Looking to the future: the recruitment, retention and return of GPs

Summary and next steps report for NHS England
Looking to the future: the recruitment, retention and return of GPs

Ipsos MORI

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1. Introduction
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1.1 Background to this report

1.1.1 The wider context

Demand for General Practitioners (GPs) in England is increasing at a time when supply is falling. To expand GP provision, the government is currently working to ensure there are an additional 5,000 doctors in general practice\(^1\) and better access to general practice by 2020/21\(^2\).

Yet, against this backdrop, evidence suggests that there are many challenges in recruiting, retaining and encouraging return among GPs. For example, the eighth wave of the ‘Worklife Survey’ looking at GPs’ perceptions of their working lives, found that the overall level of job satisfaction among GPs is at its lowest level since 2001\(^3\), with issues such as hours of work, remuneration, and increasing workloads all identified as contributing factors. As set out in the ‘Five Year Forward View’\(^4\) the government has committed to addressing workforce issues over the next five years. For example, supporting the health and wellbeing of frontline staff, providing opportunities for career progression, and ensuring concerns are raised and dealt with in a timely manner are all included.

Aligned with this, ‘Building the Workforce – the New Deal for General Practice’\(^5\) represents the coming together of key agencies – NHS England; Health Education England (HEE); the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) – (‘the Partnership’), resulting in a 10 Point Plan to recruit GPs, retain them, and encourage those who have left practice to return.

Based on all of the above, in autumn 2015, NHS England and partners commissioned Ipsos MORI to carry out research exploring the recruitment, retention and return of GPs. The main findings were presented in detail to NHS England in November 2015. This report provides a summary of the findings and focusses on the implications for the next stages for 2016; the report focuses on the ‘what next?’ question for the Partnership, based on learnings from the main research.

1.1.2 The research

As noted above, the aim of the main research was to help inform the actions of the Partnership, and the allocation of the resource available. More specifically, the research objectives were to:

- Develop a better understanding of the drivers and barriers that might encourage or discourage student doctors to take up the GP specialism;


• Explore and bring to life the **practical and emotional factors that might lead to disaffection** among a range of GPs that are seriously considering leaving the profession;

• Uncover **any suggested solutions and ideas** that GPs believe might encourage others to stay in, or return to, the speciality; and

• **Examine a range of early proposed incentives.** actions or changes to general practice ways of working that are being developed to: encourage student doctors into GP training; discourage those that are considering leaving from doing so; and encourage or help those returning to the speciality to do so.

To achieve these objectives, a qualitative programme of research was carried out between September 2015 and November 2015, comprising:

• Four discussion groups with medical students to find out their appetite to become a GP, and what might encourage them to choose this speciality in future;

• 41 in-depth telephone interviews with GPs seriously considering leaving and in circumstances that may present challenges to remain in practice, including: GPs with young families; those with caring responsibilities; early retirees; and those with health conditions.

• 23 in-depth telephone interviews were conducted among GPs who had left or were in the process of coming back to the speciality. This included those that were seriously considering emigration; those that had already emigrated; GPs in the process of – or had recently returned to – practice; and those that had left the speciality (including some that remained working as a locum).

All research was conducted between September and November 2015 by Ipsos MORI. Further details on the methodology and sample profile are provided in Appendix A.

1.1.3 Interpreting the findings

On reading this document it should be considered that, as a qualitative research study, the research findings referenced throughout this report are based on illustrative, detailed and exploratory data. They offer insight into the perceptions, feelings and behaviours of research participants, and it is important to remember that although such perceptions may not always be factually accurate, they represent the truth to those who speak them.

As all discussions were qualitative in nature, some verbatim comments from the interviews have been included within this report. These should not be interpreted as defining the views of all participants, but have been selected to provide insight into a particular issue or topic. In line with the Market Research Society Code of Conduct, all participants were guaranteed confidentiality and anonymity in taking part in this research. Therefore, all identifiable information about them has been removed and verbatim responses have only been included where these could not be traced back to an individual participant.

It is also worth noting that the participants included in the research were sampled purposively, meaning that they were deliberately selected because they fulfilled certain criteria. Where ideas have been suggested by GPs as next steps – while representing the valid perspective of those interviewed – it is not possible to say that these represent the views of all GPs interviewed, nor the views of all GPs in England.
Suggested next steps by Ipsos MORI are based on interpretation of the research findings. This means that may not stem directly from participants, but are grounded in the qualitative data. However, it should again be considered that the data derive from a purposively sampled audience.
2. The context for change
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This chapter provides a summary of the findings on the decision making around both joining and leaving the profession. In doing so, it highlights the complex combination of factors that pushed people along the decision making path towards leaving the profession. Some of these factors have been well-documented in other research, including work by the Partnership itself. This research looked in more detail at the experiences and ‘tipping point’ for particular segments of GPs, such as those with caring responsibilities.

The chapter also summarises the findings on a range of incentives discussed with GPs to further set the context for building a new approach.

2.1 Understanding the decision to leave

Those who were considering leaving the profession, or indeed had, were asked to reflect back on the reasons they had chosen to go into general practice in the first place, in order to understand the full journey to the final ‘tipping point’. Participants outlined what had attracted them to the profession – and therefore what could appeal for prospective GPs – and in doing so provided rich context for understanding current levels and reasons for disaffection.

Although one or two GPs taking part in the research said that they had ‘fallen into’ general practice – in light of not knowing what speciality they wanted to go into – the vast majority made a conscious move to work as a GP. In addition, they shared similar views of why they chose to go into general practice, with a series of common factors. A key appeal of general practice was that it could help foster a work-life balance, given the regular hours and lack of night-shifts, while the prospect of quicker progression and the opportunity to be involved in the management of a practice was also appealing.

‘For me, it’s great having a say in how things are run – I never liked hospitals; hated the hierarchy.’

(GP partner, young family)

The variety – being able to treat the ‘whole person’ and diverse patient populations – was a satisfying aspect of the role, as was the rich patient contact: it allowed GPs to feel as though their work had meaning in the wider context of patients’ lives.

Underpinning all these more practical factors was the emotional desire to want to be a GP. GPs felt that caring for patients and being a GP was something that they were meant to do, or something ‘in their blood’. One or two had parents working in, or having worked in, general practice, and this added to a feeling that the profession was a vocation to which

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they held emotional connection. This emotional pull offered some explanation as to why even those who were currently dissatisfied continued in the profession. This was particularly so, as participants outlined that many of the original factors drawing them to the profession were being eroded – as outlined below – creating various levels and types of disaffection.

Overall, however, for many people included in the research, the corroboration of social, cultural, organisational and system-based factors meant maintaining a career as a GP, or at least a full-time salaried or partner GP, was simply unsustainable. There was rarely one factor or reason behind the decision to leave, but ‘workload’ – be it as ‘physical property’, the emotional burden that came with it, or the sheer intensity of it – provided a tangible concept for participants to explain the need to leave the profession. Therefore, GPs instinctively pointed to an increase or change in workload as the overarching factor, but often it reflected deeper frustrations, each of which is summarised below.

1. A changed GP-patient relationship attributed to changing patient demographics – such as an aging population – and a shift in patient attitudes.

- Patient-related challenges for general practice have been well-documented. Certainly, the ever more complex needs of the patient population were also frequently mentioned as bringing challenges for GPs in this research too. Many felt that patients are now older, sicker, and on more medications than ever before. In addition, participants said that they are now seeing a higher proportion of patients with mental health conditions. However, as outlined previously, the varied nature of being a GP was an appeal to many entering the profession. As such, the challenge of this was not a motivation to leave on its own, but when linked to changes in ways patients engage with GPs, was less satisfying.

- For example, GPs told us that a cultural shift in the way that society responds to health and illness had created a dichotomy in patient attitudes. Patients were seen to be empowered in investigating their symptoms online, while simultaneously being less willing to treat themselves. The outcome of this was both increased patient flow – with people visiting their GP more readily at the onset of symptoms – and increased demand from patients about their care (e.g. demanding care not deemed possible or even necessary by the GPs themselves). In this light, GPs felt that they were simply ‘gatekeepers’ increasingly having to say ‘no’ to treatments that patients requested. In addition, some felt that they were also less able to spend time with those who really needed medical care, while attending to the needs of the ‘worried well’.

- GPs also said they spent much longer dealing with what they saw as ‘non-clinical’ patient matters nowadays, often to legitimise their patients’ behaviour – such as providing doctor’s notes or signing paperwork to say they are able to attend the gym. The consequence of this was a more ‘transactional’, rather than holistic, relationship, that lessened some GPs’ enjoyment of the role.

2. Changes to the role of GPs, including additional responsibilities from outside healthcare and a different relationship with secondary care.

- As suggested above, GPs felt they were under greater pressures to carry out non-core GP tasks – including arranging child protection, dealing with housing issues, and assessing patients’ fitness to work. Not only was this leading to an increase in their responsibilities, it also contributed to a diluted sense of identity among GPs; they had no clear sense of where their accountability ended and another profession picked up.
Some aspects of the current relationship between primary and secondary care also led to GPs feeling frustrated and undervalued. This was particularly evident in relation to the new demands placed on GPs, for example, the referrals system between primary and secondary care.

‘We’re everyone’s dumping ground... social services have broken down, so let’s phone a GP; someone’s admitted to hospital and needs an X-ray, so let’s send them back to the GP to refer them for an X-ray!’
(Salaried GP, early retiree)

Finally, while many GPs, particularly partners, welcomed being at the forefront of clinical commissioning, they admitted that the introduction of commissioning responsibilities led them to have less time to think about their own practices.

‘GPs are our own worst enemies. We are now part of CCGs and yet through CCGs we keep on saying we will take up more work from hospitals.’
(GP salaried, caring responsibilities)

3. Changing ways of working for GPs, including longer and more intense hours of work.

Many of those interviewed said that they usually worked 12 or more hours per day, and that this was having a significant impact on their ability to do the role and live their lives. Not only were the hours worked longer, they were said to be more intense, because of the additional patient load and the new responsibilities they had taken on. The extent of the distress this caused some participants was clear, as several reported not feeling able to take time off when they were very ill themselves, or being near ‘burnout’, with several citing mental health implications.

A lack of flexibility and control over working hours presented an additional problem. This was particularly so for certain groups, such as those with young families and/or those acting as part-time carers. For example, such GPs spoke about the challenge of getting home on time to provide medications, or to pick up children from the nursery.

‘It boils down to choice between being a good dad or good GP – we shouldn’t have to face that, or cutting corners – we can’t do that. Yesterday I was in before 7 to do paperwork, saw patients from 7 until 7 without a break, most of my colleagues are in at weekends... I get home and I’m so tired I can’t speak to my children.’
(GP partner, young family)

Even those that were contracted to work part-time said that they often had trouble with the rigidity of the work patterns they were expected to fulfil. Often this was due to there being nobody to hand over to, with the responsibility for the work generated remaining with the individual GP.

A further unintended consequence of GPs having longer and more intense working days was the sense of isolation that this could cause. For instance, some GPs said that ‘having their heads down all day, every day’ meant that they have limited contact with colleagues. This impacted on the culture of family practices that had traditionally generated positive and supportive work environments.

4. Feeling misunderstood and undervalued as a profession.
• GPs felt there was a misperception in society about the reality of what life as a family doctor was really like, resulting in widespread lack of recognition and respect for the work they do. Frustrations were further fuelled by the feeling that they are increasingly being criticised by media and government, which impacted morale across segments in the research. This perception was also held by the student doctors we spoke to and this led some to question whether they would want to be part of the speciality in the future.

• Simultaneously, many felt that they are continually required to prove their worth to the system, with a perceived increase in governance making them feel under scrutiny. While the benefits of regulation were acknowledged, on the whole it contributed to GPs feeling less trusted as a profession. Participants were disheartened by a lack of recognition of the important and good work they feel they do in a progressively more complex and stressful environment.

‘GPs are being criticised an awful lot in the press and by government who are supposed to support us, [it] does have a massive impact on whether that is seen as a career you want to stay in.’

(GP, salaried, young family)

Therefore, as outlined previously, the research identified that it was not for one clear-cut reason that GPs were considering leaving the profession, or indeed already had. For some, the culmination of these factors led them to retire early, move to another country or see leaving as an inevitable outcome in the future.

The feeling that leaving the profession was inevitable was felt across all segments, with many describing themselves as being near burnout. Indeed, GPs told us that the current situation was only sustainable if they were able to sacrifice elements of their personal life and ‘run at 100%’ all of the time. Therefore, where the factors described above were combined with having a young family, or health condition, this made the ‘tipping point’ feel nearer.

However, the decision to leave the profession was not taken lightly. Indeed, in building an approach for the future, it will be important to note that many GPs in the research desperately did not want to leave the profession, and it was certainly not a decision taken in a quick reactive response to one of the factors outlined above. As such, several told us that it was common for GPs in general to take action in an attempt to mitigate this unsustainability, such as reducing their work hours or working part-time to maintain more ‘normal’ working hours.

For example, GPs who had taken early retirement or were considering it were consulted as part of the research. For those that had already taken early retirement, several were still working as a GP, but on a locum basis, or had combined this with other jobs, such as teaching to have a more portfolio career.

However, concerns stemmed beyond their personal options to the profession more widely. GPs felt that, with more people working part-time or becoming a locum, extra pressure was placed on those working permanently in a practice. As such, some concluded that the traditional model of general practice was not sustainable. Indeed, this was most felt when discussing being a partner. For those in this role, they faced extra challenges around recruiting new staff, and particularly new partner colleagues. In one extreme case, the GP said that such a high number of her partner colleagues had left the practice that she feared being the ‘last woman standing’ and so had taken a sabbatical to sort the practice policies out and prepare for a ‘doomsday scenario’.

The impact of this was felt across all career points. Among the students included in the research – many of whom were open to the idea of being a GP – the benefits of the potential career progression were being diluted through the stories
they had heard and experience of seeing partners working through placements. As such, across audiences it was acknowledged that the ambition of being a partner was diminished to differing degrees.

2.2 The need for a changed approach to incentives

Additional context for the next stages for the Partnership was also provided when participants considered a range of possible incentives to address the crisis in recruitment, retention and return of GPs. The incentives tested as part of the research included both new incentives that were in the early stages of their development, and others that had been implemented in the past but included some proposed adaptations. A full list of the incentives tested and the audiences they were tested with is appended to this report. Participants were also asked to provide other solutions and ideas, and the findings on these are included in chapter 3.

At a surface level many of the incentives were seen as positive in their own right. However, a key finding of the research was that, at a more fundamental level or as part of a strategy for change, they were not viewed as adequate to address the complex array of issues identified by GPs. The incentives tested tended to fall under three types, each with its own limitations to addressing the recruitment, retention and return crisis. The three types were:

1. **One-off investments in GPs – such as education bursaries or childcare vouchers**: While some incentives were welcomed because they were seen as an investment in GPs, they also raised questions about how effective they could be in the current climate and in the context of other barriers to retention. For example, despite educational bursaries being viewed favourably – especially by those that already wanted to undertake further education – most GPs admitted they would not have time to take on further study at present. And though clinical mentorship was felt to be a positive step, sufficient resources were simply not felt to be available.

   When participants thought of further incentives that would help them personally (or those they saw suffering around them) they often fell under this ‘type’ of incentive. For example, one or two suggested funded sabbaticals for partners that do not wish to leave, but need some time out to catch up on management activities. While such sabbaticals were felt to be beneficial to the individual – and even long-term to the practice – the immediate impact was removal of resource from the practice at a time when everybody working there was under strain. Therefore, even when suggested, such incentives were often caveated as not being feasible.

2. **Incentives to provide a ‘nudge’**: Other incentives are designed to ‘nudge’ behaviour to address specific system level consequences of the reduced number of GPs. For instance, the rotational role to encourage doctors to practice in remote or under-doctored areas, relocation grants for hard to fill roles, or financial support to help support trainees to work in specific areas, all require a desire to work in the speciality underpinning them. These incentives did appeal to those already open to such opportunities or as ways to encourage those early in their careers to ‘fill the gap’. However, they were not seen to address the day-to-day concerns of individual GPs that were pushing them towards leaving.

3. **Incentives based around the development of schemes or ideas already in place**: Views of these incentives were mixed, but again, on the whole they did not strike at the heart of the issues raised by participants. For example, while there was strong appeal for portfolio careers, one or two questioned the need to invest in these at present when many GPs already organised their own. In addition, while the GP Retainer Scheme was appealing in principle, it was felt that it would not address some of the wider issues around hours of work and child care, mentioned earlier. There was certain appeal in extra training to improve students’ employability, although views
were mixed on the extra year suggested for this (given that shorter training was a pull into the profession for some students).

Consequently, while there were some positive responses to the proposed incentives, participants gave a clear message that it would be important to address the core issues triggering dissatisfaction. In addition, because some of the incentives had practice-level disincentives – for example, mentorship was said to take staff away from practice – they carry the risk of making the current situation worse if implemented in isolation in the future.

Therefore, not only did the research reinforce many of the learnings from other sources around the factors leading to disaffection, it highlighted that the next stages for the Partnership need to revolve around a more extensive and long-term focussed approach to change; it is only through such an approach that the value of incentives, such as those outlined above, can be realised. Therefore, the next chapter covers what can be learnt from the research in terms of designing an approach for change and what could be included in it.
3. Building a new approach
3. Building a new approach

3.1 Designing the approach

As outlined in Chapter 2, a key learning from the research was that, even when incentives and solutions were in their own right viewed positively, unless part of a broader strategy or approach, their implementation could go unnoticed, have minimal impact; or simply reinforce that as a standalone offer they do not address the issues at hand. Above all, then, this research has shown that there can be no ‘silver bullet’ approach to the complex and multifactorial issues that together were driving disaffection among the GPs consulted. Indeed, those GPs told us they were experiencing ‘change fatigue’, and any one-off or short term incentives could be met with a sense of scepticism, or could reinforce that the wider issues are not being dealt with.

Therefore, in organising GPs’ needs into a potential strategy for change, the research suggests that a longer-term approach is taken, with the needs that can be addressed more easily being tackled alongside those that need greater time investment and consideration. This package would build on the positive foundations identified – the desire to remain in the profession and the original appeal of the profession for those who are part of it – and tackle the broader reasons for disaffection. The research suggests that taking this approach has greater potential to create trust and belief among GPs that their concerns are being listened to and acted upon.

In some respects, GPs themselves told us that they understood a longer-term approach would be needed to tackle all of the issues. For example, when participants were asked about the immediate solutions for the workload crisis, many cited getting more GPs as the answer. However, there was widespread recognition that, actually, this would not be straightforward or simple. Indeed, GPs of all levels were realistic about the length of time and money it will take for GPs to become trained and competent in order to relieve the burden. Therefore, they were aware that, although immediate action is needed, this will have to form part of a much wider approach.

The next section of this report outlines the five key tasks the research suggests need to be built into this broader approach, which includes:

- **Task 1: Getting GPs on side** – making GPs feel valued and communicating the approach.
- **Task 2: Tackling professional identity** – developing a manifesto for the role, and clear lines of responsibility / accountability.
- **Task 3: Ways of working** – providing some immediate relief to the ways of working in general practice.
- **Task 4: Service design** – revisiting the model of family practice in light of the expectations of the role of GPs.
- **Task 5: Future-proofing** – looking to the next generation and revisiting the incentives.

It is worth noting that these tasks – while based on robust qualitative data – are mainly based on the views of a selection of GPs who were seriously considering leaving the profession, and a range of students that felt both positively and negatively about general practice. However, the tasks do suggest a general direction of travel for the ongoing work in...
developing this approach; the next stages for the Partnership would be to further ‘test’ and expand on these, at a practical level – building in resourcing and timings – and within the context of the wider GP community and health and social care policy.

3.2 Outlining the tasks

Task 1: Getting GPs on-side

As noted above, this report does not apply a suggested timeline to the tasks outlined, given that they need to be tested and developed further by the Partnership. However, the research suggests that, without wider belief and buy-in from GPs, the impact of any action could be minimal or even damaging. Therefore, getting GPs on side needs to be a primary, if ongoing, part of any approach and would have three key aims:

1. Show GPs that they are appreciated;
2. Show GPs that they are being listened to, and the issues that they are facing have been understood; and
3. Develop a stronger image of the profession more widely, among the media and the public.

Underpinning GP’s low morale was the fact they that they felt neither understood, nor valued by the system that they worked hard for. Indeed, GPs said that they wanted to feel recognised and valued for the hard work they do under challenging circumstances. There is a rationale, therefore, to undertake communications work with GPs in order to encourage them to feel more appreciated for the work that they do.

However, getting GPs ‘on-side’ is not simply about empowering them to ‘push through’ during a time of struggle. While GPs did express the need for acknowledgement that times are tough for them, they equally wanted to see that their concerns are being listened to and acted upon. As part of this, being transparent about the fact that there is a longer-term strategy currently in development specifically focussed on the main concern GPs in the research had – reducing the workload – would be beneficial.

Alongside this, and potentially as a longer-term objective, GPs and students also identified a need for a stronger image of the speciality to be created more widely, in order to make those currently working as a GP feel valued, as well as create a draw to the profession for new recruits. Therefore, to support communication with GPs themselves, it may be beneficial to begin a work stream to help tackle what GPs feel are misperceptions of the role among the public and within medical professions.

Indeed, GPs believed that the perceptions of the public were misaligned with the reality of the role as experienced daily by them. They believed the role is seen as ‘an easy life’ involving a large salary, low working hours, and very low levels of stress, while the reality for them involves the opposite.

‘The media need to stop dissing GPs – if the public don’t like them, why are we going to want to do it?’

(Year 1/2 student)

Others highlighted that the image of the GP within the medical profession more widely also requires updating. For instance, some students mentioned that they had been put off the profession because specialists from other settings had
been disparaging about the level of skill required to be a GP. Therefore, the future approach could benefit from ways to advocate the role, particular among future generations.

'We need to talk up the strengths of GP - its importance and its value for next generation...rather than [just] talking up things that need to be changed.'

(GP partner, early retiree)

Task 2: Tackling professional identity

The research identified that GPs were experiencing a lack of professional identity for various reasons. These included:

- Taking on responsibility for a wider pool of tasks, while simultaneously, changes in other parts of the system pushed tasks towards them. This led to them undertaking more non-clinical tasks, such as signing sick notes and taking on a more social care role;

- Being unclear how their role relates to that of newer services in the primary care landscape – such as 111 and walk-in centres; and

- Changed patient expectations of the role of a GP and the services that they provide.

Therefore, there is clear need for a piece of work on what it means to be a GP focussing on what is expected of GPs and what the day-to-day role should involve. To some extent this falls alongside Task 3 on ways of working with other services, and Task 4 which focusses on future service design. However, as an initial task the roles and responsibilities of GPs, alongside other stakeholders, such as the public, could be established.

Clear and consistent guidance is needed, which could take the form of a co-created and shared manifesto which highlights exactly the responsibilities of a GP in the modern NHS. This manifesto could include:

- The role of the GP in the context of the changing out-of-hours / urgent care landscape: For example, GPs questioned what the role of a GP is now that patients have access to a host of other services that provide similar functions or roles.

- Clarity on the responsibilities associated with the GP role: The blurred lines and boundaries with social work and other professions were a source of anxiety for GPs included in the research, as they felt they carried the emotional burden of tasks that they did not feel qualified for. Therefore, they wanted greater clarity on where they should take accountability and where accountability should be passed back to others.

- The responsibilities of the public in using GP services: It was evident throughout this research that GPs wanted to reduce the volume of patients that they are expected to see on a daily basis. One suggested way of doing this was through better public education about appropriate and responsible use of primary care; at the moment GPs included in the research felt the public have expectations of the general practice profession that cannot be fulfilled. Therefore, the public should be better informed about when it is, and is not, appropriate that they visit a GP and when instead they might consider the option of self care. There have obviously been many examples of where better self care has been encouraged by the government and healthcare providers, for instance, North Tyneside CCG’s Winter Self Care Patient Campaign – ‘Keep Calm’ – which was designed to minimise the need for
GP appointments for those with minor illness\(^\text{10}\). In this way therefore, a continuation of work already being done could potentially help.

- **What should be expected from other organisations:** GPs also felt responsibility not only lies with the public but also with other organisations that inadvertently increase the number of patients GPs felt they should not be seeing. Therefore, in line with work to better educate the public, it was said that responsibility could be encouraged to fall elsewhere or back with those organisations. The use of the wider multi-disciplinary team (MDT) was mentioned in this context and is covered in task 3.

Being clearer on the role of the GP would provide an identity for those in the profession or wanting to join to align to, as well as an understanding of where the lines of accountability lie for GPs. Educating the public on this role should sit alongside any communications to raise the image of GPs altogether, and as such, be done in a way that builds trust and respect for those working in the profession and the decisions they make.

**Task 3: Ways of working**

Alongside the previous tasks, the research suggested that there are some improvements that could be implemented relatively quickly, which relate to the way that GP practices operate on the frontline. These include:

- Harnessing the wider MDT in order to build resource to support GPs;
- Improving the relationship between primary and secondary care, including reviewing the referrals system – which was a significant cause of administrative burden for GPs;
- Continuing with and furthering innovations that have been designed to help streamline processes – such as the development of IT systems or approaches for better patient triage; and
- Accounting for the lack of flexibility in the working day.

The above does not provide an exhaustive list, and in further developing the strategy the Partnership could investigate other workable suggestions for improving ways of working. In addition, some of the suggested areas are already clearly underway and the next stages would be to find best practice examples and ways to facilitate practices in implementing them.

**Harnessing the wider MDT to build resource**

As discussed throughout this report, the volume and intensity of the workload was problematic for GPs. As well as more GPs, participants felt that **support from the wider MDT could help alleviate workload** simply by virtue of there being more people to spread tasks among. Indeed, this was already being done in some practices – for instance:

- Employing healthcare assistants to take the burden from practice nurses to allow them to assist GPs with chronic disease management; or

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• Employing pharmacists to carry out medication reviews.

In fact, the Royal Pharmaceutical Society (RPS) and the Royal College of General Practitioners (RCGP) have already been working together on to encourage the placement of pharmacists in GP practices to contribute to the clinical work related to medicines, relieve service pressure and increase capacity to deliver improved patient care\(^{11}\).

While many of the GPs consulted in this research said that they would value such support, others said that as the burden of employing additional staff fell on the practice, they may not be able to afford it. One suggested way to overcome this was sharing professionals across different practices in an area in order to help spread the cost – for instance, having pharmacists on rotation working collaboratively between practices.

However, other GPs said that part of the problem was also that appropriate community services are not available to take the burden from them. For instance, one or two mentioned that while they would value the assistance of a mental health practitioner or counsellor in the practice to help with some of their mental health cases, they were unable to fund this as a service. Another GP mentioned that while in the past they had a Citizen’s Advice Bureau representative they were unable to continue the service due to funding constraints.

**Reviewing the relationship between primary and secondary care**

As mentioned above, GPs in the research were frustrated with the current relationship between primary care and secondary care for a number of reasons. These included:

• **Re-referrals from secondary care.** GPs spoke about secondary care teams send a request back to the general practice in order to re-refer a patient on to another specialist. One GP referred to being treated as though GPs are a ‘team for secondary care to manage their referrals’.

• **Drawn-out ways of communication.** namely, ‘archaic’ ways of communication such as ‘Dear Dr letters’ where vital information is often ‘hidden’ was said to hinder the efficiency of their communication.

• **Fractured relationships between primary and secondary care** where doctors say they no longer really communicate with consultants as individuals, they communicate with teams, or only speak over email or through the ‘archaic’ systems outlined above, weakening the relationship.

Overall, participants thought that there need to be **limits drawn in the number of responsibilities that general practice can take from secondary care.** As part of this, new ways of working together were felt to be a potential way forward to prevent duplication and create efficiencies between the two settings. For example, in one practice they had a paediatric ‘hub’ with eight slots for a paediatric doctor to come and see patients at the practice. It was claimed that this approach allowed people to be seen more quickly, efficiently and collaboratively and could be applied to other groups, for instance the elderly, or those with complex multi-morbidities.

Therefore, any approach to change would look to create efficiencies in the systems already in place. Some of these may pose wider questions about the models of primary and secondary care, but on a more immediate level, introduction of a

more logical system of communication and referral between primary and secondary care would go some way to ease the unnecessary burden such systems bring.

**Building on innovations to streamline ways of working**

The third area of activity relates to activities to streamline working, some of which already exist. For instance, there was variability in how GPs approached appointments – some stuck to 10 minute appointments, others created more flex depending on the complexity of patient need. Again, to some extent, the appointment system relates back to the model of family practice altogether, and – while there are wider questions as to whether this is the most appropriate way of working in the modern NHS – a simple change could be to revisit smaller changes to see where efficiencies could be made. For example, some GPs mentioned that they had recently begun to think about the best way to triage patients to ease the flow. Developing and sharing ways of doing this could impact on other practices.

Another example of this was around the approach to information technology (IT). GPs spoke about practice IT systems that are old and laborious, further adding to their workloads. Others agreed that using different portals with different passwords was frustrating. While at the surface, such activities might be viewed as an annoyance rather than a key driver to disaffection, participants’ frustrations over time had built up to make their tolerance level for such activities low. While GPs were generally hesitant of any change that requires new processes and learning – owing to the time it takes for this to become established – the findings indicate there would still be support for innovations that seek to alleviate the workload of GPs.

As noted earlier, there are likely to be a greater number of improvements that could be made than this research has identified, and, therefore, it may be of benefit to carry out further work to understand what these changes might be. Ultimately, what is needed is a map of the current ways of working across GPs in the primary care landscape, in order to better understand how to alleviate the burden for GPs and make their working environment less stressful. Following this activity, best practice could be shared to build efficiencies across the system.

**Accounting for the lack of flexibility in the working day**

The sheer volume of hours worked was impacting on the lives of the GPs included in the research. The ideas and solutions outlined above should, in some way, go towards reducing the burden by creating efficiencies. However, there was also variability in how practices attempted to build in flexibility for those who needed it. For example, some practices worked to ensure those with caring responsibilities could leave on time, or not take on being duty doctor. However, others acknowledged that this was not always possible and could increase the burden on other staff.

One particular segment that struggled with the lack of flexibility was those with young children. The idea of childcare vouchers was tested to see if they appealed to this group and minimised the impact of long hours, and, although they were welcomed in general, access to out-of-hours childcare was a more significant barrier to retention that needed to be addressed. Therefore, the focus could be placed on devising ways to directly address this problem. For example, having a crèche in practices, with hours that reflect the working hours of GPs could be tested, as could a scheme connecting childcare providers who work between the hours of 5pm and 8pm to GPs, as this was identified as an issue. Such a scheme could be subsidised with the money for childcare vouchers, as several GPs told us they could only get private care over this time, which proved costly.
Task 4: Service design – reviewing the model of family practice

Family practice and the current model of ‘GPs running GPs’ through clinical commissioning was highly valued, but with the added pressures it brings to individual practitioners, several said it needed revisiting and potentially adapting in light of the current situation. Alongside the factors that have been already mentioned, therefore, GPs taking part in this research identified some important questions for the wider model of family practice as a whole. Questions raised included:

- Is the partner model still a viable option given the current demands on family practice? Would it be better for partners to also be salaried?
- Can small practices manage, given the extent of the increased demands placed on them?
- Does the traditional session-based model of general practice still work given the need of some GPs to have more flexible working hours?
- How can clinical responsibilities sit more comfortably alongside all the other responsibilities that also place a lot of pressure on individuals?
- If many people want to work part-time or as locums, is the model sustainable?

These questions were generally raised by those who had been partners or were currently in that role. The findings outlined in chapter 2 highlighted that partners were experiencing some unique drivers of disaffection as a result of not being salaried, taking on clinical commissioning responsibilities, and having to deal with the practice level consequences of the crisis in recruitment and retention of GPs. Despite this, career progression, autonomy and the ability to make decisions about a practice were key pull factors towards the profession.

This not only applies to career progression. The traditional model of family practice also worked because it incorporated ways of working that allowed GPs to utilise their broad clinical knowledge and be generalists. Several GPs told us that changes such as an increase in non-clinical tasks, have reduced the appeal of working in general practice.

Therefore, the need to explore these issues in more depth and develop a new approach, not only stems from a need to create a more efficient system overall, but to create a model that retains and embodies some of the pull factors to general practice.

However, it should be borne in mind that views on reshaping family practice were mixed, and certainly not tested in full in this research. Future work could include use of service design experts, but the research suggests that, given that GPs wanted to feel recognised, a co-creation process with GPs would be beneficial (potentially also including the public as service users and linking into the work on rights and responsibilities covered in task 2).

Several participants also highlighted adaptations that were already happening or they thought could be built into a redesign, such as:

- GPs working across a federation of practices; sacrificing some continuity of care in their role for flexibility and resource to ease the burden.
- Similarly, bigger practices with more GPs were also raised as a practical solution, as the management burden could therefore be spread, but again, others were wary of these changes.
Others mentioned that creating a **shift-based system** which would allow cross-over of shifts (and therefore the opportunity to hand over to other GPs as per the secondary care model). However again it was recognised that this would not be welcomed by everyone as it would represent a significant departure from the status quo.

**Task 5: Future-proofing**

While the incentives, as tested in this research, were not felt strong enough to make a significant impact on GPs’ desire to stay in or join the profession, that is not to say that they cannot form part of a wider strategy. In working the incentives into a potential approach however, the research suggests that they should be ‘future tested’ to ensure they conform to a set of design principles or ‘hygiene’ factors:

- Well-reasoned and clear objectives as to why they are being implemented and what incentive or change they seek to address;
- Clarity on further resources or support that might be needed to help implement any incentives in practice;
- Contextual information that shows how the incentive fits into any other incentives being targeted at other groups of GPs;
- Time testing – whereby they are only introduced at a time when they offer the greatest value to those in the profession, and targeted to those who may feel this impact the most; and
- A plan for sustainability – how will the incentives offer benefits to future generations as well as the current workforce?

Thinking specifically about future generations of GPs, it was clear from the research that many of the broader factors leading to disaffection had a ‘trickle down’ effect on them; as the other tasks are undertaken it can be assumed there will be positive ramifications for student doctors. Indeed, there were similarities between recommendations from students as to what can make the speciality more appealing and with what GPs themselves suggested, such as:

- Creating a positive image for GPs; and
- Being clear about the varied career general practice can offer, for instance through portfolio careers.

In addition, students said that longer training placements that help maximise their positive exposure to general practice, as well as making it compulsory placements during the FY1 and FY2 years, might also help increase the in-flow and interest to the speciality. One or two also said that decreasing the price for post-graduation membership and the exam might help it appeal to those embarking on their career and who are focussed on clearing their debts.

Finally, in looking to the future, one of the aims for the Partnership is to encourage, in some capacity, the return of GPs who have left the profession. The complex nature of the reasons for disaffection, combined with the emotional pull to the profession, meant the decision to leave had not been taken lightly by any of those included in the research. This highlights the difficult task in encouraging those who have left to return. Many told us that they simply would not do so in the current climate, and therefore encouraging return on a larger scale may take some time, with other changes needing to take place first.
For example, the research included GPs who had chosen to move abroad, many of whom said that even though they had returned, this was often for family reasons and their colleagues in other countries would not consider it. This was because they had experienced or were aware of the factors leading to disaffection.

However, these GPs, and others included in the research felt more could be done to facilitate GPs who had trained outside of the UK to work there. They felt immigration processes provided barriers and more could be done to both encourage people to move and support them through the process. As the current mechanism to support the induction or return of GPs to England, the induction and refresher scheme was welcomed in principle. However, alongside more support at the initial application stage to help potential applicants through the process – which was seen to be complex and bureaucratic – participants also said communication highlighting that the scheme is easier than people currently think is needed.
Appendices
Appendix A: methods and sample profile

‘Retain’ and ‘return’ strands

The ‘retain’ and ‘return’ strands of the research comprised a range of in-depth interviews:

- 41 in-depth telephone interviews with GPs seriously considering leaving and in circumstances that may present challenges to remain in practice, including: GPs with young families; those with caring responsibilities; early retirees; and those with health conditions.

- 23 in-depth telephone interviews were conducted among GPs who had left or were in the process of coming back to the speciality. This included those that were seriously considering emigration; those that had already emigrated; GPs in the process of – or had recently returned to – practice; and those that had left the speciality (including some that remained working as a locum).

- A breakdown of how many interviews were conducted as per these subgroups is provided below:

Table 1: ‘Retain’ and ‘Return’ sample breakdown

<table>
<thead>
<tr>
<th>Retain sample breakdown</th>
<th>Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young families (including children under the age of 12 and some under two).</td>
<td>11</td>
</tr>
<tr>
<td>Caring responsibilities</td>
<td>10</td>
</tr>
<tr>
<td>Early retirees</td>
<td>10</td>
</tr>
<tr>
<td>Health condition</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Return sample breakdown</th>
<th>Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considering emigration</td>
<td>6</td>
</tr>
<tr>
<td>Emigrants</td>
<td>5</td>
</tr>
<tr>
<td>Returning to practice</td>
<td>6</td>
</tr>
<tr>
<td>Leavers</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
</tr>
</tbody>
</table>

‘Recruit’ strand

The ‘recruit’ strand of the research comprised a number of discussion groups with students:

- Four discussion groups lasting 1.5 hours each were conducted to allow for the inclusion of a range of students with different attitudes to entering general practice. This allowed us to fully explore the motivating and/or demotivating factors affecting their decision to pursue a career as a GP or not.

- The groups were conducted at two separate universities – one with a typically high proportion of graduates that go on to become a GP, another from a university that send a relatively low number of its graduates on to become a GP.
Table 2: ‘Recruit’ sample breakdown

<table>
<thead>
<tr>
<th>Group Number</th>
<th>University</th>
<th>Definition of group</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>High proportion of graduates that go on to become a GP</td>
<td>Medical students in who are in their 4th to 5th year at university and who have a positive attitude to a future career as a GP.</td>
<td>Mix</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Medical students in who are in their 1st to 3rd year at university and who have a negative attitude to a future career as a GP.</td>
<td>Mix</td>
</tr>
<tr>
<td>3</td>
<td>Low proportion of graduates that go on to become a GP</td>
<td>Medical students in who are in their 1st to 3rd year at university and who have a positive attitude to a future career as a GP.</td>
<td>Mix</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Medical students in who are in their 4th to 5th year at university and who have a negative attitude to a future career as a GP.</td>
<td>Mix</td>
</tr>
</tbody>
</table>

Further information about the fieldwork:

- The sample was provided through a range of sources that included the Ipsos MORI GP Panel, purchased sample, and ‘snowballing’ (referral from other participants).
- Participants were recruited through our in-house specialist recruitment team and received a ‘thank you’ payment for their time.
- The interviews were conducted between September and November 2015. All discussion groups were carried out by Ipsos MORI in November 2015.
Appendix B: incentives tested

Each of the incentives – including and brief description – and the audiences they were tested with are outlined below. Participants were provided with additional information on each to facilitate discussions. Not all incentives were discussed with every participant, but each was explored across the research.

Recruit
1. An additional year of post-CCT training, to encourage new GP training applicants to go to areas that particularly need GPs (such as rural areas or those with high levels of deprivation).
2. Pilot training hubs or virtual networks where groups of GP practices can offer training opportunities to a range of professionals.
3. Financial support for GPs going into specific areas.

Retain
1. The GP retained doctor scheme, intended to ensure that doctors who wish eventually to return to general practice (as a principal or non-principal) are able to keep up-to-date and develop their careers.
2. Childcare vouchers, to enable parents to pay for child care pre-tax and NI out of their pay.
3. Becoming a clinical mentor, to clinical support and guidance to other GPs.
4. A rotational role, in which doctors from urban areas are offered the opportunity to practise in remote or underdoctored areas of the country for a few months each year on a rotational basis.
5. Portfolio careers, in which the role is divided to include – for example – sessions in general practice, sessions in other clinical settings such as urgent care centres, or acute settings, or sessions in clinical commissioning or educational roles such as at the medical school.
6. Educational bursaries to allow for additional study.

Return
1. Induction and refresher scheme to support GPs who have previously been in practice to introduce them back to the workforce.
2. Relocation grants for hard to fill roles.
3. Childcare vouchers, to enable parents to pay for child care pre-tax and NI out of their pay.
4. A rotational role, in which doctors from urban areas are offered the opportunity to practise in remote or underdoctored areas of the country for a few months each year on a rotational basis.
5. Portfolio careers, in which the role is divided to include – for example – sessions in general practice, sessions in other clinical settings such as urgent care centres, or acute settings, or sessions in clinical commissioning or educational roles such as at the medical school.
6. Educational bursaries to allow for additional study.