Royal College of General Practitioners

GP Partnership Principles

May 2025

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Executive summary

The Royal College of General Practitioners (RCGP) has long supported *"a mixed economy of contractual models for delivering general practice, while recognising the benefits and importance of the independent contractor model"*.[i]

This is based on an understanding that there are many inherent virtues of the independent contractor model, including strengthening the patient advocacy role of GPs and safeguarding practice stability, which contribute to continuity of care. It is therefore vital that the independent contractor status is maintained and that, where necessary, the partnership model is supported to evolve in order to ensure it remains a viable option of general practice service delivery in the future.

At the same time, the RCGP recognises the need to develop new ways of working in order to ensure general practice can continue to deliver high quality patient care and is put back on a sustainable footing. Many RCGP members have been involved in the development and implementation of new models of care over a number of years and this is valued and supported.

We are now at a point where we are seeing a declining number of GP partners, with an increasing number of newly qualified GPs not wishing to enter into the traditional partnership model, due to concerns about financial risk and overburdening bureaucracy associated with running a practice. This poses a real possibility of an environment in which there are too few GP partners available to support a partnership approach to delivering general practice.

A number of alternative ways of approaching the GP partnership model have been developed in some parts of the country to support the resilience and adaptability of general practice, while still retaining and building on the strengths of traditional partnership. This paper proposes some of the key principles that the RCGP believes are needed in considering these variations on the theme of partnership, and explores potential strengths and limitations of various structures, in relation to these principles. It is provided to raise awareness of these new approaches to partnership, for our members and stakeholders. The RCGP remains committed to working with governments, the BMA, and system partners to identify and support sustainable, high-quality models of general practice fit for the future. The BMA, as the medical union, is the key organisation that will be involved in contractual negotiations with the government. We must safeguard our relationships with our patients, who see their 'practice' as the place they trust with their health.

[i] This position was agreed via a motion brought to RCGP UK Council in November 2013 and reaffirmed in June 2017.

Core functions of general practice

The RCGP defines a GP as "a doctor who is a consultant in general practice. GPs have distinct expertise and experience in providing whole person medical care whilst managing the complexity, uncertainty and risk associated with the continuous care they provide. GPs work at the heart of their communities, striving to provide comprehensive and equitable care for everyone, taking into account their health care needs, stage of life and background. GPs work in, connect with and lead multidisciplinary teams that care for people and their families, respecting the context in which they live, aiming to ensure all of their physical and mental health needs are met."

It is a fundamental principle that general practice delivers a comprehensive offer of care, with patients universally able to access their family doctor and GP team for a full range of urgent and non-urgent issues, from cradle to grave. The RCGP would expect to see general practice delivering:

- Continuity of care
- Same day and routine care appointments
- Core long-term conditions management and pro-active care
- Vaccination and immunisation for vulnerable patients and those with long-term conditions
- Palliative care

As consideration is given to new and innovative ways to deliver primary healthcare, and to enable care to be delivered closer to home, it is critical that the core functions above are protected and promoted and that the inherent virtues of independent contractor status are retained. New ways of working will have inevitable implications for the way the GP partnership model is approached, and these should be explored with the importance of universal access to general practice in mind.

Background on the partnership model

The RCGP position on the partnership model is outlined in the executive summary. Lord Darzi's 2024 *Independent investigation of the NHS in England* noted that "[a]s independent businesses, General Practices have the best financial discipline in the health service family as they cannot run up large deficits in the belief that they will be bailed out."[1] This strong financial management and the associated cost-effectiveness the GP partnership model can offer, as well as its ability to deliver "local innovations that [improve] access and quality of care, while also relieving pressures on acute hospitals" must be recognised and protected.

However, the landscape of general practice has evolved significantly over the past decade. At this point of significant change and flux within the healthcare system, the RCGP is keen to engage in discussions about the future of general practice and the partnership model in order to deliver the highest possible standard of care to our patients. The Nuffield Trusts' recent paper *'The partnership model in general practice predates the NHS. Is now the time to change it?'* highlights some important risks to patient care if action is not taken to future-proof the contractual delivery models for general practice.[2]

The number of GP partners in England has dropped by 25%, from 24,491 in 2015 to 18,367 in 2025. Meanwhile, the number of salaried GPs in England has risen by 81%, now representing 48% of the workforce. This shift reflects a broader trend, with fewer trainees and early-career GPs pursuing partnership. Since 2015, the number of GP partners has declined amongst all age groups except 60-65, with a stark 72.9% reduction amongst 30-34 year olds.[3] This decline is driven by a range of complex factors, including workload and bureaucratic pressures associated with running a partnership, which not only dissuade new partners but can contribute to a cycle of rising workload for those who remain. Additional barriers include exposure to unlimited personal liability under traditional partnership arrangements, and in some cases, limited opportunities to enter a partnership due to existing arrangements.

While societal attitudes towards work–life balance are also changing, the partnership model has the potential to offer the flexibility many younger GPs are seeking, if key pressures such as workload and liability are addressed. These are areas where targeted action from governments and system partners could make a meaningful difference. In 2024, 55% of RCGP members said that reduced financial risk would make becoming a GP Partner more attractive.[4]

As general practice adapts and responds to modern workforce expectations, evolving community health needs, and wider system transformation, there is a clear need and opportunity to strengthen and protect sustainable and high-quality general practice at the core of the NHS. This will require considering a range of measures to improve the appeal and accessibility of GP partnership, particularly limiting individual risk and targeted support for early-career GPs.

GP Partnership Review

In 2018, the UK Government commissioned a GP Partnership Review which sought to identify how to reinvigorate the model in light of emerging challenges.[5] Whilst some of the review's recommendations were implemented – such as to proceed with putting in place a state-backed indemnity scheme – many of the recommendations have not been taken forwards:

- One of the review's England-specific recommendations was to consider enabling GP partnerships to hold GMS or PMS contracts under alternative legal structures, such as Limited Liability Partnerships (LLPs) or Community Interest Companies

(CICs). This would require changes to primary legislation to allow these models to hold core NHS contracts and to ensure continued access to the NHS pension scheme.

- Another key outstanding recommendation from the Partnership Review is to mitigate the personal risk and liability associated with being a lease holder or property owner. One idea recommended and outlined by the review was the introduction of a more comprehensive assignment clause, which could allow the NHS to continue paying lease costs in agreed circumstances, to try to help reduce concerns about the implications of being the 'last partner standing' and having to shut down the practice yet continue paying rent. The review also recommended that NHS England and GPC provide more support and guidance for partnerships on how to separate property ownership from other aspects of the partnership model, but little progress has been made in this area.

Principles to strengthen the GP partnership model

We have identified four principles for how the core functions of general practice and the strengths of the independent contractor model can be protected and promoted while considering any alternative approaches that might make GP partnership more appealing and accessible:

1. The strengths of the traditional partnership model, building upon those identified by the Partnership Review, should be retained as far as possible:

   - Practices should retain relative autonomy, with an agreed budget, in decisions relating to the organisation and delivery of patient care, with the ability to act as powerful independent advocates for patients, and the flexibility to innovate:
     This enables GPs to act as strong advocates for their patients, tailor services to local needs, and innovate in response to change. The partnership model, typically a small to medium-sized business model, supports responsive and agile decision-making rooted in deep community knowledge – bolstered by registered patient lists and strong GP–patient relationships.
   - Patients should remain connected to and have a personal relationship with their neighbourhood GP practice, with at-scale working being 'behind the scenes':
     Consideration must be given to which activities are best delivered at what level of scale with the benefits of small-scale neighbourhood services, rooted in their communities, delivering continuity of care retained, while scaled-up back-office functions may offer efficiency where this works for local services and populations.
   - Practices should be physically connected with and accountable to a community:
     General practices are most effective when embedded within the communities they serve. The current partnership model also allows for and promotes collective responsibility and decision making in the context of a local community, and this should continue. A physical presence in the community,

proximity to patients, and shared local accountability are essential to trust and accessibility.

- The ability of practices to provide value for money to the system should be safeguarded:

  It is widely acknowledged, including by the Darzi report, that general practice is financially efficient and the benefits of the partnership model of business ownership means general practice does not enter deficits.[6] Similarly, general practice offers value to patients and the wider healthcare system through preventive efforts, managing undifferentiated presentations, and holding of risk to help limit referrals and pressures on other parts of the system.

- Practices should continue to be supported to deliver continuity of care:

  The benefits of continuity of care for patients, practitioners and the wider healthcare system are well evidenced and understood - continuity for as much of the patient population as possible, and particularly for those groups where evidence shows the greatest benefits, must be protected and prioritised in general practice. The best approaches to delivering continuity will vary according to local needs and makeup of patients and staff, but a common theme where this works well is enabling small practice teams to take care of a defined list of patients in their locality.

2. Existing different ways of approaching the partnership model need to be evaluated. Alternative approaches could be considered through key lenses, including:
   - Operational delivery
   - Workforce and workload balance
   - Effect on health inequalities
   - Cost-effectiveness and evaluation across the short, medium, and long-term
   - Existing networks or integrated system delivery programmes
   - Connection with and understanding of local communities and responsiveness to their needs
   - Acceptability to GPs working in these models and likelihood that they will encourage GPs to work in them.

3. To ensure a long-term, viable and satisfying career path for GPs, minimising the current challenges and barriers discouraging GPs from taking on partnership as it stands should be a priority. Key challenges with the traditional partnership model that could be addressed include:
   - The risks of holding unlimited personal liability
   - Concerns around becoming the 'last partner standing'
   - The financial burden and associated risks associated with owning or leasing premises, and feasibility of buying into property for early career GPs
   - Complexity of HR and other management responsibilities related to running a business, employing staff and managing workloads, and premises.

4. Avoid vertical integration where alternative options are viable:
    - Whilst there is limited evidence about the pros and cons of the integration of general practices into hospital trusts, a major NIHR study suggests that there are modest, and only temporary improvements in patient use of hospital services, no impact on patient experience of care, and patients with long-term conditions appear to receive diminishing continuity of care.[7] While alternatives may need to be considered in areas where the GP partnership model is facing particular challenges, vertical integration poses risks to the delivery of personalised continual care that is situated at the heart of a patient's community. As such other options should always be prioritised.

Wider recommendations to support the general practice workforce of the future

Alongside consideration of measures to strengthen and enhance the independent contractor model and GP partnership, there are key changes which could deliver additional benefits in terms of delivering the highest standard of care to patients and retaining much needed GPs within the partnership model. These include:

- Accelerating the extension of occupational health and wellbeing provision across primary care as set out for England in the Long Term Workforce Plan.
- Greater encouragement and facilitation of flexibility in job planning to enable GPs to work across a range of roles as part of a full-time week, including working in an accredited Extended Role (such as within a Neighbourhood Service in England), in teaching, research, commissioning and taking on leadership positions within integrated care boards (ICBs) and corresponding structures in the devolved nations.

Opportunities to work at scale with other practices to share data and develop new and better approaches to patient care.

Comparison of existing organisational models *(Table below)*

There are a variety of organisational models in place within general practice at present. These are shaped by (and in turn shape) the type of NHS contract held, the needs of the local patient population, and the preferences of practice leadership. In addition, the choice of legal business structure affects not only service delivery and governance but also carries significant tax and financial implications. For example, traditional partnerships operate under self-employed tax arrangement and unlimited personal liability, while incorporated models provide limited liability protections but are subject to corporation tax. These factors play a key role in determining the long-term sustainability, flexibility, and appeal of different models to both existing and future GPs.

Factors such as financial transparency must also be considered. For example, the requirement for models such as Limited Liability Partnerships (LLPs) and Community Interest Companies (CICs) to publish accounts can offer greater transparency of earnings

than other models. Similarly, transparency of investment varies with the GMS contract for example offering clarity on funds invested, while other models, such as NHS Trust-led models, risk being more opaque. The population footprint covered by different models is also an important factor with evidence showing that patient satisfaction and continuity of care is higher at smaller practices.[8,9] Similarly, models that separate business ownership from clinical delivery may risk introducing a perceived or actual distance between decision-makers and patients. Evidence suggests that patient satisfaction is often highest in models that support continuity and clinician-led governance, while more corporatised or centralised models can struggle to maintain this connection, depending on arrangement.[10,11] Practices with more GP partners per patient achieve stronger outcomes on patient experience and access scores, highlighting the value of locally accountable, long-term clinical leadership embedded within the partnership model.[12]

In the table below, we have summarised some of the different models currently being explored across the UK, as they offer an insight into the possible ways to organise the delivery of general practice services. Some of these structures are well established while others are more novel and remain in development. Each model offers different strengths and limitations, which we have considered in relation to our principles to support the GP partnership model, whilst acknowledging that local context is essential in determining the suitability of any approach.

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Model	Description	Strengths	Limitations	Examples
Traditional GP Partnership	Independent contractor model. Partners own and manage the practice as an independent autonomous business, holding the contracts for service delivery with NHS. Physical premises may be owned by partners, or leased. Partners operate as self-employed contractors, who share profits of the business. Partners are jointly and individually liable for business and financial risks. In England and Wales, GP Partnerships typically hold a General Medical Services (GMS) contract.	+ GPs have greater autonomy in decision-making for patient care + Flexibility and responsive services – practices can develop specific 'ethos of care' + Incentivises efficiency + Effective and positive partnerships can strengthen professional relationships, supporting GP experiences, retention & long-term career stability, when successful. + Access to NHS Pension Scheme	– Unlimited personal liability – Shared responsibility for partners' actions - accountability for HR/staffing and wider practice management – Challenges in partner recruitment and retention – On premises: risk of negative equity with freehold buildings and/or liability for long-term leases	
Associate Partnership	A developing approach to traditional Partnership whereby Salaried GPs take on enhanced responsibilities often with less liability and financial risk, (contracts may vary). This can be a progressive pathway to partnership. More likely to be feasible in larger scale or multi-site practices. Importantly, this model requires 'traditional' GP partners to operate, a practice cannot be run by Associate Partners alone.	+ Reduces personal risk and liability for individuals in a practice. + Flexibility and lower risk appeals to younger GPs and those entering the workforce (early-career GPs), promoting retention/recruitment. + May support practice sustainability, via progression/succession planning.	– May not have full autonomy and voting rights/say in business – Variation in delivery and often no clear pathway or gold-standard for progression – May drive imbalance/inequity between GP staff	▪ Priory Medical Group, York
Scaled-up Independent Providers:				
Super Partnership	Retaining the traditional partnership model, multiple GP practices merge under a single business structure to form a single partnership, sharing governance, workforce, and back-office functions.	+ Economies of scale & financial stability + Opportunities for diversification, practices may specialise in specific clinical areas and/or link patient data to develop and provide enhanced services + Enhanced workforce resilience + Multidisciplinary team support + Access to NHS Pension Scheme	– Personal liability exposure, although may be less than smaller-scale traditional partnership. – May streamline operations through scale, but increase organisational bureaucracy – Limited independence – Risk of imbalance of resource distribution, workload and earnings/rewards between practices – Potential loss of localised relationships and continuity, depending on structure &	– Haxby (NFP, derisking through a layered model, combination of traditional partnership, corporate companies limited by shares, and an LLP) – Modality Partnership – Our Health Partnership

			delivery – associated risk of reduced patient satisfaction	– LoGranta Medical Practices (Granta)
GP Federations	Independent practices collaborate through formal or informal networks while retaining individual contracts. GP Federations can be legally structured in different ways, such as a Company Limited by Shares (Ltd), a Limited Liability Partnerships (LLP), a Community Interest Company (CIC), or as a 'Super Partnership'. If incorporated, profits may be subject to corporation tax. May face challenges with holding core GP contracts, e.g. GMS/PMS in England.	+ Ability to share back-office functions and resources + Ability to deliver larger-scale and enhanced services + May limit personal liability (derisk)	– Complexity of governance – Variations in engagement among member practices – May not suit rural areas due to distances between practices – Some may not be eligible for the NHS Pension Scheme	▪ Fylde Coast Medical Services (NFP Social Enterprise) ▪ Suffolk GP Federation ▪ Together First CIC (a GP Federation CIP)
Different Ownership Models:				
Companies Limited by Shares (Ltd) or Guarantee	An alternative legal structure that gives partners protection by limiting personal liability for business debts and obligations. Can be described as a 'hybrid' model between a limited company and traditional partnership. Roles and arrangements for partners can be defined via partnership agreements. Typically, profits are subject to corporation tax. May face challenges with holding core GP contracts, e.g. GMS/PMS in England.	+ Reduces personal risk and liability + Offers flexibility of management and operations, and scope for investment. + Process of changing partners can be smoother and support business stability (less costly and bureaucratic)	– Varied pension and tax implications for partners and staff, depending on set-up – Can be costly and complex to set up and administer – Risk to patient satisfaction if business owners/managers are at a distance from patients	▪ Primary Care Sheffield (a social purpose organisation and a Limited Liability Company by shares) ▪ Operose Health (Super Partnership)
Limited Liability Partnerships (LLPs) (not yet viable for the GMS contract)	An alternative legal structure that gives partners protection by limiting personal liability for business debts and obligations. Can be described as a 'hybrid' model between a limited company and traditional partnership. Roles and arrangements for partners can be defined via partnership agreements. Typically, LLPs are considered tax-transparent (not subject to corporation tax) and partners are taxed individually. LLPs face challenges with holding core GP contracts, e.g. GMS/PMS in England.	+ Reduces personal risk and liability + Offers flexibility of management and operations, and scope for investment. + Process of changing partners can be smoother and support business stability (less costly and bureaucratic)	– Varied pension and tax implications for partners and staff, depending on set-up – Can be costly and complex to set up and run – Risk to patient satisfaction if business owners/managers are at a distance from patients	▪ Better Health MCR (a Limited Liability Partnership PCN with social enterprise *principles*)
Community Interest	A regulated social enterprise model – a special type of limited company which exists to benefit the community rather than private	+ Supports NHS and local authority commissioned contracts + Community integration	– Greater regulation and bureaucracy	▪ Together First CIC (a GP Federation CIP)

Company (CIC)	shareholders. Typically, CICs are independent, employee-owned businesses – locally managed, nationally regulated. Requires a "community interest test" and an "asset lock" to ensure assets and profits are used for community benefit, not private gain, and is overseen by the CIC Regulator. Typically, profits are subject to corporation tax. May face challenges with holding core GP contracts, e.g. GMS/PMS in England.	+ Options for diversification beyond traditional GP + May be eligible for specific grant funding or tax reliefs. + Enables retention of profits over time for future/contingency costs – supports business resilience and responsiveness + Reduces personal liability exposure	– May not be suitable for most practices (factors incl. local context, tax, scale) – Varied pension and tax implications for partners and staff, depending on set-up	
Community Benefit Societies (CBS)	A regulated social enterprise model for public benefit, typically registered under the Co-operative and Community Benefit Societies Act 2014 and regulated by the Financial Conduct Authority (FCA). Typically commissioned under APMS contracts (flexible specificity, but time-limited and subject to tender). Challenges with holding core GP contracts, e.g. GMS/PMS in England.	+ Often, integrated relationship-based care for complex, high-need groups, via multidisciplinary teams and cross-sector services. + Reduces personal liability exposure + May be eligible for specific grant funding.	– Can be costly and complex to set up and administer – Long-term funding and legal obligations challenges may impact sustainability and workforce retention	▪ York Street Health Practice (run by Bevan Community Benefit Society)
Employee Ownership Trusts (EOT)	A less common model whereby all staff are co-owners of a limited liability company and share in its success, with shares being held in a trust. Typically, a representative Board will make managerial and financial decisions, accountable to a staff committee. Clinical liability risk is mitigated through insurance, and business liability sits with the ICB or respective equivalent in the devolved nations. May face challenges with holding core GP contracts, e.g. GMS/PMS in England.	+ More flexible, supports recruitment and retention + All staff have a greater say and leadership opportunities + Reduces personal liability exposure + Possible alternative for practices with few Partners	– Difficulties with set-up and comparison, as sparce guidance for processes/ and evaluation of impact exists.	▪ Central Surrey Health (CSH) (a NFP employee owned, social enterprise model, community health provider)
Trust-Integrated Models:				
Vertically Integrated Model (NHS Trust)	Acute trusts take responsibility for running GP practices, with staff as NHS employees, forming a single NHS organisation across primary, secondary and community services. This is a novel and uncommon model. A 2023 NIHR evaluation concluded: 'vertical integration can lead to modest reductions in use of hospital services and has minor or no impact on patient experience of care', with no case for widespread roll-out.[13]	+ GP Partners can retain clinical leadership with protection from personal liability exposure + Sub-contracting approach + Cross-sector networks	– Reduced autonomy/independence and flexibility to meet local needs – Difficulties with set-up and comparison, as sparce guidance for processes/ and evaluation of impact exists. – Potential loss of localised patient relationships,	▪ Royal Wolverhampton NHS Trust ▪ Northumbria Primary Care (Integrated, at-scale PCN, wholly owned Primary Care subsidiary of a

			depending on structure & delivery. – Potentially more expensive and increased layers of bureaucracy	Foundation Trust, led by a primary care Board of Directors)
Managed Practices	In the event that a GP practice hands back its contract (e.g. GMS or PMS in England), instead of closing, the practice may be taken over by a Federation or Trust to manage oversight and delivery of services for continuity.	+ May support continued delivery of services and continuous care for the populations/communities on the practice list. + May provide practice staff with alternate employment/stability	– Significant considerations for the original practice operators (legal, tax, contractual, employment). – If taken over by a Trust, autonomy and voice of primary care may be limited within the wider structure. – Significantly more expensive and can rely on increased number of temporary staff, such as GP locums	
Horizontal Integration (Community Trust)	Community Trusts take responsibility for running GP practices.	+ Promotes integrated neighbourhood working (aligned with 10 year health plan ambitions)	– Reduced autonomy/independence – Potential loss of localised patient relationships, depending on structure & delivery.	▪ Hampshire and Isle of Wight Healthcare NHS Foundation Trust

References:

[1] Department of Health and Social Care (2024) *Independent investigation of the NHS in England*
[2] Fisher R. (2025) *The partnership model in general practice predates the NHS. Is now the time to change it?* Briefing, Nuffield Trust.
[3] NHS England (2025) *General Practice Workforce Official statistics, February 2024*
[4] RCGP (2024) *GP Voice Survey 2024*
[5] Department of Health and Social Care (2019) *GP partnership review: final report*
[6] Department of Health and Social Care (2024) *Independent investigation of the NHS in England*
[7] Sidhu M. et al. (2023) *Vertical integration of general practices with acute hospitals in England: rapid impact evaluation*. National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research. 2023;11(17).
[8] Edwards PJ. (2022) *Bigger practices are associated with decreased patient satisfaction and perceptions of access*. Br J Gen Pract. Sep 2;72(722):420–1.
[9] Hull SA. et al. (2022) *Measuring continuity of care in general practice: a comparison of two methods using routinely collected data*. Br J Gen Pract. 72 (724): e773-e779.
[10] Ipsos (2024) *GP Patient Survey*
[11] Institute for Government (IfG) (2025) *General practice across England*
[12] Ibid