Saul Miller

And then there was one

Retirement is a question that dangles lower in the mind. The closer it gets, the more not grasping it requires reasons to continue. Sadly, COVID-19 finally caused enough difficulty for my partner that those reasons proved insufficient. After years of partnered bliss, I found myself facing becoming single-handed as the second lockdown loomed.

What followed could hardly be described as supportive. A practice rated as good by CQC in March, with a 100% positive rating from patients in the government's own survey published in July, had approval withheld for the change of contract. The CCG committee involved does not publish minutes, but I am led to understand there was a risk concern based purely on the reduction to a headcount of one principal. When challenged, the purported risk assessment really appeared that basic. Other practices, such as those run by married partnerships, large practices with only two partners, practices with questionable performance data, all seemingly avoid such questions about risk.

There is history here. In 2000, hot on the heels of the conviction of Harold Shipman in January, the government published a paper in which it promised *'a big extension of quality-based contracts for GPs in general, and for single-handed practices in particular.'*[1] A 2006 *BJGP* paper noted the 2004 Fifth Report of the Shipman Inquiry had acknowledged that a review of the literature over the previous 10 years found no definitive evidence that the clinical performance of single-handed GPs was inferior to that of their colleagues in group practice.[2] The same paper highlighted that there was no association between practice size and quality of care. The lack of evidence did not matter: a 2013 survey found that the number of single-handed GP partners nearly halved in the decade from 2002 (9.1% to 5.5%), the number of single-handed practices collapsing from 25.8% to 11.4%.[3] In 2016, the head of the CQC asserted that the days of single-handed GPs *'are over'*[4] on the basis that larger practices and federations achieve its highest ratings.[5] It appears overlooked by him that this simply undermines CQC's claims to objectivity. In 2018, in a powerful piece of personal testimony, an author accused the NHS not only of a lack of objectivity but of widespread racism.[6] The account is such that it is hard not to conclude racism was so endemic it was institutional. He describes that his generation of immigrant doctors were often pushed towards *'single handed practices in deprived areas'*. Perhaps Shipman was not the only reason single-handed practice itself became a target? As context, last year the number of whole-time equivalent GPs fell further, particularly in England and Wales.[7]

A mixture of factors underlies this: more leaving than arriving, a rising population, and a continued fall in the average number of hours worked per GP. Managing the consequences is not easy. Practice mergers present organisational risks that those in the NHS whose income is independent of the consequences of their decisions may not fully grasp. For my surgery, at present, its safest future is this way: nurturing a salaried ex-trainee towards partnership when she is ready.

The government's recently launched consultation on integrating care in the era after the abandonment of the internal market in the NHS puts the emphasis on Primary Care Networks as the functional units of primary and community care.[8] There is scope here finally to end the period of hostilities towards single-handed practices. Place-based care is what smaller practices are most expert in and why we are so often rated so highly by our patients. The super-practice industrial model may have its place but has proven no panacea. In the end, the biggest risk to primary care everywhere is any reason that causes retirement to dangle lower in the mind of all those for whom it is a choice. As 2021 dawns, there are already enough of those.

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