clinical roles; for GPs to supervise and quality assure new clinical roles; for all practice and primary care network staff to understand new ways of working; and for multi-disciplinary teams working across organisational boundaries
- technology to support new, more efficient and more convenient forms of service delivery
- premises to be developed in order to accommodate new clinical staff and new services
- organisational development support for the introduction of a new workforce and new ways of working.

Without this investment, change will be at best slow and difficult to sustain – and at worst will fail.

Maintain realistic expectations about the pace of change that can be expected from a workforce that is already known to be under intense pressure and where time and resources are needed:

- to enable staff to learn new skills and develop new working relationships
- to develop trust in new ways of working so they become part of routine care
- to involve patients, carers and the public in designing new ways of working
- to involve patients and carers in developing communications about changes in GP services and how to make best use of them
- to increase staff and patient awareness of, and willingness to use, digital delivery of selected GP services.

Ensure that high quality data is generated, collected and analysed for all new initiatives being introduced to redesign general practice. This data can be used to monitor progress against stated objectives. However, new methodologies will also be needed to evaluate the broader effects of complex changes in service delivery that are constantly adapting in response to new professional roles and other factors.

Introduction

With an increasing number of GPs leaving clinical practice or working part time, and many practices unable to fill vacant GP posts (BMA, 2018a), hundreds of thousands of patients are being forced to re-register with another practice after their own practice has closed (Siddique, 2018). Plans to increase GP numbers through pulling more graduates into GP training posts and recruiting internationally are making slow progress (BMA, 2018b).

This briefing presents ideas on how general practice can continue to be provided as the shortage of GPs becomes chronic. It combines findings from a workshop with research evidence and specific examples of innovative practice around the country to identify generalisable lessons from current innovators and to outline the ways in which national and local policy can support new ways of delivering general practice.

The original workshop explored three themes:

- Changing our conceptualisation of general practice to better address the overall health and wellbeing of patients
- Developing a more diverse clinical workforce that works together in new and different ways
- Using technology innovatively.

The themes were selected because they are prominent in the current policy agenda; they have potential to create additional capacity in general practice without the need for additional GPs; and because current examples of innovative practice in each domain exist as a starting point for discussion about their potential for wider use.

The workshop aimed to describe opportunities created by recent policy in the above domains; to understand what is helping and what is hindering implementation; and to identify ways in which national and local policy can support change.

Workforce and policy context

After several years of increasing GP numbers (Dayan and others, 2014), recent figures reveal a 6% fall in the number of full-time equivalent (FTE) NHS GPs between 2015 and 2018, with 441 fewer in post in 2019 than the previous year (NHS Digital, 2019).

The 2015 New Deal for General Practice promised 5,000 new GPs by 2020 (Hunt, 2015), but progress here has been slow. The current estimated shortage of 2,500 FTE GPs is predicted to increase to 7,000 FTE GPs by 2024 (Beech and others, 2019). Campaigns to promote general practice among medical graduates (see, for example, the Royal College of General Practitioners (2019) 'Think GP' campaign) resulted in GP training places being filled in 2018 for the first time in several years (Rimmer, 2018). However, up to 8,500 retirement and pre-retirement GPs may leave the workforce in the next five years. This would counter the impact of improved recruitment, although new digital services that allow home working and flexible hours may encourage some GPs who are currently not practising to return to work (Ipsos Mori and others, 2019).

The 2016 GP Forward View (NHS England, 2016a) offered various solutions to the GP workforce shortage, including GP practices working together at scale to share services and staff; use of technology; introducing new clinical roles; and more effective team working. These changes had been occurring slowly until the publication of the NHS Long Term Plan in 2019 (NHS England, 2019a) and the accompanying GP contract framework (NHS England, 2019b) mandated the introduction of GP networks and the deployment of a range of digital technologies. Funding was also provided to employ shared clinical staff (such as pharmacists and social prescribers), so the scene has been set to deliver general practice in ways that allow for the shortage of GPs.

Preserving the core functions of general practice

Any initiatives to redesign services will need to maintain the broad clinical scope of general practice if it is to remain the foundation of the NHS, where the majority of clinical encounters take place. The work of general practice spans consultations for single problems; standardised tasks and procedures; coordination with other health and social care providers for complex ongoing

conditions; and the interpretation and management of undifferentiated and changing symptoms with a wide range of underlying causes (Reeves and Byng, 2017).

Evidence suggests that the ability of GPs as expert medical generalists to address a broad range of needs and to interpret them in the context of each patient's personal and social context can improve outcomes and reduce overall demand for care (Rosen, 2018). Approaches which seek to address the GP shortage by deconstructing general practice into its constituent functions (to be delivered by non-doctors or using technology) need to be mindful of the interplay between these functions. If the ongoing, trusting relationship that some patients still develop with their doctor is disrupted, there may be unintended consequences, such as delayed diagnoses; increased referrals; and increased use of services.

The workshop

Participants at the workshop included clinicians, managers, policy makers, educationalists and researchers who participated in the three themed small-group discussions in line with their personal interests. The groups considered the opportunities and barriers associated with wider implementation of existing innovative services. They also considered ways in which national or local policy could enable promising initiatives to be rolled out more widely.

A plenary discussion drew together the ideas from small groups to identify a set of recommendations to policy makers that would help to support general practice and enable it to transform in line with the Long Term Plan.

Theme 1: Re-conceptualising general practice to involve patients in decisions that affect their health and wellbeing

The model of general practice described by Professor Al Mulley (Managing Director at the Dartmouth Institute for Health Policy and Clinical Practice and Professor of Medicine at Dartmouth Medical School) is rooted in a different logic, design and skill mix to most current GP services in England. The model maintains a relentless focus on the combined physical, behavioural and social

factors that shape health and wellbeing, and seeks to personalise care by:

- Promoting healthy behaviours and preventing ill health
- Systematically applying patients' personal preferences and values to shape treatment choices
- Identifying and addressing the social factors – such as housing and financial pressures and work stresses – that affect health and increase demand for health care.

Taking account of these factors may help to reduce the waste and harm that occurs when patients are not supported to make treatment decisions that reflect their personal goals and preferences. This model focuses heavily on the social determinants of health and wellbeing, which are often neglected in clinical assessments. The approach creates an opportunity to avoid substitution of high-cost medical care for a social intervention that would better meet patient needs and preferences (e.g. replacing a handrail in a home, rather than replacing a hip). This has the potential to contribute to a return on the £4.5 billion invested in general practice and primary care (see 'What does the evidence say?' below).

Understanding the model

This 're-conceptualising' model described by Professor Mulley uses 'health coaches' to expand the clinical team's capacity to engage patients in clinical decisions and to assess the personal and social factors affecting their health and wellbeing. Coaches talk to patients before they see the GP, using motivational interviewing techniques to explore the underlying causes of physical symptoms and, where possible, to identify social, behavioural and environmental solutions that can address them more effectively than biomedical interventions.

Coaches are often recruited from outside health care, ideally from the same communities as patients and sharing many of their lived experiences. They draw in GPs to assess and respond to clinical aspects of the conversation and help to ensure that treatment decisions reflect patient preferences (such as replacing a handrail). They also link patients to other local services to address the wider issues affecting their health.

This model of primary care is being used in over 30 sites in the US by Iora

Health (Govindarajan and Ramamurti, 2018). It requires a fundamental redesign of general practice, since four to five health coaches are employed – at relatively low cost – for each GP and patients typically spend longer with their coach than with clinicians. The typical general practice 'workforce pyramid' (with more GPs than nurses and other clinical support staff) is inverted, fundamentally changing primary care staffing ratios.

If many transactional tasks can be delegated to coaches, GPs have more time with patients to develop an effective therapeutic relationship, working in collaboration with coaches to support patients to make important choices regarding their health and wellbeing. The model also makes rigorous use of data to identify patient needs, track patient experience and clinical outcomes and report on progress against agreed objectives for general practice.

What is already in place that may be generalisable?

This model has some shared characteristics with the introduction of social prescribers into general practice to identify social determinants of poor health and to help patients navigate to the appropriate alternative services. Funding for primary care network social prescribers through the GP contract framework (NHS England, 2019b) could be interpreted as putting the first building blocks of this model in place. Practices in Frome in Somerset (NHS England, 2016b) and Halton in Cheshire (Baird and others, 2018) are already demonstrating how GP practices can promote health and wellbeing through links with their local communities.

Patient and staff perspectives

Workshop participants had mixed views about this model: some welcomed it because coaches have the potential to engage people in their health, wellbeing and clinical care, as envisaged in the original Wanless Review (2004). Participants also felt that the 30,000–50,000 populations of primary care networks is the right scale for coaches to build links with the local community.

Others were concerned that the range of non-medical and social problems that health coaches address should be steered away from general practice rather than encouraged into a medical model. Participants also questioned the cost of this approach, arguing that GPs provide cost-effective care and introducing other types of practitioner may ultimately cost more. The model represents a significant departure from traditional doctor–patient interactions

in general practice and would require patients to accept fundamental changes in services, which they may or may not be willing to do.

What does the evidence say?

Research on the factors that shape health and wellbeing has been compiled into a **unified estimate which suggests** that around 30% of poor health can be attributed to social circumstances and physical environment, and more than an additional 35% to behaviour (**GoInvo**, 2017). There is evidence that motivational interviewing in the clinical setting can be effective for achieving sustained change in patient behaviour. Self-determination theory posits that such success is achieved when there is time to confer on patients a sense of autonomy, of competence, and of relatedness to the practitioner or clinical team (Vansteenkiste and Sheldon, 2006). There is also evidence that engaging patients in decisions about their health – in the way that well-trained health coaches do – can help them make choices that are consistent with their preferences while also reducing demand on the system (Stacey and others, 2017).

There has not been a methodologically rigorous evaluation of the Iora Health model, but estimates reported in the Harvard Business Review suggest it can save 15–20% of total health care costs, with 35–40% fewer admissions, high net promoter scores and low rates of patients leaving Iora, which suggests high patient satisfaction (Govindarajan and Ramamurti, 2018). Although direct comparison with the English health system is not possible, these figures suggest that reductions in overall costs and service use may be achievable.

Next steps

Workshop participants highlighted that this approach to re-thinking the delivery of general practice is not yet ready to be rolled out widely in England. Rather, there may be a local context in which to test out a broadening of the social prescriber role and significantly increasing the number of social prescribers per head of population. This approach is also consistent with an 'interpretive' dimension of general practice, in which people's health problems can be understood in the light of their wider health and social care context. The group highlighted the following issues for action by policy makers:

- Take a 'learn as you go' approach to testing this model of general practice,

sharing learning as it emerges and considering its implications for the future delivery of general practice. Evaluation of the model may require new methodological approaches, as these kinds of initiatives tend to be complex and adaptive evolving in response to the relationships that develop between team members and resources available in each local context. (Pype and others,2018),

- Allow local areas to modify the role of social prescribers in response to local contexts.

- Invest in the generation, extraction and synthesis of high quality data in order to monitor outcomes, costs, and patient and staff satisfaction.

- Training and development is required to ensure that emerging 'coaching roles' for social prescribers are integrated with other roles in the general practice team.

Theme 2: Delivering general practice with a different staff mix

By 2023/24, an additional £891 million per year will be invested in the workforce for general practice and primary care (NHS England, 2019c). The challenge will be to ensure that this substantial funding generates a workforce incorporating different clinical roles (such as pharmacists, physiotherapists and mental health workers) that can address population health needs; provide high quality care with high staff and patient satisfaction; support the delivery of primary care services; and deliver a good return on investment.

Workforce transformation has already begun. By March 2019, a 1.5% fall in the number of FTE practising GPs was offset by a 1.9% increase in the number of nurses and a 5.6% increase in the number of other direct patient care staff across England (NHS Digital, 2019b). This trend is consistent with recommendations in various policy papers (Beech and others, 2019; Primary Care Workforce Commission, 2015; NHS England, 2016a), which describe future services staffed by teams of medical and other clinical professionals supported by technology and working across groups of practices (see Figure 1).

Figure 1: Redesigning the general practice workforce to work across network

Traditional model

Future model
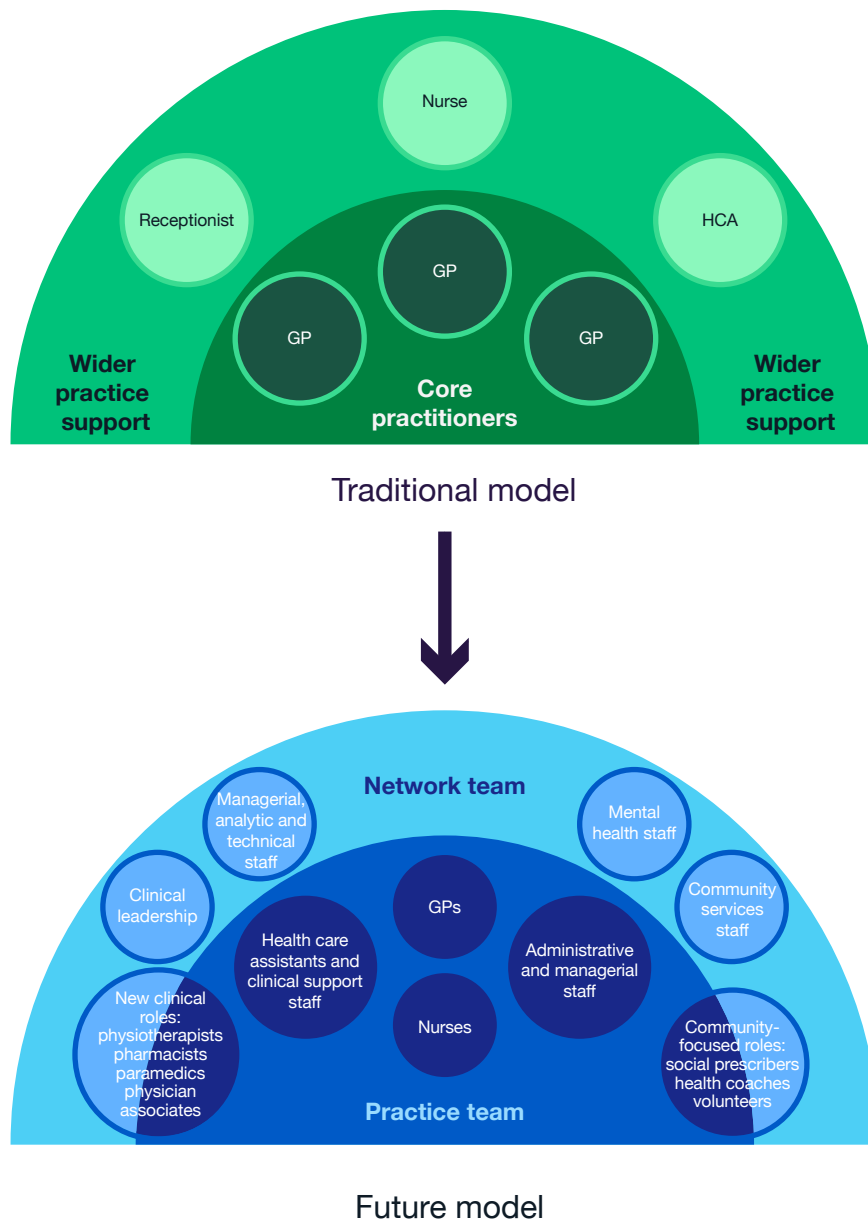
Source: Beech and others (2019)

Introducing the staff mix model, Dr Nav Chana (Clinical Director, National Association of Primary Care) acknowledged the potential for multi-professional teams to address population health needs and improve quality. This will blur the boundaries between the staff within general practice and wider services. GPs will need to work closely with a range of clinicians and with local community health and social care providers. This model focuses on team-based care, with teams designed around the needs of the population and

team composition based on the care functions and skills needed, rather than national or local formulae calculating staff numbers per head of population.

It was noted that high quality team work doesn't emerge 'out of nowhere'. Clinicians and other professionals will need new skills for which significant training resources will be needed. Furthermore, effective team working requires detailed design and development. GPs will need to develop a different understanding of their role; new relationships with a range of clinicians; skills in supervising other clinicians; and new ways of working.

The emphasis in this model is on inter-professional training and development, and practices working with other primary care providers for which systems and processes are needed to ensure the right patients are steered to the right person for their needs. The development of training hubs is an opportunity to create the right education and training environments to support inter-professional learning (Ahluwalia and others, 2013).

What does the evidence say?

There is some evidence that team-based approaches – linked to changes in practice, better use of technology and better and expanded use of non-medical staff – have the potential to offset the increase in demand for services while improving access to and quality of care (Green and others, 2013; Auerbach and others, 2013; Bodenheimer and Smith, 2013).

However, research to date suggests that moving towards team-based care is unlikely to save money and requires skilful implementation for the full benefits to be achieved (Nelson and others, 2018).

There are also valuable lessons from the past about how to create effective multi-professional team working. The policy to de-institutionalise patients in psychiatric care and to create community mental health teams demonstrates how the large-scale introduction of team-working can be successfully implemented – albeit over time and with significant investment in professional and team development (Gilbert and others, 2014).

What is already in place that may be generalisable?

Around the country, practices in areas with significant and ongoing GP shortages are already redesigning their general practice workforce to sustain

services. In Kent, a practice that cannot recruit any GPs uses a combination of nurses, pharmacists and physiotherapists to deliver day-to-day appointments. A GP (either a locum or a GP seconded from the local GP network) visits the practice for a few sessions a week to provide appointments and to support the other clinicians and oversee patients with complex needs.

In Yorkshire and Humber, a regional training programme is in place to develop new skills among nurses, pharmacists and health care assistants. The long-term vision is to alter current staffing ratios in which GPs are typically the largest professional group in a practice to one in which GPs form a smaller proportion of the practice workforce, and who spend part of their time supervising other clinicians as they deliver selected elements of clinical care.

The group noted that current workforce planning tends to be about staff numbers and how to address lower than expected numbers in different roles. There is less emphasis on understanding population health needs and the care functions and skills required to address these needs. Workforce planning needs to change so that it is informed by local needs assessment and given nuance by an understanding of local context, including the specific needs of local communities and population sub groups. Once these details are understood, identifying the care services and professional skills that are required to address them can form the basis of a local workforce plan.

Equally important to the successful transition from the current workforce to one fit for the future are resources for professional training and development to ensure the re-designed multi-professional teams work effectively together. Organisational development support for practice to introduce the operational processes needed to support new ways of working is also required.

The two other small groups in the workshop also touched on issues that will affect the future development of the primary care workforce. For example, the technology group noted that video consultations are being delivered by doctors working from home. This allows GPs with carer responsibilities to return to the workforce, Remote monitoring technologies are also releasing clinician time that is currently spent monitoring long-term conditions. Equally, the 'reconceptualising general practice' group heard that non-clinically trained health coaches can reduce the time a GP spends with a patient with complex health and social needs, freeing up time to consult with additional patients.

Patient and staff perspectives

The group noted that the move towards team working may be particularly difficult for GPs who are used to working independently rather than in collaboration with others. This requires both a short-term response in terms of supporting current GPs to re-think their roles, and also long-term initiatives with undergraduate training to embed these new working practices into everyday work.

The group also highlighted the importance of addressing the detail of workforce development at a local level in order to retain support and enthusiasm from staff – for example, offering flexible hours and family-friendly ways of working in order to draw people back into the workforce and retain current staff. An array of options for maximising recruitment, retention and returning to work, summarised in response to the New Deal for General Practice, provides a useful resource for this work going forward (Snow Miller, 2015).

Patients may be sceptical of staff without traditional professional identities and there is evidence that, while satisfaction may be high, patients may not always return to consult someone in an extended role (Banham and Connelly, 2002). However, there are examples that show that, with time and education, patients will accept new and extended roles, so long as they have trust in the clinician they see (Dyer and others, 2014).

Next steps

The group made two recommendations to national policy makers:

- Develop workforce planning processes that link local health needs assessment to analysis of the care functions and clinical skills required to address identified needs. This should be the foundation for the workforce strategies that integrated care systems develop.

- Invest in the capabilities and capacity of the local training hubs (formerly known as community provider education networks) to support primary care networks and their constituent practices. This is needed to transform professional understanding of clinical roles, the nature and value of teamwork within practice and between practices, and wider services and ways to work effectively together.

Theme 3: Technology

The priority attached to 'digital first' general practice in the 2019 GP contract makes the introduction of more technology inevitable. But it also raises questions about how to ensure technology provides benefits for both patients and staff given the shortage of GPs.

Sophie Castle-Clarke (Senior Fellow at the Nuffield Trust) described six broad groups of technologies that could have an impact in general practice and primary care, proposing that three might make the biggest contribution to delivering general practice with too few GPs:

- Online triage
- Remote consultations
- Remote monitoring and self-management support.

Participants at the workshop heard that there is mixed evidence about patient experience and impact on GP workload associated with these technologies. If carefully linked into a patient's medical record and targeted towards clinical conditions that can be resolved without face to face contact, it was argued that online triage and remote consultations could save time and increase patient convenience. However, if online triage technology is programmed to be clinically risk averse, there is also a greater risk of increased workload.

What does the evidence say?

Evidence on digital general practice remains limited, although a cluster of studies have evaluated e-prescribing (Cornford and others, 2014); e-triage (Semigran and others, 2015); e-consultations (Banks and others, 2018); telephone consulting (Newbould and others, 2017); the digital-first service provided by GP at Hand (Ipsos Mori, 2019) and other alternatives to face-to-face consultations (Atherton and others, 2018). Evidence about impact on workload is mixed, with evaluations of e-consultations and telephone consultations describing an average increase in workload for staff, although this tends to vary between practices.

Studies of e-mail contact with GPs across Europe, while several years old, show mixed results in terms of impact on workload, but Newhouse and others (2015) conclude that e-mail can increase overall virtual and physical

engagement among those with chronic and multimorbid conditions. The detailed evaluation of e-prescribing by Cornford and others highlights the length of time needed to change established working practice and embed new ways of technology-enabled working. Importantly, there has been very limited economic evaluation to date, so value for money associated with digital technology remains unproven.

Studies of patient satisfaction describe subgroups of patients who are highly satisfied with digitally enabled general practice. However, Atherton and others (2018) report that face-to-face encounters are still considered the gold standard by many, although patient and staff views vary. Some patients value the convenience and efficiency of non-face-to-face encounters, while others prefer to meet in person. Staff are generally selective in their decision about when to offer patients alternative forms of consultation.

What is already in place that may be generalisable?

Participants at the workshop discussed a range of current services around the country that demonstrate the three technology roles outlined above.

A growing number of practices are using different forms of digital triage to manage demand for appointments. Online 'symptom checkers' embedded in practice websites or apps are informing patients about possible diagnoses, options for self-management and can provide advice on which health professional to contact. Following on from self-management advice, digital triage systems using telephone and/or e-consultation are also increasingly common. These allow some 'administrative' problems (such as queries about hospital referrals) to be steered away from clinicians and managed by clerical staff, and enable clinicians to pre-assess patients' symptoms before contacting them.

One example of the potential for digital technology to support services in areas with recruitment problems is the Modality GP partnership in Hull, where patients in a group of practices with unfilled GPs posts can choose to have a video consultation with a doctor working outside the area.

Technology to support self-care and self-management also has the potential for common household voice detection technologies and technologies for home monitoring to monitor physical signs, medication compliance and

individual activity levels. It can also alert a family member or professional if a person departs from their normal routine. Apps providing information about specific conditions (such as 'My COPD') are also available to support patients living with the condition to monitor symptoms, manage medications, prevent clinical deterioration and more.

The group acknowledged that while online symptoms checkers and triage systems have the potential to avoid clinical contact completely, if programmed to be risk averse, they may recommend professional assessment for relatively problems that could be self-managed. Hence, they may drive more patients to seek professional help. They also vary in their accuracy (Semigran and others, 2015).

Patient and staff perspectives

Participants acknowledged a variable appetite for technology-supported consultations in general practice. They recognised that while a technology-hungry sub-group of predominantly younger people were very comfortable with digitally enabled health care, others have a variety of reasons why they want to have direct personal contact with a GP or other clinician.

Recognising these differences, participants stressed the importance of involving patients – and, where relevant, carers – in all aspects of designing the roles that technology will play in a practice. This needs to include how it should be implemented and how to communicate about it to patients who are reluctant to engage in order to change expectations of GP consultations.

Workshop participants who were clinical service providers also emphasised that some staff struggle to cope with technology and with change. They noted that staff did not always agree with the level of priority attached to introducing some technologies and were not always clear what benefits they would add. Given the competing demands of other high priority service development in general practice (such as forming networks, improving access and developing new staff roles), it is essential to identify and prioritise technologies that will add greatest value to patients, clinicians and practices in a given local context.

Introducing new digital services requires a fundamental change in clinical practice and in support roles (such as receptionists and health care assistants). Implementation must combine technical aspects with initiatives to change

staff understanding of their roles, their working practices and their ways of interacting with patients.

Next steps

The group identified four priorities for the introduction of technology to support service delivery with fewer GPs:

- Focus on technologies that can support patient triage and divert patients away from GPs if they have administrative needs that can be dealt with by clerical staff or clinical needs that can be effectively managed by other clinicians or through self-care

- Develop local processes to prioritise which technologies will provide greatest value to patients and to staff and phase their introduction to avoid overwhelming patients and staff with too much change at the same time

- Involve patients and a wide range of practice staff at every stage of work to develop and implement digital and other technologies, including which type of technologies to introduce, how they can best be implemented and how information about them should be communicated

- Invest significant resources in both capital and running costs for technologies to support general practice, and invest in the training and organisational development needed to ensure they are used by staff and patients once they have been introduced.

Implications for policy makers and implementers

There already exist numerous examples of ways in which to re-design general practice in response to a widespread shortage of GPs. Many practices are using digital technologies to triage and manage patients or to experiment with new clinical roles. Some places are going further, and re-thinking the balance between biomedical and social determinants of health, and building new links between GPs practices and the communities they serve.

One challenge for policy makers lies in preserving the breadth of purpose and activity that takes place in general practice, while innovating in the areas described above. It is essential that the impact of new ways of working is monitored and that the only approaches that become generalised are those that both improve outcomes and retain the medical generalist role,

Another challenge is lies in getting the right balance between pace of change, and recognition that time is needed to develop the necessary skills and trust in colleagues to work in new ways. The general practice workforce is already stretched and many are leaving. Many people struggle to cope with change in day-to-day routines, let alone wholesale technology-driven transformation and new professional roles. Support with change management and organisational development will be essential to enable change at pace.

A third challenge centres around place-based variations: a focus on localness may result in different services being available in different primary care networks across a single borough. This may not be a problem if additional funds are available to develop new services. But as networks start to adapt their services in response to local need, the resources needed to do this may be obtained by disinvesting from services with weaker evidence of local need. If so, then geographic variations will emerge with the risk of challenge from local residents.

Conclusion

Drawing on outputs from the workshop and wider research on the design and delivery of general practice, we have identified four ways in which policy makers can best support the changes that are required to sustain general practice with fewer GPs.

Keep it local

Allow the design and delivery of new forms of general practice to occur at borough or locality level so that services can be tailored to local contexts and the needs of local populations. Avoid the imposition of national 'blueprints'. Key elements of local design and delivery include:

- Local population needs assessment to identify what skills and functions are required to address local needs; what skills gaps exist in the local workforce; and how to develop staff skills and roles in order to address identified needs. This will

  i   support locally developed workforce plans and will allow training hubs to tailor their education and training support to address local needs

  ii support local priority setting to identify which technologies will add greatest value to patients and staff in a local context

  iii support involvement of local patients groups to shape service redesign

  iv support recruitment of a cadre of local workers from the same communities as registered patients.

Invest substantially in change

The NHS Long Term Plan promises £4.5 billion of additional funding to general practice by 2020/21. Much of this will be used to establish primary care networks, to part-fund additional clinical roles at GP network level and to invest in digital technologies – all of which is consistent with priorities identified during the workshop. However, funding must also be set aside and sustained over several years in order to

- invest substantially in training hubs – as a minimum by restoring the budget for workforce development to its 2014/15 level of £247 million, as

outlined in our recent report *Closing the gap* (Beech and others, 2019).

- invest in the capital and running costs associated with new technologies
- invest in premises development to ensure practices have space to accommodate new ways of working
- invest in organisational development support and the development of resources to help local organisations undertake the changes described in this report, while avoiding being prescriptive about how to implement change
- support 'test and learn' initiatives to try out new ways of working and modify them based on early experience.

Maintain realistic expectations about the pace of change that can be expected from a workforce that is already known to be under intense pressure

It will take time for staff to learn new skills and develop new working relationships and for patients to engage with new forms of service delivery.

- Linking the redesign of general practice pathways and workforce to local needs and priorities (see recommendation 1) must involve clinicians and patients. This will build engagement and increase the likelihood of effecting change but it requires time and resources that must be built into implementation of the Long Term Plan.

- Free up time for clinicians from different professional backgrounds to learn about each other's roles and acquire skills to work together in new ways. Time is also needed to enable staff to build trust in each other's work. This may require a period of reduced workload as staff test new relationships and ways of working.

- Create opportunities to engage patients and staff in designing communications to keep people aware of proposed changes, how they will affect the way services are delivered and how to make effective use of them.

- Recognise that implementing new technology in health care requires time to learn about and embed its use before the technology can be expected to deliver benefits.

Ensure that high quality data is generated, collected and analysed for all new initiatives that are introduced to redesign general practice

- Require that practice staff are trained to understand the importance of generating high quality data and the processes through which to do this.

- Recognise that the already hard-pressed general practice team is unlikely to have the necessary skills and resources to extract, synthesise and analyse data. This may mean investing in additional staff and/or resources to ensure that data can be generated and extracted.

- Support the development of new research methods to evaluate the impact of service changes.

Workshop participants

Participant	Job title and institution
Rena Amin	Pharmacy Lead/Associate Director, NHS Greenwich Clinical Commissioning Group
Dr Helen Atherton	Associate Professor in Primary Care, University of Warwick
Dr Manpreet Bains	General Practitioner, Imperial College Health Partners
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Paul Bate	Director of NHS Services, Babylon Health
Sophie Castle-Clarke	Senior Fellow in Health Policy and Digital Programme Lead, Nuffield Trust
Dr Nav Chana	Clinical Director, National Association of Primary Care
Mark Dayan	Policy Analyst and Head of Public Affairs, Nuffield Trust
Prof Hilary Diack	Head of Primary & Community Care Education, Health Education England
Tara Donnelly	Chief Executive Officer, Health Innovation Network
Prof Vari Drennan	Professor of Health Care and Policy Research, Kingston University & St George's, University of London
Nigel Edwards	Chief Executive, Nuffield Trust
Prof Nick Harding	Senior Medical Advisor, NHS England
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Stephanie Kumpunen	Senior Fellow in Health Policy, Nuffield Trust
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Ashley Moore	Deputy Head - Primary Care, System Transformation Group, NHS England

Participant	Job title and institution
Prof Al Mulley	Managing Director for Global Health Care Delivery Science, The Dartmouth Institute (United States)
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