East London Health & Care Partnership

Finance Report to the Inner North East London Joint Health and Overview Scrutiny Committee

April 19th 2017

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1. Introduction.

The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals, called sustainability and transformation plans (STPs), are place-based and built around the needs of the local population.

The NHS Five Year Forward View was published on 23 October 2014 and sets out a new shared vision for the future of the NHS based around the new models of care. It has been developed by the partner organisations that deliver and oversee health and care services including Care Quality Commission, Public Health England and NHS Improvement (previously Monitor and National Trust Development Authority).

Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

We want people in East London (EL) to live happy and healthy lives. To achieve this, we must make changes to how local people live, access care, and how care is delivered. During 2016, 20 organisations across EL have worked together to develop a sustainability and transformation plan (STP). This builds on our positive experiences of collaboration in EL but also protects and promotes autonomy for all of the organisations involved. Each organisation faces common challenges including a growing population, a rapid increase in demand for services and scarce resources. We all recognise that we must work together to address these challenges; this will give us the best opportunity to make our health economy sustainable by 2021 and beyond.

We have adopted a joint vision:

1. To measurably improve health and wellbeing outcomes for the people of EL and ensure sustainable health and social care services, built around the needs of local people.

2. To develop new models of care to achieve better outcomes for all, focused on prevention and out of hospital care.

3. To work in partnership to commission, contract and deliver services efficiently and safely.

EL is an area with significant health and wellbeing challenges. Our population is set to grow by 18% in the next fifteen years, and five out of our eight boroughs are in the lowest quintile for deprivation in the UK. Health inequalities are high, with many residents challenged by poor physical and mental health driven by factors such as smoking and childhood obesity. People frequently move around

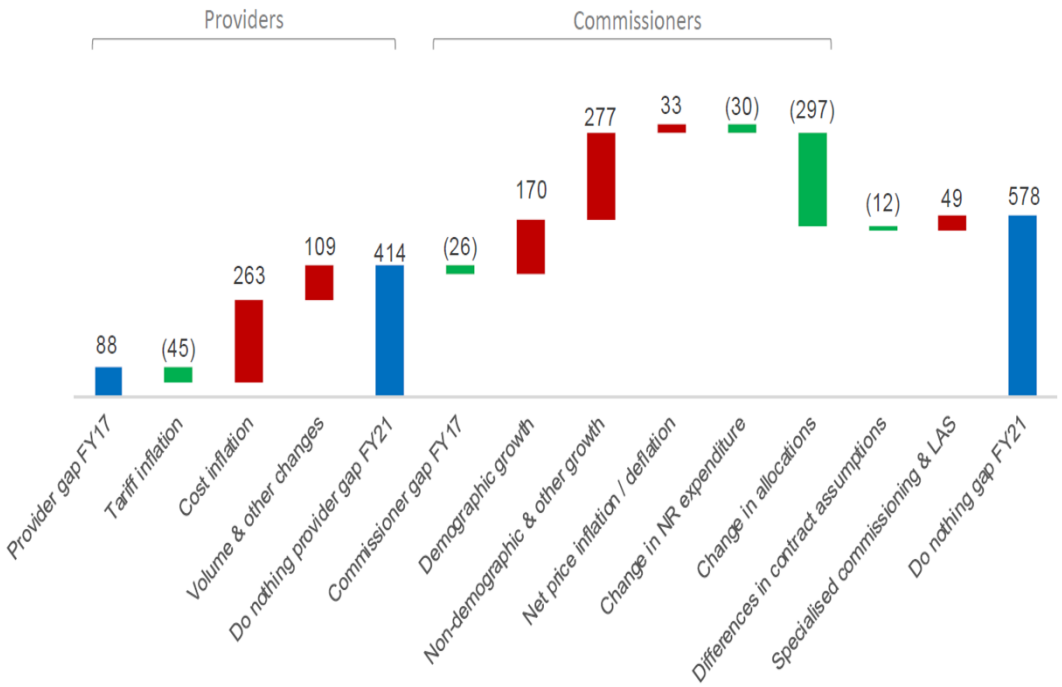
the patch and are highly dependent on secondary care. This makes our challenges unique and places significant pressure on local services.

2. Summary of the Financial Challenge

2.1 Do Nothing Scenario

The forecast EL provider deficit in FY16/17 is c£88m which will rise by £319m to £414m in FY20/21. EL CCGs are projecting a £26m surplus (including carried over surpluses from prior years) but CCG allocations uplifts of £297m are not sufficient to offset cost pressures over the planning period. Differences in contract assumptions net out to around £12m by FY21 overall and specialised commissioning and LAS add a £49m pressure, resulting in a total financial challenge of £578m in the 'do nothing' scenario to reach a break even position.

Achieving a 1% surplus target for commissioners increases the gap by another c£30m to around £610m.



2.2 Do Something Scenario

Our total financial challenge in a 'do nothing' scenario would be £578m by 2021. Achieving ambitious 'business as usual' cost improvements as we have done in the past would still leave us with a funding gap of £336m by 2021. Through the STP, we have identified a range of opportunities and interventions to help reduce the gap significantly.

This will be aided by Sustainability and Transformation Funding (STF) funding, specialised commissioning savings and potential support for excess Public Finance Initiative (PFI) costs. Significant work has started to evaluate the savings opportunities.

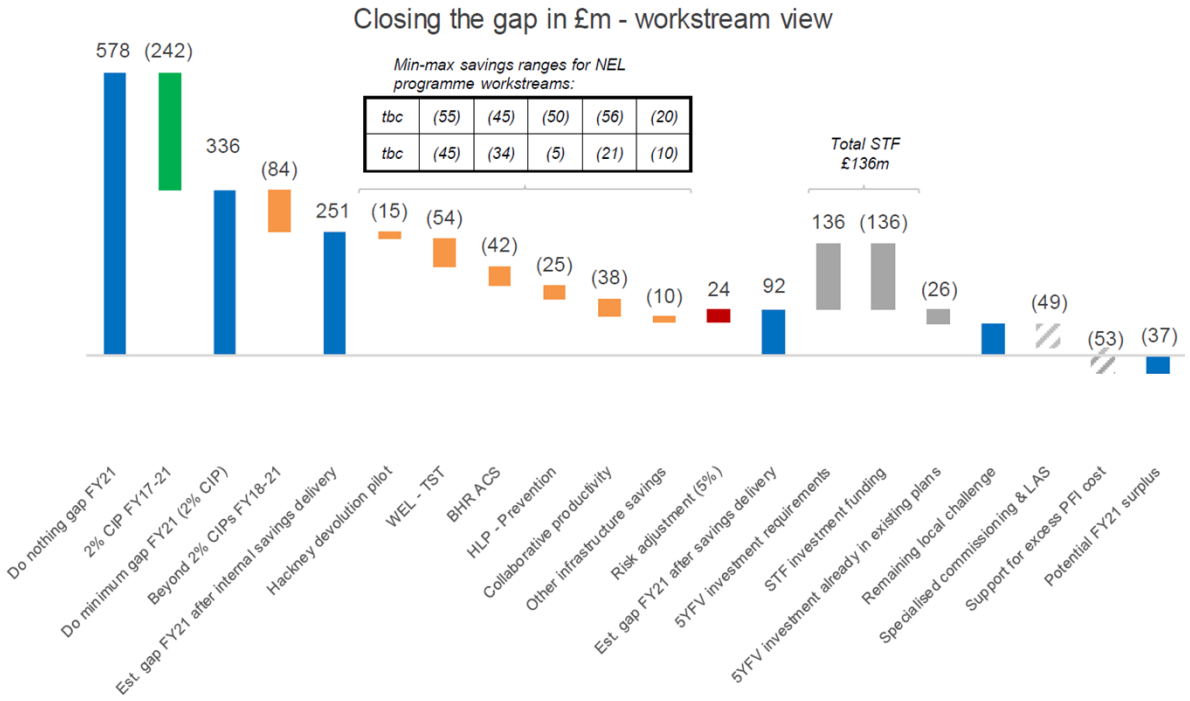
We have developed our governance structures to support the next stages of planning and implementation. Our robust governance structure allows individual organisations to share responsibility while balancing the need for autonomy, accountability and public and patient involvement.

The EL transformation journey has started. We are committed to meeting all NHS core standards and delivering progress in every priority. Together we will deliver a sustainable health and wellbeing economy across EL. It's a significant challenge, but one we welcome as it provides opportunities to make a real and lasting difference to the lives of local people.

Over the course of the last year, ELHCP STP has developed several work streams through which it has identified potential solutions to closing the financial gap.

3. STP Solutions

The ELHCP STP Work streams have been working closely with STP partners to develop solutions to close the gap. Some of those solutions are listed below.



3.1 2% CIP & Beyond 2% CIPs - £326m

Providers are normally expected to deliver business as usual savings of approximately 2%. This is in sync with the expected provider efficiencies within the current tariff guidance and assumptions made by other London STP's. Some providers have put forward CIP schemes over 2%.

3.2 WEL TST - £54m

Transforming Services Together sets out to improve and modernise healthcare services across three London boroughs – Newham, Tower Hamlets and Waltham Forest – addressing inequalities, helping patients take control of their own health and tackling the problems faced by health services across the area.

This area of east London has a growing and ageing population, with 270,000 more residents – the equivalent of a new borough or a city the size of Southampton – expected to arrive in the next 15 years.

TST seeks to avoid a projected deficit across the three boroughs in just over a decade. If no changes are made, 550 more hospital beds would be required, which is unaffordable and not the best way to provide services for local people.

Key TST schemes include but are not limited to:

- Expand integrated care to those at medium risk of hospital admission.
- Put in place a more integrated urgent care model.
- Improve end of life care, improving access, capacity and co-ordination in primary care.
- Establishing surgical hubs including interventional Radiology.
- Establishing acute care Hubs on each site.
- Increase proportion of natural births.
- Transform patient pathway and outpatients.
- Reduce unnecessary testing.
- Deliver shared care records across organisations.
- Explore the opportunity that physician associates may bring.
- Developing a strategy for future of mile end Hospital and Whips cross hospital.

3.3 BHR ACS - £42m

Accountable Care Organisations (ACO) are a new way of structuring health and social care services, which were referenced by NHS England chief executive Simon Stevens in his Five Year Forward View (5YFV).

The partners working together on the business case for an ACO in Barking and Dagenham, Redbridge and Havering are:

- The three local clinical commissioning groups (CCGs)

- Three local authorities – London boroughs of Havering, Redbridge and Barking and Dagenham.

- The acute hospital provider Barking, Havering and Redbridge University Hospitals NHS Trust

- The community and mental health provider NELFT NHS Foundation Trust. They are working together with UCL Partners, an academic and health partnership providing operational support and clinical leadership.

The primary aim is to improve the experience and quality of care for patients and service users by ensuring it is joined up and seamless, and leads to better health and wellbeing for our residents. However, it is clear that there is a major challenge in the coming years for health and social care to be financially sustainable. A key test for an accountable care organisation will be that it is more efficient, helping us tackle some of the financial challenges facing the NHS and local government and protecting the interest of patients and service users.

Key BHR ACO schemes include but are not limited to:

- Gastroenterology Virtual pathway
- MSK Service Re-design
- POLCE
- Dermatology service redesign
- KGH UCC
- Right Care
- Community Health Service re-design
- Acute provider productivity.

3.4 Healthy London Partnership (HLP) Prevention - £25m

HLP was born in March 2015 when London's NHS (32 Clinical Commissioning Groups (CCGs) and London Region of NHS England) agreed to come together using the recommendations set out in Better Health for London as a blueprint to meet the challenges set out in the Five Year Forward View.

A key strength of HLP is its partnership approach, including Public Health England, NHS England, London's 32 CCGs, London Councils and the Greater London Assembly, as well as members of the public and patient groups. We have come together to address the unique health challenges London faces and deliver this transformation.

Our aspiration is based on the belief that a truly great global city is a healthy city. The aim is to take London from seventh in the global healthy city rankings, to the number one spot. We want to make London a place that helps its residents to make healthier choices, improves the health of its most vulnerable, provides consistently excellent care for people when they need it most and enables its health service to prosper and flourish to the benefit of all its citizens.

3.5 Collaborative productivity - £38m

ELHCP STP expects to make significant productivity savings within its providers. Key areas expected to deliver these savings are:

- Bank and Agency spend
- Back office
- Procurement
- Theatre Productivity

3.6 Hackney Devolution - £15m

Hackney devolution is a shared vision of delivering an integrated, effective and financially sustainable system that covers the whole range of wellbeing-from public health initiatives for school children, timely and appropriate access to GP's and community pharmacists and top quality hospital treatment as well as supporting people to remain independent in their community for as long as possible.

Some of the expected benefits are**:**

- Giving parents easier access to immunisation for very young children by providing more community based services.
- Tackling Obesity through better co-ordinated services and greater local powers to create a healthy environment.
- Quicker progress towards parity of mental health and physical healthcare services.
- Providing tailored, more integrated support for people at the end of their life.

4. Conclusion

We have set out a bold plan for how we intend to work together as one system to deliver outstanding health and wellbeing services for all local people. We began by recognising the six key priorities that we needed to answer as a system. A summary of the actions we are going to take in response to each question is set out below:

1. **The right services in the right place: Matching demand with appropriate capacity in EL to meet the fundamental challenge of our rapidly growing, changing and diverse population we are committed to:**

- Shifting the way people using health services with a step up in prevention and self-care, equipping and empowering everyone, working across health and social care.

- Ensuring our urgent and emergency care system directs people to the right place first time, with integrated urgent care system, supported by proactive accessible primary, community and mental health care at its heart.

- Establishing effective ambulatory care on each hospital site and mental health community based crisis care, to ensure our beds are only for those who really need admission, so we don't need to build another hospital.

- Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, with integrated flows across community and social care.

- Addressing demand for acute and mental health inpatient services: streamlining outpatient pathways, introducing new technology, delivering better urgent and emergency care, coordinating planned care/surgery, maternity choice, improving psychosis pathways, and encouraging provider collaboration

- Ensuring our estates and workforce are aligned to support our population.

2. **Encourage self-care, offer care close to home and make sure secondary care is high quality We have a unique opportunity to bring alive our system-wide vision for better care and wellbeing. We are already working together on a system-wide clinical strategy:**

    - Transforming primary care and addressing areas of poor quality/access, this will include offering accessible support in localities and hubs from 8am to 8pm (seven days a week), with greater collaboration across practices to work to support localities, and address workforce challenges.

    - Investing in mental health, community, Learning Disability, & substance misuse services to improve quality and tackle health inequalities. Ensuring parity of esteem and good mental wellbeing, embedding this throughout all of our services.

- Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, maximising new technologies and pathway redesign.

3. **Secure the future of our health and social care providers, many of whom face challenging financial circumstances. They are committed to working together to achieve sustainability and changes to our EL service model will help to ensure fewer people either attend or are admitted to hospitals unnecessarily (and that those admitted can be treated and discharged more efficiently):**

    - We have significant cost improvement plans, which will be complimented by a strong collective focus on driving greater efficiency and productivity initiatives. This will happen both within and across our providers (for example procurement, clinical services, back office and bank/agency staff).

    - The providers are now evaluating options for formal collaboration to help support their shared ambitions.

    - ACS development (CH/BHR devo business cases Oct 31 2016) in development with LA and efficiencies being established.

4. **Improve specialised care, by working together we will continue to deliver and commission world class specialist services. Our fundamental challenge is demand, and associated costs, are growing beyond proposed funding allocations. We recognise that this must be addressed by:**

    - Working collaboratively with NHS E and other STP footprints, as patients regularly move outside of EL for specialised services.

    - Working across the whole patient pathway for our priority areas from prevention, diagnosis, treatment and follow up care – aiming to improve outcomes whilst delivering improved value for money.

5. **Create a system wide decision making model that enables placed based care and clearly involves key partner agencies**

    We are committed to establishing robust leadership arrangements, based on agreed principles that provide clarity and direction to the EL health and wellbeing system, and can drive through our plans.

This will be achieved through genuine partnership between the health system and Local Authorities to create a system which responds to our population's health and wellbeing needs.

6. **Using our infrastructure better**

We need to deliver care in modern, fit for purpose buildings and to meet the capacity challenges produced by a growing population. We are now working on a common estates strategy which will identify priorities for FY16/17 and beyond. This will contain a single EL plan for investment and disposals, utilisation and productivity and managing PFI, with a key principle of investing any proceeds from disposals in delivering the STP vision.

East London Health & Care Partnership

Appendix 1

Summary of Key TST Areas

Efficiency - progress

We recognise the efficiency targets are challenging as is managing the flow of people attending A&Es. However WEL CCGs have achieved the required efficiency savings in the last three years and are on track to deliver the 2015/16 target. New schemes in the TST programme (and others) will continue to ensure we achieve our targets. For instance:

Waltham Forest Integrated Care

Population based approach to systematic risk stratification involving community based intervention(s) for adults according to level of need e.g. planned case management; unplanned care rapid response and psychiatric liaison; GP national & local enhanced schemes; care coordination and self-management.

This has achieved an 18% reduction in unplanned hospital admissions in 2015/16 and £2million health savings which have been reinvested in other service.

Tower Hamlets urgent care

This scheme introduced streaming of people attending A&E and a tariff restructure to encourage urgent care centre (UCC) usage. This resulted in A&E attendances being reduced by c14, 000 and savings of c£3million.

East London Foundation Trust community rapid response

Aims to prevent avoidable emergency admissions and readmissions to hospital using short term intensive packages of clinical and social care and a presence in A&E/UCC. The Service works closely with all care homes in Newham through regular visits.

51% of referrals have prevented an admission to A&E.

Reducing unnecessary testing

Local discussions with clinicians (over 100 attended an event in October) agreed that c25% of pathology tests are unnecessary and 20% of primary care initiated MRI requests could be avoided (as per clinical guidance).

In the first two months, enabling and encouraging GPs not to request Gamma GT tests (which have no clinical value in the vast majority of cases) has saved around £54,000. The test is still available but guidance has been developed and circulated to GPs.

Anomalies in the budget spent on AST tests (£1000/year in Newham compared with £400,000 in Tower Hamlets) suggests that sharing good practice would result in significant savings.

These small changes suggest our target efficiency of £5 million a year is achievable.

Efficiency - Summary

In summary, the increasing demand driven by the existing population and increases in population and the need of that population, cannot be reasonably afforded if provided in the existing model of care and given the expected levels of resource allocation.

In order to continue with the current model of care and cope with this situation, demand would have to be curtailed requiring the rationing of key healthcare services or additional funding would have to be sought from central government. Neither of these options is reasonable or feasible and therefore efficiencies in the delivery of healthcare need to be found.

The acute providers will continue to look for internal cost improvement plans to improve their efficiency in delivering standard items of care, and thereby improve their financial viability.

Commissioners will look to more transformational measures to change the method by which some aspects of care are delivered to move towards more efficient methods.

The Transforming Services Together programme provides an opportunity to significantly improve care provided to our population and will provide a sizeable but not exhaustive proportion of the necessary transformational efficiency measures.

Workforce - Modelling

The current primary care workforce model was developed in June 2016 and addresses the issues highlighted in the TST Strategic Investment Case Part 3 (High Impact Changes Page 41). If we do not change our model of care:

- In Newham, Waltham Forest and Tower Hamlets we would require an additional 195 GPs (over current levels) within 10 years if we do not change the way we work and introduce new roles
- Whilst we have examples of good practice, around 40% of those responding to the GP National Patient Survey report they cannot see a GP of their choice and over 30% find it difficult to get through on the phone
- Up to half of practices in some areas are shut at lunchtime
- Patient experience of GP out-of-hours services is ranked one of the worst in England
- Less than a third of the capital's GPs believe they have received sufficient training to diagnose and manage dementia
- We don't have sufficient career development opportunities for GPs and nurses in training
- Some (particularly single-handed) practices are in premises unfit for modern practice
- We do not have sufficient multi-disciplinary teams
- Rising living costs are making living locally almost impossible
- Many outcome indicators (e.g. for cancer survival and support for people with long term conditions) are in the bottom 20% nationally.

Whilst this paper focuses on the model of care and activity in **GP surgeries** it should be noted that TST and other local schemes describe a range of other activities that are intended to support the GP surgery and wider primary care workforce including:

- the development of multi-disciplinary teams
- the development of proactive care which will identify people at risk and diagnose patients more quickly - reducing the burden of disease on both patients and the NHS

- support for helping people to lead healthier lifestyles, support to put patients in control of their own care and to self-care

- shared care records and interconnectivity between primary care and between primary and secondary care - reducing time spent in gaining health histories, reducing the need for repeat tests, enabling people to be treated more quickly and providing more opportunities to access the primary care system

- more opportunities for innovative ways of conducting appointments e.g. online, by telephone or by video - reducing the need for face-to-face services

- the development of federations of practices and hubs which will increase back office efficiency and be able to offer more services in one place

- cross-system recruitment and retention schemes into new and existing careers, to make east London a destination for a highly skilled workforce

- provision of key worker housing

- financial incentives for staff e.g. support with student loans

- flexible working options

- Improving career development opportunities.

Activity shifts and workforce numbers in GP practices

In order to meet the demand within GP practices and the expected reduction in available GPs we will need to shift activity from GPs to other, more appropriate and more efficient roles.

PRIMARY CARE DEMAND							
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Baseline Activity (incl growth)	4,641,745	4,732,256	4,817,936	4,914,155	5,020,515	5,126,353	5,230,997
Shift to Pharm/Com	0.00%	2.96%	4.00%	5.00%	6.00%	8.00%	9.00%
Shift to Self Care	0.00%	1.85%	2.96%	4.07%	5.60%	6.70%	7.41%
TST Shift to 1ry Care	0	0	9,331	53,174	63,507	74,046	84,793
1ry Care Workforce		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Activty % to GPs	80.0%	79.5%	74.0%	72.0%	64.8%	61.7%	59.4%
Activty % to nurses	20.0%	20.0%	24.0%	24.0%	26.0%	26.0%	26.0%
Activty % to PAs	0.0%	0.0%	0.0%	0.0%	3.2%	4.3%	5.6%
Activty % to Pharm	0.0%	0.5%	2.0%	4.0%	6.0%	8.0%	9.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL Activity		4,732,256	4,827,268	4,967,329	5,084,023	5,200,399	5,315,790

Table 1: Activity Shifts within (and from) GP practices. June 2016-2021
*Pharm/com is activity shifting to pharmacists in the community and other community-based staff.

The model describes a shift of activity to Physician Associates (PAs) and Pharmacy and Community Workers where (in 2021) GP activity is reduced by 20.1%. This reduction is made up by an increase in activity taken on by nursing of 6%, Physician Associates 5.6%, and Pharmacy of 9%.

The model integrates the activity described above with the number of staff required:

- Using a baseline for activity within GP practices as 80% for GPs and 20% for Nurses (including administration and clinical duties).
- using efficiencies based on local statistics and tested locally with clinicians including a 26% reduction in 'Did Not Attend' (DNA) rates (which waste GPs time) over five years – to be tackled by quality improvement initiatives such as text reminders, more proactive care and better management of the issue
- building in an increase in the number of 'longer appointments'
- using data from focus groups that has shown that around 30% of the GP workload can be transferred to other health and social care professionals (e.g. treating coughs and colds)
- Using national data that indicates that around 11% of a GP's time is spent on administrative tasks such as filling in data returns.

The data shows that an additional 81 clinical staff and 23 administrative staff would need to be in place in GP surgeries to meet the activity shifts set out in Table 1. We are already building the supply for physician associates and pharmacists to meet this challenge.

Staff Required - Post TST productivity/efficiency savings							
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**Change from 2015-16**
GP	601	559	532	477	454	445	-156
Nurse	158	206	211	214	207	220	+62
PA	0	0	0	24	33	44	+44
Pharmacist	4	16	33	49	65	73	+69
Locum	0	0	0	0	0	0	0
Admin	133	134	135	137	137	138	+5
Community	25	35	45	55	75	87	+62
Senior Admin	0	4	7	11	14	18	+18
TOTAL	921	954	964	967	986	1025	+104

Table 2: GP Surgery Workforce Modelling June 2016-2021 based on activity shifts in Table 1 and efficiency savings

*Due to different data extractions, 'Community' currently includes healthcare navigators, medical assistants, physician associates etc. but in later years physician associates have their own line.

Healthy London Partnership (HLP) Modelling

We have been working with Healthy London Partnership (HLP) across Waltham Forest, Newham and Tower Hamlets and had two initial workshops in October 2016 to build on the existing workforce modelling.

This process builds on national data and, working with local clinicians, we will model current efficiencies and those being proposed; and then look at how these ways of working can be used to introduce new roles or reassign roles to reduce workforce gaps. Initial efficiencies include the use of telephone appointments and benefits in practices that have multi-disciplinary professionals.

The initial modelling from HLP with a 'do nothing' plan shows a consistent picture with the TST modelling. By 2021 if we do nothing we will have a shortage of 122 GPs. Assumptions made are that 15% of GPs over 55 will retire by 2021, (29% of GPs are aged 55 and over), a population increase in WEL of 76,000 to 2021 (8%) and that we recruit available GPs in line with current London levels.

Analysis shows a gap in the nursing workforce required if we do nothing and this gap is likely to increase as in Waltham Forest 52% of the workforce is over 55 and in Newham 43% of the workforce is over 55.

HLP has highlighted significant differences in baseline numbers of staff across the TST footprint. Tower Hamlets has a lower than the national average of patients per GP and nurse, but Waltham Forest and Newham have higher numbers of patients per GP and nurse.

Training posts and careers

Work is ongoing to map and review training posts and pilot posts to see where training takes place. The data suggests that to deliver a sustainable model we will need to encourage mid-size and smaller practices to provide training as well as large practices to build sufficient capacity and a system to train the workforce of the future.

We are working with colleges to encourage careers in health and build pathways into new roles. We are developing a careers and jobs portal to signpost job seekers to posts and career pathways available in the CCGs.

Workforce - progress

Physician associate at Allum Medical Centre

Allum Medical Centre in Waltham Forest has used a physician associate as part of a range of innovative changes to the way practice staff are working. By sharing the workload the practice can see more patients. The physician associate sees more than 100 patients a week so the patient list size has increased by more than 1,000 without the need to employ more GPs. The practice offers up to 120 same-day appointments each day.

Physician associates programme

The business case was developed in January 2016 to move this project forward and a steering group and a clinical lead appointed. A new curriculum for a physician associate (PA) role in primary care has been developed (other PA roles have been successfully based in secondary care).

- Recruitment is taking place in November 2016 with students starting the two year course in January 2017.

- The CCGs have agreed a matched funded sponsorship arrangement for the first cohort of 24 students for second year fees on successful completion of year 1.

- An engagement event with GPs across TST in September 2016 to discuss the placement and training requirement for physician associates resulted in all 24 placements being filled with an even split across the three boroughs.

- In conjunction with GP practices we are developing posts for successful candidates.

In addition we are looking at developing alternative methods of training to give future cohorts different options to undertake training. Twenty GPs in the TST footprint have signed up as prospective employers to start development of a higher level apprentice standard for physician associates. We will explore different funding streams from Health Education England and providers as this system develops from April 2017 which could allow us to have a flexible employment and training model to sustain the role, and multi- disciplinary teams in primary care across TST.

Pharmacists in GP practices

We have a three year pilot funded by Health Education England (HEE) of 13 pharmacists in Newham GP practices. Further funding has been made available from the GP Five Year Forward View to increase numbers for April 2017. Feedback from practices in the pilot is that this role allows GPs to increase clinical time.

We have two events in November to promote new ways of working and for community pharmacists to shape working practices and roles in GP practices and primary care.

We will be introducing a rotation scheme for pre-registration pharmacists into primary care and GP practices, and an agreed discharge pilot scheme for pharmacy to support patients with respiratory, diabetes and cardiovascular problems. Both schemes are scheduled to start in April 2017 and will see pharmacists working with patients from secondary to primary care.

Practice nurses and support within GP surgeries

We have 26 GP practice nurses in training posts in Newham, Tower Hamlets and Waltham Forest. The Community Education Provider Networks (CEPN) are co-ordinating work to retain nursing staff in the area from this cohort. Recruitment for the January 2017 intake is ongoing through the CEPNs for similar numbers of nursing staff.

There are two other initiatives to build the nursing multi-disciplinary workforce:

- A nursing pilot for rotational nursing posts between acute and primary care will be recruited to – for commencement in January 2017.

- North East London Foundation Trust (NELFT) has just been selected as a pilot site for new nursing associate roles. These posts will start in early 2017 and be based in secondary care (at NELFT), with placements in primary care to be developed.

Workforce - Summary

In order to meet the shortfall of supply of GPs in EL, (high retirement rates and a shortage of available new GPs) and to develop a more efficient, patient-centred service, we will need to develop and increase the numbers of practice nurses, physician associates and pharmacists to provide a full multi-disciplinary team (MDT) workforce model. We are currently on target to deliver physician associate training placements in 2017 and a workforce supply in 2019. We have a pharmacist pilot programme in Newham GP practices and will look to expand this across TST in 2017-18.

This, combined with ensuring that we continue to develop and deliver portfolio careers and flexible employment options for GPs, will allow us to develop our multidisciplinary teams in GP practices.