



Independent Evaluation Report for the GP Retention Intensive Support Sites (GPRISS) Programme

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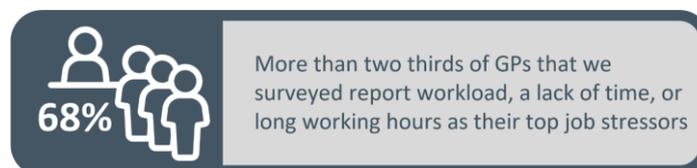
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This evaluation was commissioned by NHS England and NHS Improvement to provide an independent evaluation of the impact of running multiple interventions, delivered at three levels (individual, practice and system), on seven GP Retention Intensive Support Sites.

1. Executive summary

General Practitioner (GP) retention is one of the principal challenges facing the primary care workforce, with the GP Forward View committing to increase the GP numbers by 5000 full-time equivalents by 2020. Growing evidence exploring causes of GP attrition nationally has highlighted a number of causes including workload, perceived support and recognition, pay, bureaucracy, financial or regulatory risks and changing patient demands. To develop and test interventions locally, seven GP Retention Intensive Support Sites (GPRISS) were announced in June 2018 in areas with particular retention problems. The majority of interventions developed by the GPRISS teams were aimed at GPs, but also included those aimed at the wider workforce and practice managers.

A mixed methods evaluation including qualitative and quantitative analyses using interviews, an online survey, and focus groups, was conducted alongside GP retention initiatives from November 2018 to April 2019. The evaluation showed most GPs perceived the GPRISS initiative and its component interventions positively. GPs reported a positive impact on their job satisfaction, patient care, practices, and the wider health system. Moreover, GPs reported that the initiative left them feeling more likely to stay in general practice and within their local areas. The positive impact was felt most by GPs in their first five years of practice, those working in larger practices, and those who had received different interventions aimed at an individual, practice and system level.



Qualitative evidence highlighted specific considerations and lessons learned likely to be of interest to those implementing interventions to retain GPs across England. A recurrent message from interviews and focus groups was that success relies on developing a local approach and support offer to improving retention. The evidence highlighted the importance of understanding the needs of GPs at different career stages, benefits of early engagement activities with GPs, utilisation of workforce data when planning interventions and openness to ongoing communication throughout implementation. Additionally, evidence suggested that GP-focussed interventions should be supplemented with interventions that support practice managers and the wider workforce within primary care. Developing people on the ground, with the capacity and capability to drive GP retention initiatives, was seen as vital to the success of GPRISS. Success was found to be contingent on having a skilled project team comprised of staff with the capacity to offer strategic leadership, a clinical GP lead who could offer knowledge of general practice, and the involvement of key stakeholders working within primary care. Another key enabler for project teams was the ability to access dedicated funding to kick-start initiatives.

At the time of conducting this evaluation, it was not possible to measure the relative impact of all interventions due to the design of the GPRISS initiative (i.e. multiple concurrent interventions with

staggered implementation). The evaluation team were unable to use national workforce datasets to inform analyses because workforce data for the period following implementation of initiatives will not be available until at least summer 2019.

2. Key Findings

There are a number of key findings from this evaluation that may inform the national GP workforce programme as well as regional and local GP retention initiatives. Recommendations in [section 9](#) have been informed by interviews, focus groups, an online survey and an after action review described in [section 5](#).

Analysis of the online survey, completed by 192 GPs and other stakeholders, provides early evidence of potential benefits of the programme (see [section 7](#)). For example, 60% of GPs who responded agreed that the combined impact of GPRISS interventions will improve their job satisfaction, compared to only 17% of GPs who disagreed. Moreover, there is some evidence that multiple interventions targeted at individual GPs, GP practices, and the interface between general practice and wider healthcare system (the hothouse approach, described in [section 4.2](#)), helped increase the programme's efficacy. Survey results demonstrated that GPs who received interventions at all three levels (individual, practice, and system) tended to feel more supported than those who only received interventions aimed at one or two levels.

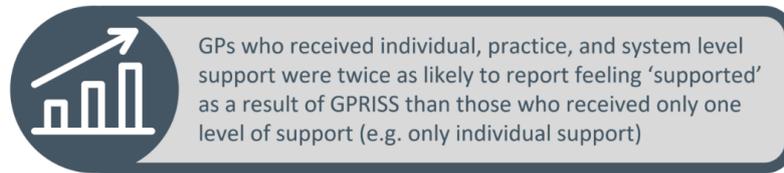


There are a number of themes from the interviews and focus groups that also help to explain the successes and challenges of the programme (detailed in [section 8](#)). Representatives from intensive support sites described feeling heard, the fact that there was national acknowledgment of challenges facing primary care and dedicated funding as key enablers for GP retention. However, there were mixed feelings about the flexibility and multi-level nature of interventions of the GPRISS approach. Some people reported reservations about managing numerous interventions simultaneously and the need to avoid potentially confusing messages to GPs.

Key learning and examples of good practice emerged from those interviewed at intensive support sites. These included assembling an immediate implementation team with an embedded clinical lead and change agent, and building on existing successful local and national GP retention interventions which could be tailored or rolled out across an STP footprint. Additionally, interviewees highlighted a need to be mindful of retention of the wider primary workforce in addition to the issues that affect GP retention.

There were also challenges to the programme and implementation teams as described in [section 8.5](#). Chief amongst these was time, both the short duration of the programme (particularly given the long term outlook of the desired outcomes) and the timing of implementation during the end of the financial year when resources are stretched. Sites also had to overcome negative perceptions amongst GPs. For instance, sites noted stigma associated with GPs reaching out for support.

Additionally, in some areas, stakeholders outside general practice may be viewed with scepticism. Finally, there were a number of practical challenges to getting interventions off the ground. These included navigating procurement quickly and structuring interventions to minimise impact on clinical work.



From the lessons learned, and resultant recommendations, (see [section 9](#)), there is a need to balance GP retention in important ways in terms of:

- Local versus national – intensive support sites noted the importance of collecting local information and developing a local approach to offers while also noting that it would not have been possible to get certain interventions off the ground quickly without national support, and access to existing national offers and tools (for example to model workforce numbers).
- Individual versus practice and system – while individual support was, in many cases, more visible, there was an acknowledgement that many critical issues, in terms of workload in particular, needed to be unblocked at practice and system level. It was considered that all three levels of support are needed to really improve job satisfaction to influence GPs to stay in the profession and in an area.
- Early career versus late career –it was not enough to focus on a single stage in a GP’s career journey. Several sites have been successful in increasing training places and retaining more GP trainees post-registration. In addition, the perception of support amongst First5 GPs was high bearing in mind there were interventions specifically targeting GPs in their first five years of practice. Mid-career GPs, however, represent the largest group numerically and so called ‘Wise5’ GPs (GPs approaching retirement) are leaving the profession in large numbers due to work pressures, changes to pension regulations, and a lack of flexible employment options. One site went as far as looking at the employment needs of new parents and found ways to better retain these clinicians through new ways of working and more flexible working patterns.
- A narrow versus wide view of GP retention – most sites took a broad view of retention as including GP recruitment, with the ultimate aim of increasing capacity in the general practice workforce. Similarly, while most interventions were aimed at GPs, it was noted that the wider general practice workforce was equally important. This includes practice nurses, healthcare assistants, non-clinical practice staff and new roles in general practice such as practice pharmacists, physicians’ associates, care navigators, and allied health professions. Engagement also varied in terms of which combination of partners worked best in each area. Most sites struggled to engage secondary care but other local partners, including GP federations, Local Medical Councils (LMCs), the Royal College of General Practitioners

(RCGP), Clinical Commissioning Groups (CCGs), Sustainability and Transformation Partnerships (STPs), and others working at a system-level, were instrumental in championing the interventions.

Case Study: Weston & Worle Front Door Redesign

An example of a practice level intervention

In order to improve patient access, enhance continuity of care and optimize workflow management, Weston and Worle have taken steps to transform appointment booking services by redesigning front door services. Access and continuity are sometimes seen as competing priorities but they are essential attributes that complement one another. Good access facilitates continuity, and high levels of continuity reduce demand. This, in turn, reduces waiting times and increases accessibility. Within Weston and Worle, a digital access tool (askmyGP) is being used by patients to access GP services. The tool allows practices to efficiently assign patients appointments with appropriate clinicians. This is achieved by matching clinical capacity with demand. The triage system also takes into account which clinicians are likely to know each patient's history and needs best. For GP appointments, patients have the option of choosing telephone, video and face-to-face consultations. Within each practice, micro-teams cover the working week and manage patient lists. The teams are usually led by GPs with the support of a nurse or an advanced practitioner.

3. Introduction

Despite the 2015 government commitment to add 5,000 full-time equivalent GPs to the primary care workforce by 2020, latest statistics (December 2018) indicate GP numbers (excluding locums and registrars) have fallen by a further 565¹. The workforce challenges are being driven by insufficient recruitment coupled with increasing attrition due to many GPs reducing their working hours, changing careers, leaving for other countries or retiring early². Research highlights a complex web of interlinked factors leading to poor GP job satisfaction among^{3,4}. These include workload, administrative burdens, perceived lack of support or recognition, feelings of isolation, financial and regulatory risks, changing patient demands and the potential for litigation⁵. Worryingly, some of these factors are believed to be getting worse, driving attrition further^{6,7,8}. Evidence suggests that the falling numbers of GP full time equivalents (FTEs) across the UK is negatively affecting patient satisfaction⁹. This could be attributed to an under-resourced primary care system that struggles to give patients timely and appropriate care.

¹ <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-31-december-2018>

² <https://bmjopen.bmj.com/content/9/2/e026048#ref-1>

³ https://jech.bmj.com/content/71/Suppl_1/A84.1

⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4723211/>

⁵ <https://www.england.nhs.uk/wp-content/uploads/2018/05/local-gp-retention-fund-guidance-v1-2.pdf>

⁶ <http://www.rcgp.org.uk/-/media/Files/Primary-Care-Development/RCGP-annual-assessment-GP-forward-view-year2-aug-2018.ashx?la=en>

⁷ <http://blogs.ishtm.ac.uk/prucomm/files/2018/05/Ninth-National-GP-Worklife-Survey.pdf>

⁸ <https://www.kingsfund.org.uk/blog/2018/08/gp-trainees-workforce-future>

⁹ <https://www.kingsfund.org.uk/blog/2018/02/public-satisfaction-gp-services>

A number of the workforce challenges facing primary care have been acknowledged in recent NHS England (NHSE) policy such as the General Practice Forward View (GPFV) and the NHS Long Term Plan. The GPFV set out the need to expand and support GPs, through increasing workforce capacity and developing capability in the current workforce. A range of initiatives were proposed, including calling upon the skills of the wider primary care workforce to reduce the workload of GPs, financial incentives for GP trainees and returners, and investing in leadership and portfolio opportunities for experienced GPs. More recently, the NHS Long Term Plan aimed to build on the General Practice Forward View to increase the number of doctors working in general practice. Plans were outlined for two year fellowships for newly qualified doctors, a state backed GP indemnity scheme, and ongoing work with Health Education England (HEE), British Medical Association (BMA) and the medical Royal Colleges on CPD, training and development opportunities.

NHSE is spearheading national campaigns to recruit and retain GPs. These are based on commitments set out in the GPFV¹⁰ and aim to improve working environments and make the profession more attractive. One of such initiatives is the GP Retention Intensive Support Sites (GPRISS) programme which offered £3 million to support areas struggling with GP retention. The programme is working with seven early-implementer sites across the UK to conduct local diagnostics and test area-specific interventions to retain GPs in those areas.

The core principle underpinning the GPRISS initiative is that interventions should be delivered at three levels (individual, practice and system) to achieve greatest benefit (see [section 4.2](#)). GPRISS interventions vary from process-orientated (e.g. referral process) to behavioural (e.g. coaching mentorship) and are implemented at all three levels. The interventions aim to improve the work environment, reduce workload pressures, and/or encourage a positive culture around being a GP. This may be achieved by improving support systems, interfaces with secondary care, or trust and relationships between GPs and other staff in the health economy. The ambition of GPRISS, although implemented over a short time, is to achieve long-lasting and strategic impact.

Case Study: Newham Quality Improvement Programme

An example of a system level intervention

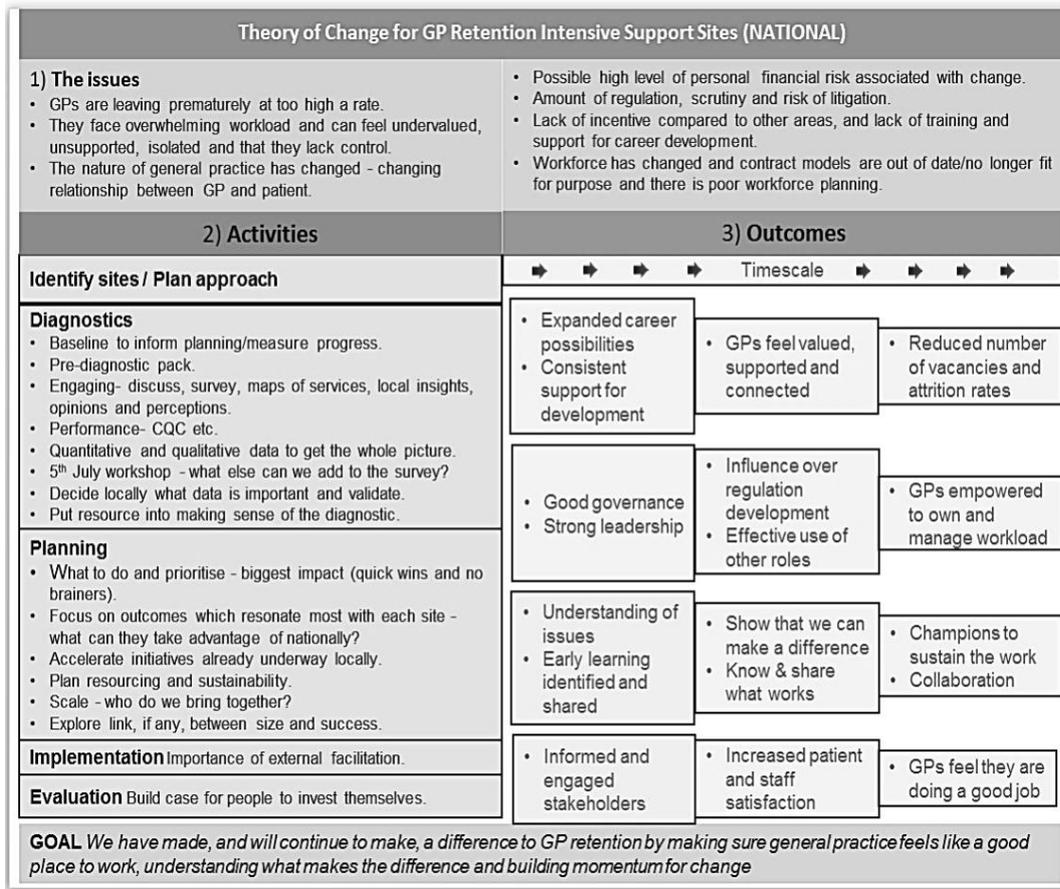
Newham CCG has maintained a strong focus on embedding Quality Improvement (QI) across its primary care landscape. The rationale underpinning why QI can improve GP retention is that, when quality of care improves, practices will become more efficient and patients' experiences will improve. This will lead to increases in GP satisfaction. Overall, the wellbeing of practitioners will advance synergistically with the welfare of patients. Newham's QIPP programme is being delivered to first 5s who are interested in bettering themselves as clinicians, as well as improving the wider primary care system. The team planned to focus on 12 first 5s who would become QI leads upon completion of the scheme. After receiving considerable interest, the scheme was tweaked to include members of the wider workforce within general practice. The Scheme has 2 phases: initial training, followed by implementation of a specially-designed toolkit made available to participants.

This evaluation focuses on understanding the replicability and sustainability of interventions delivered by the GPRISS scheme, both financially and practically. Moreover, it explores what

¹⁰ <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

measures have been put in place to enable continued intervention maintenance (or scaling). A mixed method approach, incorporating quantitative and qualitative analyses, was adopted to understand the context, implementation and impact of interventions at each site as depicted by the theory of change model below (Figure 1). The overall aim is to use the evidence gathered to inform NHSE’s long-term strategy, along with associated toolkits, so that appropriate advice is available for STPs as well as evolving integrated care systems (ICS) to replicate and deliver retention interventions.

Figure 1: Theory of Change for GP Retention Intensive Support Sites (National)



4. GPRISS sites

Seven sites, with particular challenges retaining GPs, were chosen from across England (see figures 2). Sites varied in size and configuration but all had strong local leadership.

Figure 2: Map of GPRISS site locations



Each site was allocated £417,500 to support the project and the various initiatives.

A change facilitator was allocated to each site to provide change management leadership and expertise to create and agree clear, measurable and practical plans for GP retention and to ensure key stakeholders were enthused and motivated to make agreed changes over the intense six month period.

4.1 Evaluation questions

In November 2018, NECS Research and Evidence and NEL Healthcare Consulting were selected to evaluate the GP retention intensive support sites. A high level evaluation plan was produced and agreed with NHS England in December 2018. This was shared with project teams at the intensive support sites. A mixed methods approach was chosen, in which interviews, an online survey and focus groups were used to answer the main evaluation questions. The questions focussed on the following areas:

- Effectiveness of interventions chosen,
- Net impact of the intensive support sites and multi-component interventions,
- Local barriers and enablers, context and relationships encountered during intensive support site implementation,
- Lessons learned including unexpected benefits/dis-benefits, and degree of local GP engagement in the initiative.

4.2 Hothouse approach

NHSE promoted a hot housing approach as a lean solution to deliver change in a short timeframe. This involved delivering interventions at different levels within the health system to increase overall impact. Interventions were delivered at three levels:

- Individual-level (for example coaching and mentoring).
- Practice-level (for example the use of 15 minute standard appointments)
- System-level (for example interventions aimed at reducing administrative workload created by acute hospitals as part of the 2017-19 standard (hospital) contract).

This hothouse approach is supported by research which suggests combining individual, group and organisational-level approaches can yield systemic changes that create a participatory environment, promote open communication, encourage manager and peer support, inspire shared learning, and facilitate employee involvement in planning and implementing programmes¹¹. Additionally, the National Institute of Clinical Excellence (NICE) guideline on mental wellbeing at work (Guideline PH22), recommends that “interventions for individual employees should be complemented by organisation-wide approaches that encompass all employees”¹². This may be achieved by combining proactive preventative strategies, at an organisational-level, with secondary individual-level management approaches.

This evaluation considers the impacts of different levels of interventions delivered by the GPRISS initiative.

Case Study: Black Country GP Mentoring An example of an individual level intervention

The Black Country’s mentoring scheme takes advantage of the skills and knowledge of experienced GPs within the area. This allows for younger GPs to receive guidance from mentors who have encountered similar issues and challenges specific to the area and helps re-energize the mentor's career and allows them to "give back" to the profession. The STP’s scheme has been achieved by adapting and up-scaling a popular pre-existing scheme implemented by one of its CCGs (Dudley CCG), in which a retired GP became a mentor and provided guidance on health, finances, partnerships, professional development and burnout-related issues to younger GPs. Currently, the STP has recruited 6 mentors from different age groups, genders, ethnicities and stages of their careers. Instead of being assigned a mentor, younger GPs are given the opportunity to choose one of their liking by reviewing brochure. This contributes to a more personalised approach to mentoring. To support both Wise 5 and younger GPs, the Kirklees and Huddersfield mentoring scheme offers a chance for retired GPs, or those who can no longer practice due to ill health, a chance to mentor their juniors in Bradford. This scheme is supported by the RCGP.

¹¹https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/506777/25022016_Burnout_Rapid_Review_2015709.pdf

¹² <https://www.nice.org.uk/guidance/ph22/chapter/1-Recommendations>

5. Method

This evaluation adopted a mixed method approach, incorporating quantitative and qualitative methods, to evaluate effectiveness the GPRISS initiative. This section provides details of methods used.

5.1 Initial desktop document review

A desktop document review was undertaken in the first phase of the evaluation. Research and relevant national policy around GP attrition and job satisfaction was reviewed. Key documents from the seven sites, examining each site's theory of change, action plan and highlight reports were shared. Local interventions were categorised to better understand and compare them across sites. Site profiles were created to document the local primary care context (e.g. levels of deprivation, influence of GP federations, local education provided, new care models etc.).

Common themes or groupings of the 102 interventions (33 at an individual level, 32 at practice level, and 37 at system level) across seven GPRISS sites can be seen in table 1 below.

Table 1: intervention themes

Theme of Interventions	Number
Coaching & mentoring	19
Communications, engagement & marketing	14
Capacity / workload	10
Back-office / systems	10
Education & training	9
Career development & progression	9
Leadership development	6
Peer support	6
Integration / primary care at scale	6
Standard contract provisions	3
Other	10
Total Interventions	102

To better understand the causes of GP attrition, findings from the document review were organised using a driver diagram, an improvement tool often used to break down complex problems such as GP retention into a set of more manageable problems. With regard to the central question "What are the preventable causes of GP attrition?", the identified problems were broken down further into factors associated with the job/profession and factors external to the job. The evaluation team also found Herzberg's two factor theory¹³ of job satisfaction to be useful in organising the factors internal to the job, as there is a considerable academic management literature supporting this theory. It posits that job satisfaction relates not just to 'hygiene' factors (such as pay and job security), but also to 'motivators' (such as growth opportunities and a sense of achievement). In this context, most of the GP job stressors found during this review were related to one or more of these factors, presented in table 2.

¹³ http://www.lifesciencesite.com/ljsj/life140517/03_32120ljsj140517_12_16.pdf

Table 2: GP job stressors and Herzberg’s two factor theory of motivation in the workplace

Herzberg’s 2 factor theory	GP Job Stressors	
Hygiene factors	Working conditions	Workload (volume), appointment length, intensity of work
	Peer relationships	Isolation / lack of support
	Leadership quality	Practice & system GP leadership
	Job security	Litigation
	Compensation	Pay, indemnity cover, pension
	Status	Inappropriate demand from secondary care
Motivators	Responsibility	Sufficient clinical challenge
	Job satisfaction	Paperwork
	Recognition	Patient complaints / demands,
	Achievement	Negative media coverage
	Growth Opportunities	Variety of clinical work, career pathways
	Advancement	Lack of career guidance

There are also factors external to the job which may be equally important (but less easily controlled) to GP retention, for example factors specific to the GPRISS sites, such as rural location, which may act as detractors for some GPs. As there is no specific research around external factors, the evaluation team used a common PESTLE (political, economic, social, technological, legal, environmental) framework to consider these, but most are beyond the scope and influence of the GPRISS programme.

5.2 Qualitative fieldwork – initial interviews

Evaluators interviewed 29 members of staff involved in developing and delivering the GPRISS initiative across seven geographical locations in England. During these initial interviews, a range of GPRISS project team members, including project leads, clinical leads, change facilitators and NHSE regional representatives, were invited to participate.

Table 3: Stakeholder mapping

Stakeholder Categories	Communication / Engagement Methods	Involvement / Support
Change facilitators	Site visit, interviews, info sharing calls, focus groups, survey, after action review	High
Lead clinicians		High
Project lead		High
Local commissioners	Focus groups, final report	Med
Regional teams	Info sharing calls, final report	Med
GPs (incl. first 5, mid-career, and wise 5)	Surveys, focus groups, interviews	Med
Wider practice workforce (practice managers & other practice staff)	Focus groups (may vary by area depending on involvement)	Med
GP Federations	Interviews (where relevant), focus groups,	Med
HEE	Final report	Med
NHSE Retention programme	Weekly reporting	High
LMCs	Final report	Med-low
Local providers (esp. Acute)	Final report	Low
Patients & Public	Final report (once published)	Low

This initial phase of qualitative fieldwork was undertaken in January 2019 with face-to-face interviews. Where this was not possible, telephone interviews were used. All interviewees approached were provided with a participant information sheet which outlined the aims and context of the fieldwork. After an opportunity to ask any questions, interviewees were invited to sign a consent form to participate in the project. An interview guide was developed in line with the evaluation questions and covered questions about aims of the GPRISS initiative, current status of general practice at each site, and the geographical area and patient population the intensive support site served (see [appendix D1](#)). Participants were asked further questions around the rationale for interventions chosen, progress to date, and enablers or barriers to implementation. Each interview was recorded and transcribed for relevant information. The information was analysed thematically and quotes to demonstrate key findings were extracted.

5.3 Quantitative data collection

All available data sources were reviewed around proposed outcome measures for GPRISS. These included GP workforce data which is collected and reported quarterly. Unfortunately, the GP workforce data collection fell in the middle of the GPRISS programme implementation period and suitable data for assessment of the impact of the initiative will not be published until summer 2019. In any case, the final outcomes of the programme, in terms of measurable increases to the number of GP FTE, will take some time (e.g. summer 2019 at a minimum) to fully demonstrate.

5.3.1 Survey design

An anonymous survey of GPs and other stakeholders was designed to collect information about the impact of the GP retention interventions at each site and of the GPRISS programme as a whole.

The survey comprised 29 questions: 14 questions were specifically for GPs and seven for wider stakeholders (outlined in [appendix B](#)). The survey was designed to take no more than seven-10 minutes to not take up too much respondent time. The questions fell into several broad categories including: respondent demographics, current GP job stressors, ratings of the individual interventions received, the impact of GPRISS on GPs, practices, patients and the wider health system, and GP intentions in terms of working patterns, staying in an area, and staying in general practice. Where appropriate, questions included five point Likert scale responses (i.e. strongly agree to strongly disagree), ranking and scoring to elicit unbiased responses.

The survey was conducted between the 18 February and 29 March 2019 using SurveyMonkey and participants were acquired using a snowballing sampling approach. Survey links were sent to each intensive support site team who then sent on participation requests and survey links to practices and GPs who received one or more interventions. Survey links were also sent to other local stakeholders (wider practice workforce, commissioners, and members of the implementation teams) involved in the programme at the discretion of the sites following guidance in a dissemination plan sent to them. Note that responses from GPs who received interventions were analysed separately to control for bias.

Case Study: Isle of Wight – Promoting the Area An example of a system level intervention

The Isle of Wight faces particular challenges relating to geography; the island is not readily accessible from the mainland and has some of the highest ferry fares in Europe. With this in mind, the CCG has made considerable effort to promote the area as an exciting and beautiful place to live and work. The island boasts a wide array of restaurants, historic and popular attractions, world famous events and festivals, and choices for outdoors pursuits. From a career perspective, the islands population demographic offers a unique opportunity to practice multiple elements of primary care (such as, rural and urban medicine, geriatric medicine, medicines optimisation in care homes, and minor surgery) within a small catchment area. The CCG has developed a recruitment programme with a strong emphasis on marketing materials to promote the island using digital platforms and social media. It is also working with local recruitment agencies, and is in the process of securing ferry discounts for GPs travelling to and from the mainland.

5.4 Qualitative fieldwork – focus groups

In March 2019, evaluators returned to the intensive support sites and conducted focus groups with key stakeholders. The focus groups enabled further collection of rich data and an opportunity to build upon findings from the online survey and initial interviews.

A quota-sampling approach was used to acquire focus group participants representative of specific groups within primary care. Each site was asked to bring together a focus group of six to eight participants comprising at least two recipients of GPRISS interventions (i.e. GPs, practice managers) as well as two representatives from the GPRISS project team one or two representatives from wider

stakeholder groups including regional teams, local commissioners, LMCs, providers, GP federations, etc.). However, there was an understanding that each intensive support site was unique and the format of the focus group would need to be flexible. In some instances, there were challenges assembling representation from all suggested stakeholders within the timeframe and therefore focus groups across the sites varied in size and composition.

A discussion schedule was developed to follow on from the initial interviews and explore pertinent responses from the online survey (refer to [appendix D2](#)). Questions within the focus groups aimed to explore:

- Specific interventions – what has worked best and why and what could be improved upon
- The hot house approach, thinking about multi-level (system/practice/individual) interventions and whether there is a greater impact than if done individually
- Reflecting on the implementation process, aims and sustainability,
- How relationships locally, between GPRISS sites and with the national team impacted on outcomes

The focus group recordings were transcribed and this data was integrated into the working thematic analysis from the initial interviews.

5.5 After action review

During information sharing calls with sites, there was a desire to incorporate some sort of closure in the programme. This was not initially part of the evaluation plan, however, the evaluation team suggested using an after action review (AAR) approach which is widely used in healthcare and other sectors as a way to reflect on individual and collective learning following complex shared endeavours. An after action review session was held with all of the sites and the NHSE programme team represented on 18 April, 2019. This facilitated session sought answers from all participants to the four AAR questions:

1. What did you expect to happen?
2. What actually happened?
3. Why was there a difference?
4. What can be learned?

The transcribed notes from the AAR have informed the thematic analysis in [section 8](#).

6. Site characteristics

Note: This section provides a brief overview of the site profiles. For more detail, please refer to [appendix A](#).

The desktop document review revealed that the GPRISS sites varied considerably in size, with catchment populations ranging from 144,464 to 1,759,774 people. When considering Index of Multiple Deprivation (IMD) scores, the official measure of relative deprivation in areas of England, five GPRISS sites fell within quintile four (the second most deprived quintile). Only Mid and South Essex, and Weston and Worle sites had scores of quintile three (the middle). When examining the age distributions across sites, the Isle of Wight CCG and Weston and Worle had high proportions of people aged over 60 (34% and 30% respectively) whereas Newham CCG had the highest proportion (41%) of people aged between 20 and 39 years.

Similar workforce challenges were reported across most GPRISS site. For example, most sites had high proportions of GPs approaching retirement age. Newham CCG, Weston and North Kirklees reported the highest rates of GPs aged over 55 (33% at each site). The Isle of Wight CCG reported that 42% of GPs on the island had indicated that they intended to prematurely leave or retire from the profession in the next five years. Using general practice appointments data from NHS Digital and data from NHSE's Workforce reporting tool (both from October 2018), it was determined that all GPRISS sites, apart from Weston and Worle, had fewer GPs per practice than the national average of 5.4 GPs per practice. When considering the number of patients per GP, all sites apart from Lancashire and South Cumbria had higher rates than the national average of 1,589 patients per GP. North Kirklees and Greater Huddersfield had the highest rate, with 477 more patients per GP than the national average. All GPRISS sites had higher rates of monthly appointments per GP than the national average.

Site-reported factors affecting GP retention were wide and varied. Some of the main factors included:

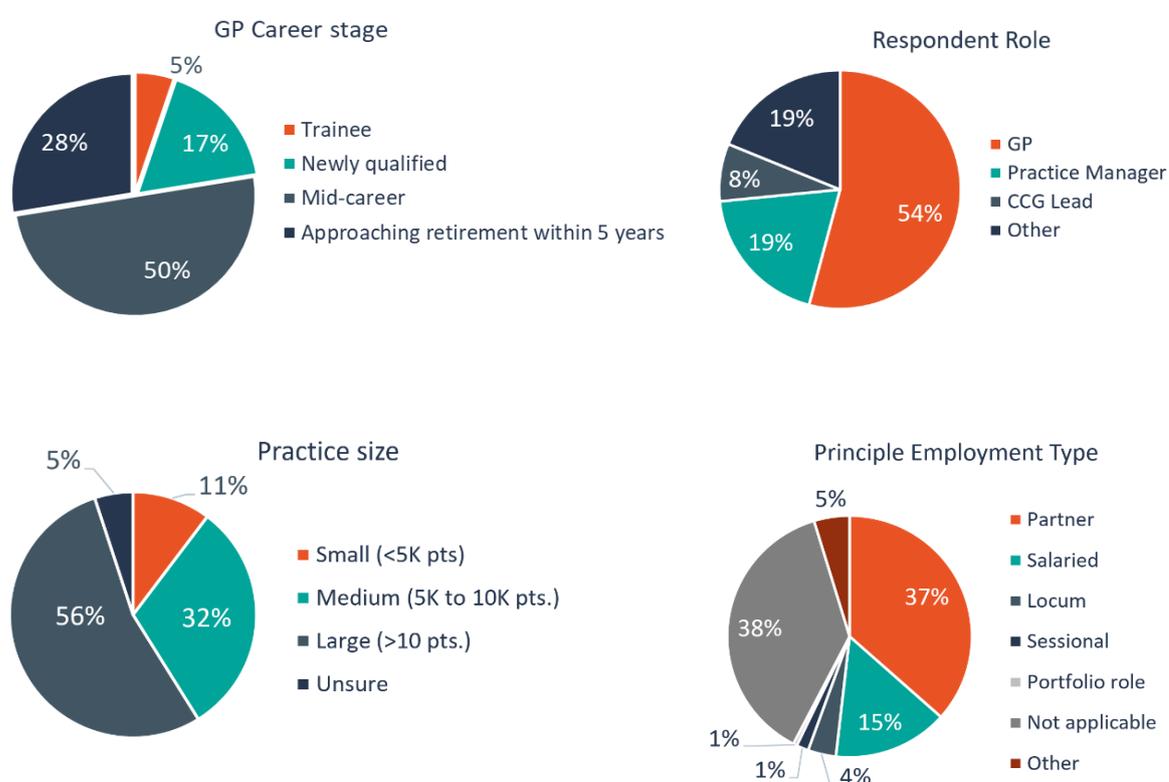
- Geography: Rural areas struggle to keep trainees, post-qualifying, due to the pull of big cities.
- High patient-to-GP ratios and increasing workload (appointments, prescriptions, lab results, and letters) quickly lead to burnout.
- Minimal development of wider primary care staff means there is little support available.
- Ineffective recruitment: Some practice vacancies have remained unfilled for long periods of time despite persistent advertising.
- Mid-career GPs (in salaried and partner roles) feel that locum work provides a better work-life balance.
- Fewer GP partners leading to more single-handed practices that struggle with demand.
- Communication and collaborative working are yet to be established across GP federations.
- Inappropriate premises: Some practices are located in premises not suitable for modern primary care.
- Pressure on acute trusts is transferred to primary care to pick up the excess workload. For instance, a deficit in hospital beds means that patients invariably have to be looked after by primary care services.

7. Quantitative findings

7.1 Respondent demographics

There were 192 responses to the survey, of which 54% (104/192) were from GPs. Of the 88 non-GPs who responded, 42% were practice managers, 17% were CCG leads and the rest (41%) belonged to the wider primary care workforce. Non-GP responses are presented separately in [appendix C](#). A high proportion (60%) of respondents were female, slightly higher than the national average of 54%. The distributions of age, career stage, and practice size are broadly representative of national primary care workforce, and are summarised below in figures 3 to 7. Overall, 21% of respondents were part of GPRISS implementation teams.

Figures 3 to 7: Survey Respondent Demographic Breakdown



7.2 Job stressors

In order to ascertain local-level stressors encountered by GPs, a subset of the job stressors relevant to the remit of GPRISS was chosen from the University of Manchester GP Worklife Survey¹⁴. Applicants were asked to rank their top five stressors, which were then converted to scores in the figure below. Although the scoring of the question is slightly different from the GP Worklife Survey (2018), the top job stressors in this evaluation are consistent. The most commonly reported job stressors were workload, insufficient time to do the job justice, increasing demands from patients and paperwork. These responses were also supported by the focus group results, found in [section 8](#).

¹⁴ <http://www.population-health.manchester.ac.uk/healthconomics/research/Reports/EighthNationalGPWorklifeSurveyreport/EighthNationalGPWorklifeSurveyreport.pdf>

Figure 8: Ranking of GP job stressors

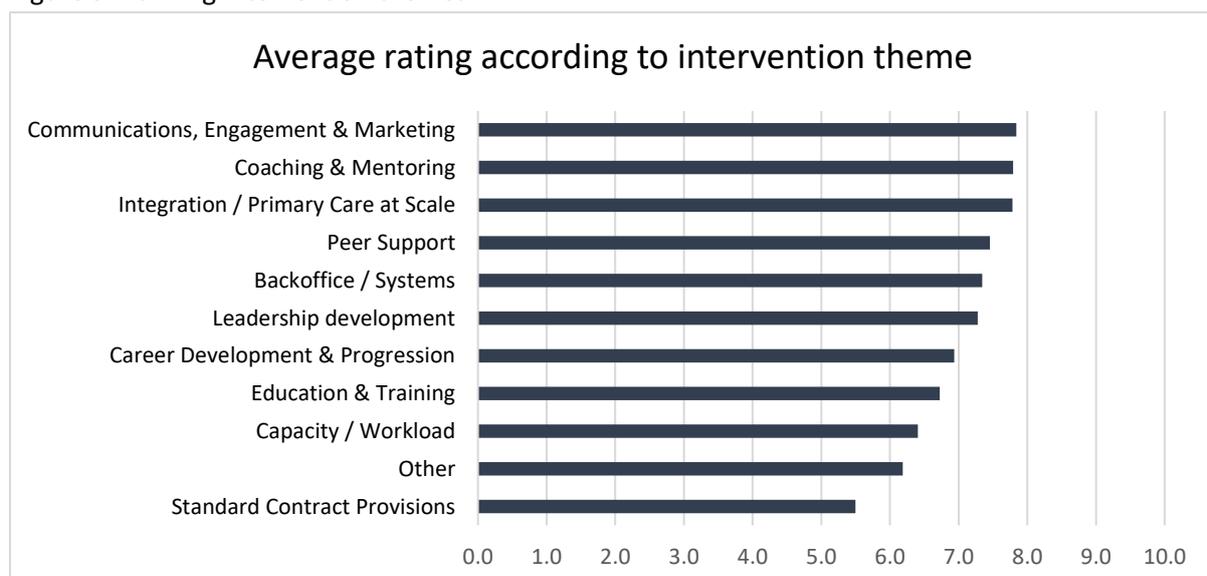


Note: scores were allocated to each participant's rankings, which were then added together.

7.3 Intervention ratings

In terms of the ranking of individual GPRISS interventions, GPs who had received one or more interventions were asked to identify (from a pre-populated list based on the interventions at each GPRISS site) which they had participated in and to rate them on a scale of 0-10 for impact on their job satisfaction. As multiple interventions were performed across the GPRISS sites, the analysis grouped individual interventions into common themes. The scores for each theme were then aggregated and averages calculated (see figure 9). It must be noted that some interventions had not been fully implemented or completed at the time of this evaluation. As a result, some of the GP ratings were based on limited exposure to interventions that had little time to embed and take effect.

Figure 9: Ranking intervention themes



The data highlights that interventions involving communications and engagement, coaching and mentoring and integration/primary care at scale received the highest ratings whilst those related to NHS Standard Contract provisions were rated the lowest. It is important to note that, at the point the survey was completed, many interventions were just in the process of being rolled out. Therefore, it is potentially too early to infer relative benefits of the interventions based on this data (this view was reported by multiple stakeholders during interviews, focus groups, and the after action review). With this in mind, a key recommendation is to repeat the survey in six months giving interventions sufficient time to embed.

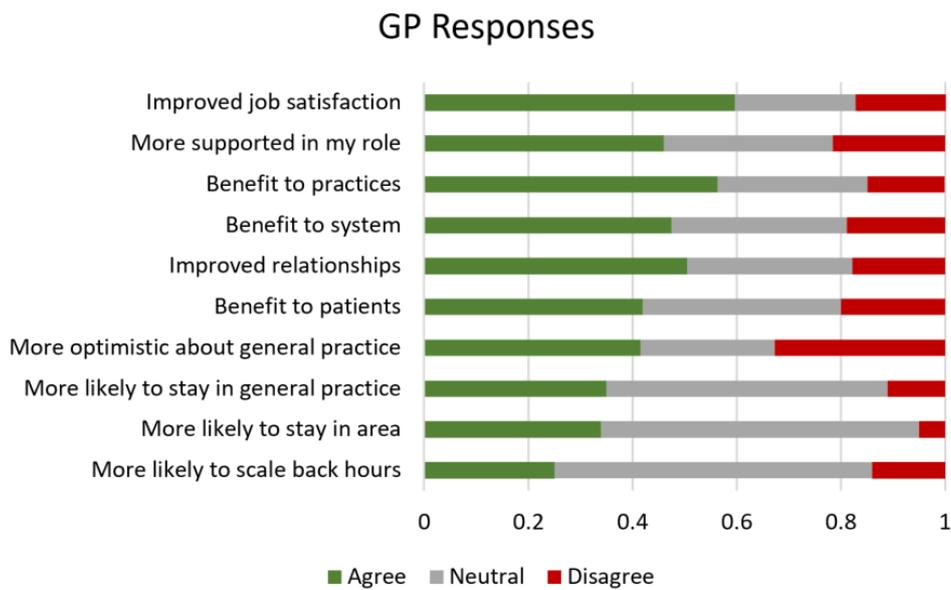
7.4 Perceived benefit

For all reported findings 'strongly agree' and 'agree' responses were pooled and 'strongly disagree' and 'disagree' were aggregated. For more detailed results, please refer to [appendix C](#). GPs were asked a series of questions on the likely impact of the entire GPRISS programme for their own job satisfaction, benefits to the wider system, and their career intentions. This data is presented below in figure 10. In questions focussing on the individual-level impact of GPRISS, more GPs stated that the programme had a positive impact on their job satisfaction (60% agree, 17% disagree), feelings of support (46% agree, 22% disagree), and levels of optimism (42% agree, 33% disagree).

In questions examining practice and wider system benefits, more GPs felt GPRISS has had (or will have) a positive benefit compared to those who did not. There was a strong positive response demonstrating a benefit to practices (56% agree, 15% disagree). Furthermore, more GPs agreed that the primary care system had benefited (48% agree, 19% disagree) and working relationships had improved (51% agree, 18% disagree). Non-GP responses in terms of the perception of the wider system benefits were, on average, 10-20% more positive than GPs. These can be found in [appendix C](#).

Respondents were less clear about their future intentions. For the question exploring intentions to stay in general practice over the next six to 12 months, 35% of GPs agreed and 11% disagreed. Similar response rates were observed for the question exploring intentions to stay in respective localities. Interestingly, more GPs reported being more likely to scale back their hours (25% agree, 14% disagree). This finding was explored in subsequent focus groups which indicated that working hours may be scaled back to pursue portfolio careers and by virtue of participating in interventions, but also as a result of rising workload. In relation to the high proportion of neutral responses to the impact of GPRISS on future intentions, focus groups reported that most GPs (for example, those approaching retirement) will have already planned what they are going to do in the next six to 12 months but that also the interventions have not yet had time to bed in.

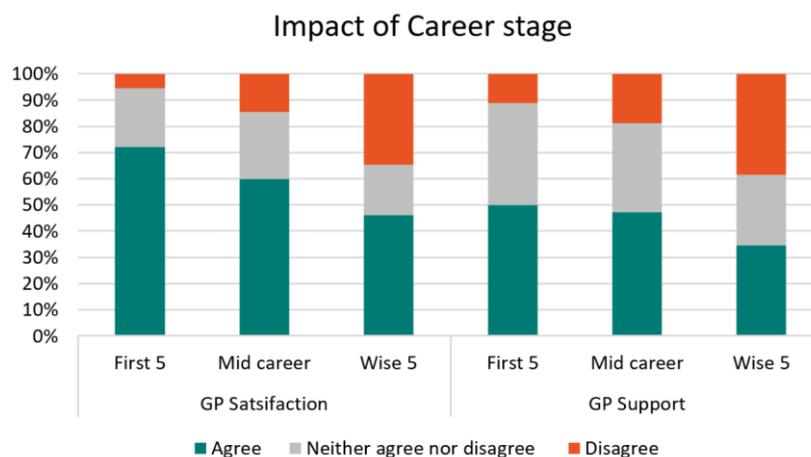
Figure 10: Summary of GP survey responses



Sub-group analyses were performed of selected demographic factors around responses to the GP survey questions and a number of these highlighted populations that would respond more favourably to interventions:

- There appears to be an inverse relationship between career stage and perceptions of satisfaction and support (see figure 11 below). This may be due to a number of well-established support schemes for first five GPs (e.g. the RCGP First5 programme). We also know that attrition rates are highest in this cohort, hence this group (as well as trainees) may be most amenable to interventions of any kind. Conversely, the data also suggests a potential lack of support for GPs in their lead up to retirement. While there were specific interventions focussed on this cohort, it is important to carry out further investigations as it is also a group that suffers from high attrition rates.

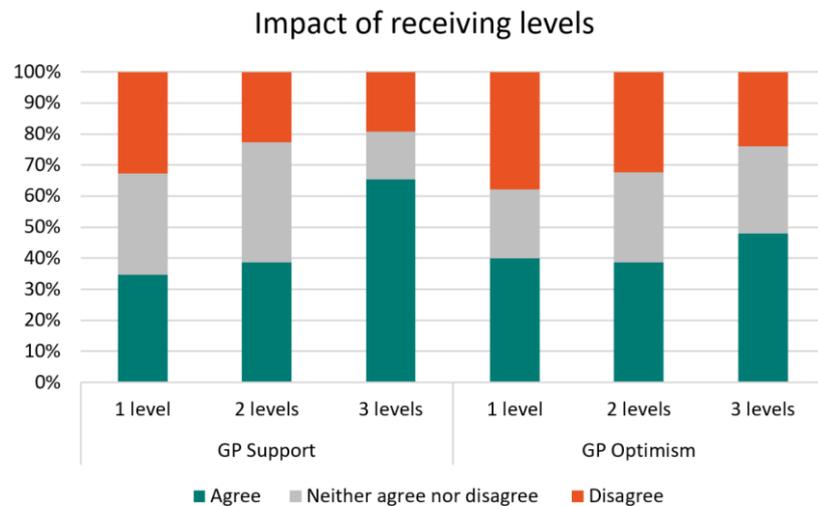
Figure 11: Impact of career stage on GP satisfaction and perception of support



- There is a positive trend between the number of levels received (individual, practice, and system level support) and perceptions of support and optimism (towards general practice) (see figure 12). This supports NHS England’s hypothesis in relation to the hot house approach: That interventions need to be aimed concurrently at individual GPs as well as practices and the wider primary care system to fully address GP retention. This view was also supported in the focus groups and an after action review.

Figure 12: Impact of receipt of varying levels of interventions on support and optimism

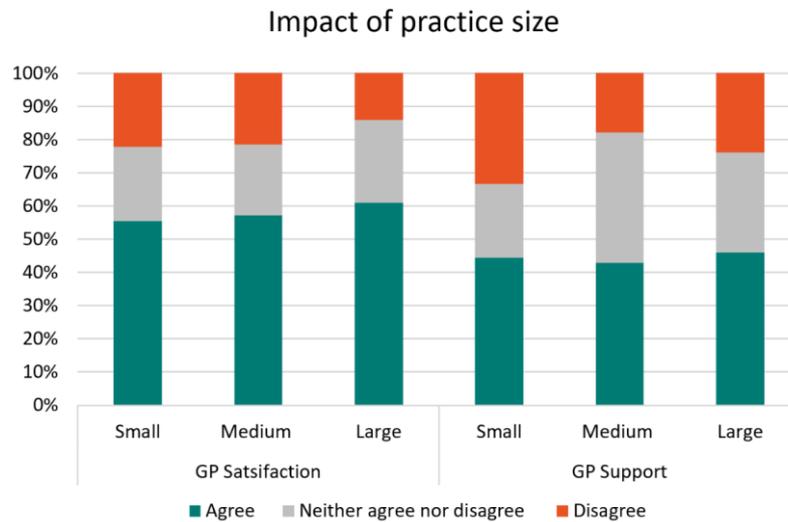
NB: 1 level refers to any level; 2 levels refers to any combination of individual, practice and system; 3 levels refers to all levels.



- Finally, the data highlighted a potential relationship between practice size and GP satisfaction and perceptions of support (see figure 13). The data suggests that larger practices are able to make use of, and benefit from, multiple GPRISS interventions. The observation may have an alternative explanation: That larger practices have more support for and hence greater employee satisfaction (evidenced by a Nuffield review of general practice at scale¹⁵).

¹⁵ <https://www.nuffieldtrust.org.uk/research/is-bigger-better-lessons-for-large-scale-general-practice>

Figure 13: Impact of practice size on GP satisfaction and perception of support



8. Qualitative Findings

Six common emergent themes were identified from qualitative fieldwork collected during one-to-one interviews and focus groups at the seven intensive support sites.

8.1 Theme 1: ‘Getting it right at the start’

8.1.1 Comprehending the GP retention agenda: Understanding the national and local aims

Across all sites, the aims of the GPRISS initiative were well-understood by all interviewees. When awarded funding, there was a common understanding that sites faced considerable challenges retaining GPs.

“GPRISS involves a pot of funding to support challenged system; systems which have been identified as having exceptional pressures around GP retention and recruitment. The aim of the initiative is to support seven selected sites across the country to implement various techniques to see if they can alleviate some of the retention problems. It involves identifying issues around retention and working through those issues”.

Although there was a common understanding of the aims of the initiative, interviewees viewed GP retention through a number of different lenses. Firstly, there was an appreciation that there was a need to attract new GPs to the profession; *“The aim of GPRISS is for sites to come up with context specific ideas for increasing GP numbers in their localities”.* Secondly, it was considered that attention and resources were needed to create a desirable, enriching and supportive working environment, therefore retention was viewed from the perspective of those GPs already working in primary care;

“Retention is about developing a workforce that is happy. Retention is also about ensuring people with the skills and abilities are kept because they want to work in the areas, and not because general practice is an incentivised career to be in...It is important to get the GP workforce happy by implementing structural and HR-based solutions, as well as, developing new roles and ways of working that will yield benefits for both patient and staff”.

There were mixed views regarding workload and the number of clinical sessions GPs worked per week. Some of the representatives offered the perspective that existing GPs should be encouraged to increase their number of clinical sessions, whereas others interviewees felt GPs were already stretched. The two differing views are explored in the below quotes;

“clearly we need more GPs, but we need more GP sessions, the real issue, I think locally that...so we actually have a very significant number of GPs that are potentially available, however the pressures of work of being such, that rather than doing five sessions per week, and coming in at 7am and leaving at 9pm which is not conducive to family life, people have just cut their sessions back”.

“The default is no longer to add to the workloads of GPs. The entire health system is very aware that using GPs more wisely is a reasonable thing to do. The focus is not only about keeping GPs, it is also about putting more support around them”.

Across the seven sites, there were a number of different definitions of retention which influenced project teams when implementing their interventions. Overall, members of the GPRISS project teams who were interviewed suggested that retention was about maintaining enough GPs within general practice to deliver primary care services.

“Retention is about having enough GPs in the practice to deliver services. At the moment morale is very low in general practice. GPs are leaving because they are fed up and demoralised, so retention is about turning things around so they don’t feel demoralised about their roles or become burnt out, and insuring they stay within their roles”.

Moreover, representatives from the sites also defined retention as specifically focusing on retaining GPs within their localities.

“Moreover, it is important to make sure that GPs are happy working in [place name]. The team recognises that they ‘can’t turn X into Paris’, but what they can do is ensure that GPs enjoy what they do. With this in mind, the GPRISS team’s approach is not to work on things like financial incentives, but rather, to work on the ‘hearts’ of their GPs and to make general practice in the [place name] a core part of what they do and who they are”.

Regardless of the definition or perspective of retention adopted, those interviewed emphasised that retention interventions would need to differ for GPs at different stages of their careers.

“Retention can mean different things to different GP populations. It can relate to people approaching retirement age. It can also be about GPs at early stages of their careers, who no longer want to stay in the area or the wider NHS because of pressures. It also relates to GPs who want to leave due to health reasons and how they can be supported. Retention is also about getting people to return to work”.

8.1.2 Diagnostics, including workforce data

Upon commencement of the GPRISS initiative, those interviewed described the importance of obtaining baseline workforce data. Furthermore, they highlighted that opportunities should be taken to collect new information and develop a “clear” or “full picture” of local GP workforces. One site

reported; *“In terms of GPRISS, the scheme has helped all practices and crossed all boundaries to reach all kinds of GPs, we found all these doctors who were there but we didn’t even know they were there”*.

Through an initial diagnostics phase, sites had been able to understand where to start, identify who their key stakeholders were, and determine areas and target populations who should receive interventions. For example, one of the sites described the intention to use initial scoping data to identify future workforce issues;

“it’s really important to know what we’ve got to see where in the future our gaps are going to be, obviously that 23% of our GPs are over 55 years old, it would be really interesting to know is that across the patch or actually are were going to have a problem in a network area.”

The sites commented on the existing data collection tools and the need to effectively use tools to regularly capture workforce data in the future. Importantly, the accuracy of available workforce data was a concern;

“We wanted to make sure that what we had down and NHSE had got was actually correct – so we sent out phase one, collection of data around how many GP partners, salaried, regular locums each practice had, what their whole time equivalents were, whether they were male or female, what their ages were. Just so we knew that we had absolutely accurate data at that point in time, because things change very quickly in general practice”.

8.1.3 Early engagement with GPs and practices to develop interventions

Across the intensive support sites, key stakeholders were keen to emphasise the value and importance of engaging GPs and practices as part of the overall project, especially when designing interventions. The aims of early engagement were described as *“to really understand what it is that practices need and practices want”* and ask *“what is the support that we really need to focus on to retain your services...find out what the issues are both for the GPs and practice staff”*.

GPRISS project members described the various methods used to engage GPs and practices, such as practice conversations, face to face dialogue, workshops and an awards ceremony;

“The CCG ran an awards ceremony to engage GPs and that was really well received. The GPs were happy to celebrate general practice/primary care and recognising what people have contributed to the profession and locality. The fact that both the CCG and the federation were jointly involved positively affected morale of the whole tribe not just the elders”

Overall, the sites felt that engaging GPs and practices within their localities had been positive, resulting in GPs feeling that they were being listened to;

“(GPs and practice) appreciated that engagement, so they appreciate somebody actually coming and spending time with them, actually sitting down and explaining what NHSE are trying to do with GPRISS, and getting their views on it is that they want and need”

There were a number of other benefits resulting from engagement strategies, including subsequent attendance at GPRISS events, the ability to discuss difficult or previously *“shut down”* topics, and the

opportunity to obtain feedback on planned interventions and to collect rich data. In some instances, practice discussions led to local solutions being identified. The GPRISS project teams gathered and presented early ideas to GP audiences while developing and refining their theories of change and intervention plans;

“Also, having GPs to help us shape the programme has helped...it has helped us to talk to GPs at different times to see how we’re doing, to shape the different programmes, so a bottom up approach, so when I am sitting there with our project team, thinking about how should we do this, how should we roll out this programme...there’s a test phase, you can see what they’re saying, what is realistic and get some feedback”.

Engagement of GPs and practices was reportedly *“invaluable”* for CCGs, GP federations and local primary care teams delivering interventions, who could be *“seen”* and considered *“approachable”*. Moreover, it generated interest and enthusiasm in the overall initiative. Some of the GPRISS project teams were keen to stress that the value and benefits of stakeholder engagement outweighed any delays to planned timescales. For example, a representative from one of the sites remarked;

“A reflection of trying to listen to what people around us were telling us rather than coming up with a list ourselves and that helps the buy-in to the programme. So, the complexity that plays into the timescale, might mean we’ve got things off the ground in the time but haven’t necessarily a load of activity go through these things because it’s about co-design as well as about making sure that we’re not doing something in a room in a CCG office, that’s going to impact on primary care but not talking to primary care about it”

8.2 Theme 2: Team working & Relationships - ‘Assembling the right people for the job’

8.2.1 The GPRISS implementation team

The GPRISS implementation teams were made up of CCG staff (including those with joint posts across two or more CCGs), regional NHSE representatives, a change facilitator (where in post), and clinicians or clinical leads. The core implementation team met regularly, and were referred to as a programme board, task and finish group, or steering group across the sites.

Within the implementation team, close working relationships were established between individuals who worked for different organisations. Responsibilities were allocated pragmatically; including the oversight of interventions, and the completion of governance and reporting tasks. In addition to the individual roles described above, the implementation teams invited representatives from the following organisations on to their programme boards; Royal College of GPs, Health Education England, Local Medical Council and Time for Care/Quick Start. The rationale was that such representatives would offer commitment, capacity and existing interpersonal relationships which would enhance delivery and leadership on some interventions, as described;

“So, there’s certain organisations that we have pulled together, that I think the tasks or intervention has got their name written all over it. So, the contracting toolkit, is around commissioners and LMCs, whereas anything to do with education that’s HEE. That’s how we have tended to divvy up some of the objectives and some of the work”

One particular organisation, which some sites felt had been instrumental in supporting their intervention delivery, was their local GP federation. For example, one participant stated; *“Importantly, GPs are well-disposed to the federation in comparison to how they would interact with CCGs. The federation is seen as an organisation that is supportive, the federation is seen to be doing things with GP rather than doing things to them.”*

Where change facilitators were in post, there were observed inconsistencies in their roles and utilisation of their skills. Many of the change facilitators led on or project managed specific retention interventions, analysing workforce data and facilitating GP engagement. At one of the sites, the change facilitator had been able to support a small number of practices through the change process, using coaching techniques to identify and work through any resistance whilst successfully implementing an intervention. Overall, the comments and reflections from all interviewed stakeholders, including change facilitators themselves, suggested there were uncertainties about the responsibilities of the role and challenges around integration and identification of opportunities to embed change facilitators within the GPRISS project teams, as summarised below;

“I have worked a lot in change facilitation in the past...when I started, I couldn’t see how to fit into that (theory of change model) at all, so it’s trying to work out with the site what my role was, that is still an ongoing thing, I have found it really difficult to be of use, it’s like they agreed to have somebody on site but then didn’t say this what we are wanting from you. So, I had to then say this is what I think I can offer you. So, I am supporting with one of the interventions, I am doing all of the practicalities of that, which is project management, not change facilitation”.

8.2.2 The importance of a clinical lead

Within the majority the implementation teams, the importance of including and involving a clinical lead was emphasised. Notably, the early involvement of a clinical lead was commented upon; *“looking back on things it would have been better if clinical leads were identified at the start: an overall clinical lead was chosen but leads for individual initiatives hadn’t been identified”.*

Clinical leads were perceived to be championing change, generating new ideas, offering a link to *“what was happening on the ground”* and allowing the GPRISS project teams to gauge support or feedback on chosen interventions.

“The fact that we have got GPs, people like X, he is a very unusual GP, most GPs don’t generate ideas at rate of knots, he is so strong at that, so clever and so solution focused, he has got the ear of his colleagues, people like him and trust him, and X also, having that really strong clinical leadership, being really visible about it...you have got clinical leaders right in the middle being able to drive it forward, and being able to articulate a vision that people can get behind, those are the elements that are creating the hope”.

Representatives from two sites commented on two specific benefits of clinician involvement in their retention projects. Firstly, they noted that interventions and changes to working patterns were being implemented in conjunction with clinicians rather than being done to them;

“part of the issue I think is the way that the wider hospital projects have been led, is that it is stuff that has been done to them, as opposed to this has been facilitated, but this is the idea

of the practitioners, it's them that decided on [name of intervention], it's them that had to fight for it...So it's really them who have championed this, and I think that has been the important thing around engagement and how they got involved”.

Secondly, they perceived that the involvement of clinicians led to a more sustainable project. However, this perspective was offered with a note of caution, that future projects may not have the opportunity for such levels of engagement;

“Engagement is firmly about trust and relationships, and having clinical engagement is critical for project sustainability. Thus, having a clinical lead within the team has been very beneficial. One potential challenge of rolling out initiatives to the wider NHS is the wider piece of engagement required in situations where it won't always be “doctor to doctor” engagement”.

8.2.3 Improved relationships between GPs, practices and stakeholder organisations

There was an overall consensus across the sites that the GPRISS initiative had been positive for relationships between key stakeholders. Firstly, some of the sites documented improving relationships between individual GPs and practices within their locality;

“Furthermore, by getting GPs in one room it allows them to know who else is working near them so they can form support groups and share their learning/experience”.

“One unexpected result from the programme is people are meeting up and communicating with each other. In fact a number of GP WhatsApp groups are being created and maintained by the project manager. As soon as the team sets up the clarity system (an online forum), the WhatsApp groups will be incorporated into it”.

Representatives from one of the sites even reported improved relationships and connections between practice managers as a result of receiving GPRISS interventions;

“Working together on the interventions has been really beneficial, I am only two years into general practice, as a practice manager in my first year I didn't really speak to practice managers much, short of our monthly meeting. But now I feel like I'm on the phone to someone every other day, asking for something and helping or talking about stuff, so the working together towards [name of intervention] and some of the other initiatives has been a good benefit”.

Secondly, representatives from the sites felt that relationships between the many different organisations working within primary care had “developed” and “matured”;

“So, I do think it's strengthened our relationship, it was good anyway, but I think it strengthened our relationship with CCG colleagues...it's been really useful to sit in the rooms with LMC colleagues, with Federation colleagues and say ‘we know the issues, we're not burying our head in the sand, we know what's going on’, but ask ‘what needs to be done, what needs to happen to make a little bit of difference in terms of retaining GPs”.

Project team members commented on the support they had been offered from providers, HEE, and local DCO teams as well as practical changes such as the opportunity to have conversations with

primary care colleagues working in the same geographical areas. They also highlighted the subsequent inclusion of the GPRISS project team in key events and meetings. At one of the GPRISS sites, one participant felt that relationships had improved to such an extent that one's organisational affiliation was no longer apparent;

"If you walk into a steering group meeting for this programme, you wouldn't immediately know who's there from CCG, who's from a practice, and who's from NHS England, until they start speaking about their own perspectives and coming up with ideas. It's a group of people who have come together to work towards one vision to make a transformed sustainable system that works better for people working in practice and also works better for patients. We haven't cared who's coming from where, we've all got something to bring, we've all got something to contribute and we've been doing it together and that has been, I have never experienced. I've been in the NHS since 2002, I've never experienced anything like this, it's been amazing.

Importantly, the positive changes in relationships were crucial in communicating to members of the wider primary care system that GP retention was a shared challenge for all involved;

"I am quite excited by the fact that I do feel for the first time in a long time, both with practice staff, with GPs, they do see that things need to change and they do now see that this is an issue for all of us, so involving ourselves at NHSE, involving the CCGs, involving our colleagues that are working in the STP, the ICS".

8.3 Theme 3: The GPRISS Approach

8.3.1 Feeling heard, flexibility and funding

While reflecting on the overall approach, representatives from the intensive support sites felt that the GPRISS initiative had acknowledged the challenges facing primary care, both locally and nationally. One stakeholder stated that *"nationally, somebody does care"* and another expanded on this perspective, stating;

"There's a message about at a national level it has been heard that the problems you are describing are significantly worse than most place, it has been heard that this is a particularly challenging area for the reasons you have described and we are going to put some resource into that, and we going to give you the freedom to enable you to find the solution".

As alluded to within the above quote, some of those interviewed felt that the overall approach had given the project teams the *"liberty and flexibility"* to design a programme of GP retention which met local needs while considering the trends identified from local workforce data. Others commented that the GPRISS initiative provided the opportunity to try out new ideas and roll out these ideas across the geography, including the collection of evidence; *"GPRISS has allowed us, has afforded us the luxury to be able to pilot, test a few ideas out, and then be able to gather evidence that 'yes that could work'."* Conversely, in other cases GPRISS project team members felt there had been a lack of flexibility and warned that this could affect their credibility having previously engaged with GPs and practices in their local area;

"You go out to GPs and ask them 'okay what do you think', 'what would make a difference to you' and then you develop your plan, and then you go to NHS England and say 'this is our

plan', and they say 'no you've got to take this out, you've got take this out, you've got to add this in'. The team that has to deliver this has an immediate credibility issue and so that immediately puts the recipients of this on the back foot...I think that's the difficulty or part of the challenge that has to be addressed if we want systems to develop their own solutions, you have to give them the freedom to do that as well, and not become too prescriptive."

Where there was perceived flexibility, this generated "a real sense of excitement" among those implementing the GPRISS interventions. In some instances such feelings of excitement were cascaded to practices, and an appetite or desire for change had emerged:

"I have never seen an appetite for change in primary care, like we see now, literally never in all my years working in primary care. I haven't been hearing an appetite, the hope meter is going up, people believing in it, they can see that stuff is happening, that is really exciting, we need to capitalise on that".

The allocated and dedicated funding from the GPRISS initiative was also an important element of the overall approach;

"One of the enablers for this is for someone to say to us this is a pot of money, funding, but you've got to spend it on GP retention, so you've got to focus your thinking around initiatives that are going to support GP retention and I don't think we do that, we absolutely cover off things around GP retention in other programmes...but for someone to actually say to you this is a dedicated piece of pie around, how to keep your GP's, has been a bit of a different approach".

As described within [section 4.2](#), the GPRISS approach involved combining interventions targeted at individual GPs, GP practices and the wider primary care system. The individuals interviewed expressed mixed feelings and thoughts about combining interventions across these three levels;

"The team felt that the interventions that took individuals out of practice would get them energised. The team felt that focussing on a practice, would take the focus away from individuals: if you focus on the practice, you may do things differently"

"I think there are more strengths than weaknesses. I think we need to have that those different dimensions of support, if you haven't got individuals engaged then you don't stand a great deal of success of engaging a practice, if you haven't got practices cited and harnessed and signed up to these things then you're not going to deliver at a place, so you know, those levels are really, really important".

Across the majority of the intensive support sites there was also a perception that there was an inherent difficulty in elucidating the success or impact of single interventions on GP retention when numerous interventions had been implemented simultaneously. Despite the challenges associated with the short project timeframe, and in addition to challenges understanding the impact of single interventions, there was an acknowledgement that this intensive approach could bring some benefits;

"There is a great discipline in saying that its 6 month, but one of the big problems with the NHS is that we have plans to do stuff, sometimes we even have resources, but we implement so slowly, the rigour that we have had to do something over a short period of time has been quite energising and focusing. We're not used to doing stuff as big as this so quickly".

8.3.2 Unexpected benefits

In addition to the development of relationships between stakeholders in primary care, other unexpected benefits of the GPRISS approach have been identified. Firstly, some of the GPRISS project teams described looking to the future to consider the sustainability of their retention programme of work. For example, one site reported; *“the team is now assessing their structure and capabilities to see how they can make the project more sustainable going forward, after March 2019. A future retention budget is now being discussed by the CCG”*.

Another example included the steps taken at one site; *“Now things are more settled, we are now able to focus and build the resource and the team. Now an 18-month project lead has been allocated to GP retention for continuity after the end of GPRISS. HEE, NHSE & CCG funding has been pooled together to design a stable team for the future”*.

Additionally, representatives from some of the intensive support sites reported that their learning and evidence gathering as part of GPRISS had helped with other pieces of primary care focused work. This included development of bids or business cases for community or clinical pharmacists, enhanced continuity of care and digital technology for remote working. Furthermore, at one of the sites, another unexpected benefit was described, namely the potential for a GP retention intervention to have a positive impact on patient satisfaction;

“I was just thinking that some of the other satisfaction will come from places that we didn't really imagine because this was very much focused on being efficient in the practice and being able to deal with the demand but actually bizarrely I am looking forward to seeing my patient survey when it comes out...I've been looking out for when's our next survey going to be, for the patients it's absolutely amazing...so I think that transformation is so extraordinary for patients and for the wider practice team”.

8.4 Theme 4: Interventions.

8.4.1 Structuring a multi-level initiative

At a number of the GPRISS locations, there was an acceptance that implementing multiple interventions required a staggered approach to the benefit of both the project team and GP target audience;

“The reason to stagger the interventions at different levels was to ensure that the team didn't lose sight of the overall goal. Additionally, it allows the team to identify what exactly works for them and what doesn't work for them”.

“Mobilisation has been staged/staggered over 3 to 4 months to ensure that there was a steady and manageable workload on the team. Moreover, we didn't want to bombard GPs with all information about their schemes at once”.

Whereas, one site opted to impose a structure where multiple interventions were built upon one another;

“we have also thought of schemes that support one another, doing new front door, it's not just an IT programme, that supports the different workflow optimisation, which is supported by MDT working, which is supported by new models of care (e.g. paramedics visiting service), supported by new workforce ideas (e.g. portfolio working), supported by more training and variation in people's role...The schemes are built in concentric circles out from one point, so

all of the things fit together, even though there's a wide range; they support each other, its building blocks".

Across the seven sites, there were differing rationales and decision making processes underpinning which interventions to implement. For some, interventions were chosen based on previous involvement in pre-existing programmes; *"the reason why the team didn't take on productive GP and time to care programmes is that the area already had 2 waves of these products and felt that those systems are in place. With this in mind they wanted to know what else they could add"*.

Other intensive support sites selected a mix of interventions dependent on the degrees of difficulty implementing them; *"In honesty, the team viewed the 15 minute appointment as the key goal but it was also recognised that solely focussing on that would be quite risky. As a result, we agreed to spread the funding across other safer initiatives which were easier to deliver"*.

Interventions were also selected that could provide a solution to both the GP retention issue as well as known challenges within the local patient population; *"We are looking at creating portfolio careers because of the types of patients we have here, there's a significant number of frail people...So, we're looking, the business case will determine what the frailty proposition looks like from a joined up point of view, what skills are requires, what opportunities we can create for GPs and nurses to be able to specialise in that"*.

8.4.2 Building on existing national and local interventions

Across the intensive support sites, project teams described their awareness of existing initiatives that were currently or had previously taken place in the surrounding geographical areas. Where the project teams observed local successes, and such initiatives were aligned with GP retention, resources were allocated to implement these initiatives in a new locality, on a larger scale or to target a different section of the GP workforce.

"The mentoring has worked out so well, it made sense for this to be expanded across the STP. Now there are 6 trainers or mentors across the STP (of different ages, sexes, ethnicities and stages of their careers), and GPs have the options of choosing which mentor they see"

In other instances, project team members felt that the GPRISS initiative had given them increased access and chances of success when applying for national offers. For example, commentary was offered on the national Time to Care initiative;

"to know that actually, if we applied, that we were applying through GPRISS we would be accepted, which unless we did a bid that was horrendous, which we wouldn't have done, but we knew that because of GPRISS actually we had that national support, so that time for care applications would be accepted".

There was also the perception that GPRISS had enhanced their ability to negotiate access to other national programmes. This facilitated the aim of offering equal access and uniformity across the area, as this representative described;

"When we first set up ISS, two of the three sites were part of the TEARS programme, but [place name] was the third site that wasn't, so I went straight to HEE and said 'well I need to offer TEARS as part of the overall package for all three sites, otherwise that means [place name] is disadvantaged'. And again we had to go through the process, because the reasons they weren't eligible was because they had a good uptake for training, so then HEE agreed to

look at the data and they were able to demonstrated that actually although they have had good uptake, they hadn't had good out turn in people then taking up posts and staying in the area. So because of that they agreed that [place name] could be part of the TEARS programme, so we could offer that across all three sites".

8.5 Theme 5: Challenges.

8.5.1 Timescales

Stakeholders at both the initial interviews and focus groups raised timescales as a significant challenge. There were three specific aspects regarding time which posed a challenge.

Firstly, representatives from the sites commented that the duration of the project was short, limited and tight, and they had to act quickly. Individuals reported that it felt like they were delivering a long term programme, *"essentially it is a six month project with an aspiration of a five year delivery"*. Most stakeholders expressed a desire for more time for all aspects of the project, including diagnostics, implementation and reflection or evaluation. As a result of the short or tight project time frame, some sites encountered a specific challenge where they were implementing interventions and running diagnostics in parallel. For example;

"If you were to ask me has the project has been a success or failure, I would say that the timescales have been so short, that we have had to do parallel running, whereas I would have preferred to data collection in the first instance and then start setting out the interventions. To get them implemented and evaluated before March, I know that if we're lucky to just get things started, and I think to actually start them and then leave them running for three months before you even evaluate, we're just not going to have the time scales to evaluate a lot of the interventions properly"

Secondly, there was a general perception that GPRISS had been implemented at a *"bad time"* of the year, namely the winter months. Participants felt the timing of interventions being offered were *"inappropriate"* and *"not ideal"*, with multiple expressions of interests being available simultaneously and over the Christmas and New Year period. It was thought that this time of the year was the *"worst"* and *"busiest"* period in primary care, with high patient demand and postponed or short deadlines. This may explain some of the low uptake experienced by national interventions.

Thirdly, participants highlighted the sometimes limited availability and capacity of project team members, who occupied existing primary roles in key organisations involved in the GPRISS initiative. In particular, participants highlighted the limited availability of the following roles as a challenge; clinical leads, change facilitators and strategic project or programme managers who were often managing multiple portfolios of work. This was summed up by one participant; *"Another challenge is ensuring that people can work in a regular and routine way that does not take them away from their day to day jobs."*

Furthermore, members of the implementation teams also reported a challenge around asking for support and involving key organisations as part of their GPRISS interventions. Some interviewees and focus group participants acknowledged the pressure that organisations such as local CCGs were under, and in some areas the CCGs had limited capacity to support or lead on interventions.

“Time is an issue, the CCGs are under a lot of stress and don’t have time really focus on the initiatives. The CCGs don’t have enough resources to have dedicated people allocated to the schemes and give the schemes the time they need.”

On reflection, there were feelings among the participants that *“everything is not going to be shiny and complete at the end of March”* and *“there is some incongruity between the pace that is expected, and the pace that people on the ground feel is needed in order to make change possible, realistically, delivery will go well past the March deadline”*. Therefore, there was some acceptance among project members that the intensive support site work was *“laying the foundations”, “pump priming”* or *“you’ve sowed the seed and you can’t see the tree the next day...you need to have realistic timescales”*.

Across all the sites, representatives advocated that the momentum generated by GPRISS would need to be maintained. They highlighted that long-term support and further funding were required to successfully address GP retention. During such discussions, the question of the sustainability was raised;

“this is another example of non-recurrent funding and what happens when it falls away and how do we work on the sustainability of GP retention because it absolutely needs to be sustainable otherwise there’s no point doing these GP retention schemes because next year there’s going to be no money for it, and therefore we’re going to struggle with GP retention again”

Furthermore, there was also a challenge described around providing short-term interventions and subsequently asking GPs to make long term commitments to remain in general practice. This was summarised by one stakeholder;

“This is a long term programme of work; it’s not something which is going to finish as of 31st of March. I think that has been one of the biggest drawback for us, because having those face to face to conversations, like I say you’re asking for commitment but then you also notify the practice staff or the GP that ‘well we have a programme of work here but it finished in March’. Straight away that switches them off, because that shows that you’re are asking for commitment but you’re not prepared to commit a couple of months’ worth of support to them. So, that’s definitely been the biggest drawback”.

8.5.2 Overcoming negative attitudes in primary care

Another challenge identified by the intensive support sites was the perceived negative attitudes and despondent feedback received from GPs. Participants interviewed perceived there was a degree of fatigue, low morale and scepticism from the GPs, regarding *“yet another new initiative”* and *“we’ve tried this before”*.

Additionally, GPRISS site members described a lack of trust and paranoia around initiatives which are being implemented by NHSE and CCGs, with some GPs and practices appearing suspicious, cynical and wary. Some examples included negative comments made on social media pages promoting intensive support site interventions, as well as an observed reluctance of GP practices to share information with the GPRISS project team.

Consequently, the intensive support sites reported *“it has been an obstacle getting people to have faith that the system is actually going to do what it says”* and there has been a need to demonstrate the inherent benefits behind the project. This sub-theme is aptly summarised by one stakeholder;

“On the ground, people are intrinsically suspicious, morale is low and there is likely to be some resistance to change. Federations are new beasts and practices mistrust each other, there is a real sense of threat that people are going to take their business away. When living and working in such an austere environment, the more resistance is apparent and the more one has to navigate against the headwind. As a result, projects and initiatives need to demonstrate to GPs and practices that there is some net gain involved”.

8.5.3 ‘The balancing act’: GPs engaging with retention interventions & managing clinical demands

In a similar manner to the GPRISS project team, another significant challenge was noted with GPs being able to access and participate in the offered interventions due to their primary role.

While all of the GPRISS project teams acknowledged that patient care was of the upmost priority, they highlighted that it had been a challenge or a *“really tricky balancing act”* to engage clinicians in the intervention on offer. The sites reported inherent difficulties with GPs working long hours in environments with high levels of clinical demand, meaning they could not commit to the interventions on offer;

“If you are going to offer coaching and mentoring that’s fine, but before you offer it to all these GPs, you have got to take a step back, how are we going to cover the clinical appointments that are going to fall off because of the fact that we’re taking all the GPs, so it’s being able to go in with a proper plan of attack, say we’re going to offer you that, this is how we are going to support you, both from the GPs point of view but the practice point of view as well to make sure that the practices can deliver the service”.

Sites highlighted that, whilst time away from clinical practice would be beneficial for individual GPs, this is likely to have an impact on other clinical staff, practice managers and the overall GP practice;

“One emergent problem about providing education events and peer support meetings is the backfill cost; the GPs will have to take time out during practice hours resulting in locums being brought in. This means that whilst the initiatives are great for GPs, they won’t necessarily benefit the practice”.

8.5.4 Navigating traditional geographical boundaries and bureaucratic processes

A final set of challenges highlighted by stakeholders from a number of the sites was related to navigating traditional geographical boundaries and bureaucratic processes. For those intensive support sites who were working across multiple CCGs, some challenges were described relating to the spread and combined size of the locality, the different cultures and demographics of the patient population and primary care workforce. For example;

“I think the first difficulty that we have had that we have got three CCG localities, spread quite far apart, and some of them have massive geography,...effectively we have three discrete sites with very different demographics and it will be interesting whether the themes and needs are exactly the same for all three. So, geography has been an issue”.

Some intensive support sites reported challenges identifying people within large stakeholder organisations who occupied specific local roles, which if identified could be of assistance with specific interventions on their GPRISS programme. This is summarised below;

“navigating the system has been an interesting one for us and understanding all those key stakeholders and finding out who the people are, and if there’s any work nationally that can be done around, well actually who is your RCGP link? And I can tell you now we still don’t know...and when we tried to think about how to translate that RCGP element here, we’ve really struggled, and actually what we’ve decided is that our GP Federation might be a better place to take that work, so I think we probably naively assumed that some of those organisations would have structures that mirrored each other in all the different regions and they don’t, that’s a key bit of learning and some of the barriers that we’ve had”.

Finally, the short duration of the GPRISS initiative meant that, in some instances, the implementation teams encountered significant challenges with procurement processes, as summarised below;

“Just some of the financial processes that are in place across the NHS and CCG, they’re not set up to manage projects like this, which need to be delivered at this pace. They are just not set up so, the procurement processes, the accounting setups are just not set up to cope with this kind of work. I don’t think the CCGs were meant to this kind of business, it’s not what we were set up to do, it’s a big challenge to get all those sort of back office processes through to do this properly, safely within legislation. You know it’s been it’s been a real challenge”

8.6 Theme 6: Lessons learnt

7.6.1 Communication

Representatives from the sites reported the need for a clear communication strategy when implementing multi-level GP retention interventions due to the amount of information to be shared with GPs, the wider primary care workforce and key stakeholders. There was the suggestion that dedicated administrative and communication support was required to implement such a strategy; *“all of the projects require some level of back office support, not only from an administrative perspective but also from a comms perspective to broker discussions and navigate a complex system”.*

GPRISS team members recommended that communication with GPs needed to be through multiple channels, repeated or frequently shared and succinct. It was advised that consideration should be given to the timing and location of information sharing events, the clarity of any written materials like posters, and sharing positive experiences through word of mouth. One approach to such communications was described;

Furthermore, general practice is demanding and not all GPs have time to review information sent to them and/or attend meetings. With this in mind the team devised a plan on how they would communicate with the target audience using F2F and electronic routes, as well as providing multiple points of contacts for GPs to request/receive more information. There is still a worry that emails are being received by GPs and they automatically think that they do

not have time to engage with the information because they are overwhelmed. As a result a multi-pronged comms approach is needed.

Stakeholders from the sites also stressed the need to keep all methods of communication open throughout the project to receive feedback and spread key messages across the STP footprint.

“Communication with member practices is crucial in order to keep them interested and to help them understand specific aspects of the project: such as, although the project is being implemented in a short time period, results are only expected much later”.

Overall, when communicating with GPs and practices, there was need for a careful approach which built trust between individuals and organisations;

“It was all about the comms strategy and getting things out to people. This was quite important as GPs were inherently suspicious, and morale was low. There was a lag in the time it took to build trust. Trust is a key thing that NHS organisations work so hard to build, and it does get undermined every time there is a reorganisation cycle within the NHS.

8.6.2 Other issues influencing GP retention

Across the initial interviews and focus groups, representatives from the sites referred to other issues which they felt were relevant to GP retention. These issues were either addressed inadvertently through GPRISS interventions or were not delivered as part of this project. These issues are as follows;

- Indemnity concerns for all GPs, including those GP starting their career and those close to retirement. Two examples are described below:
“With this in mind the intervention for the first 5s is aimed at supporting and empowering GPs by providing them with information about essential things like, indemnity, pension scheme decisions, contracts and all the things that aren’t part of the RCGP examinations but are crucial for the role (“the intangibles”)”.

“There is also an aspect of addressing concerns about indemnity concerns in this population in case they are thinking about continuing or coming back to work (if they have retired). This is achieved by subsidising indemnity costs or providing financial advice through legal firms. There will also be a push to increase knowledge about the NHS retainer scheme”
- One of the interventions implemented across many of the intensive support sites was the opportunity for portfolio careers. Though some stakeholders commented on the issues this created regarding GP contracts, pensions and tax payments;
“When delivering this intervention is quite challenging as dual roles can have implications on contracts, pensions and taxes. As a result, legal advice is required. It is not currently known if this is immediately worked out (with respect to commissioning of dual roles) in the way GPs would like but it would be nice to get things in place for the future as this would benefit everyone.”
- The vulnerability of being a single-handed partner or the “last man standing” phenomenon;
“One issue affecting retention is around premises and leases, the ‘last man standing scenario’. Historically, big primary care centres have been supported by big private finance initiatives with

25-year leases, under PFIs. Over the years, partners in these practices have retired leading to a situation where the liability for the whole lease is left to the 1 remaining partner ('the last man standing'). In these cases the single partners are under a lot of pressure and practically want to hand their lists back because they are approaching the end of their leases. This is not a unique situation in our area; it is happening all over the country".

- The adequacy of continued professional development opportunities for GPs and the HR practices within primary care were raised by some of the stakeholders interviewed; "We should not be losing sight of things like those appraisals, CPD, individual performance review. Whatever the term is that happens within a practice be it the professional role of the CPD rule or be it the role of just good HR practices, induction of staff, mentorship, buddying, preceptorship, you know all of these things that we know work very well retaining our staff that actually we should be blending this into it so and because we don't have a good handle on that across the systems in general practice per se not just here".

8.6.3 Consideration of the wider practice workforce

Although the aim of the GPRISS project was to focus upon the retention of GPs specifically, the sites frequently commented on the need to consider and "not forget" the wider general practice workforce;

"Although GPRISS is mainly focussed on GPs, it is important not to forget the other wider roles in the general practice workforce. They are becoming more important in the provision of primary care and it is important not to forget them".

When implementing their chosen interventions and communicating with GP practices, the GPRISS project teams accepted that some areas of their work needed to be expanded in the future to include other staff within the practices.

"Actually one of the things we want to communicate is it's a team problem, it's not just GPs, if the GPs are happier it's no good if the practice nurses are in melt down, and equally many times our practice managers will say we have no head space, we are on our knees. We have to address the whole team".

9. Implications & Recommendations

Based on the findings from the survey, interviews, focus groups and after action review, there are a number of emerging recommendations for NHSE, local commissioners, and others working to improve GP retention and ultimately to create more capacity in general practice. Some of these recommendations are shorter term while others may require further system changes or for groundwork to be laid.

9.1 Recommendations for NHS England and the regions

Follow up review: There is not enough evidence at present to weigh the impact of individual interventions and this may reduce uptake locally, particularly where there is not a clear cost benefit analysis and uptake is dependent on GP surgeries, federations and other private businesses making an investment. We recommend a further review of impact of GPRISS in at least six months to allow interventions time to 'bed in'.

Toolkit: There are a variety of national offers including time for care, RCGP First5, coaching and mentoring, the Productive General Practice Series, and contractual changes and these are not always coherent for small stakeholders. Development of a toolkit to support local stakeholder to implement GP retention and other workforce interventions would help to simplify the offer and ensure that learning from this programme is put to use.

Resources: without the funding provided by GPRISS, the change agents and project teams that this funding enabled, it would not have been possible to get initiatives off the ground in such a short time frame or at all. Local systems following the examples of GPRISS will need dedicated funding and other support as well as enabling a flexible approach that takes account of different system configurations. In addition, it was noted that in most systems, particularly those with the greatest workforce challenges, it is difficult for GPs to engage given their clinical commitments and priority should, therefore, be given to interventions that are capacity releasing in the short term.

9.2 Recommendations for local commissioners and others working to improve GP retention

Baseline Data: In order to understand local needs are and what is working, it is important to first understand your baseline workforce data. The national GP workforce dataset provides a starting point but does not include GPs working outside of general practice (for example in urgent care settings). Others in the system including the local GP vocational training scheme (VTS) director, general practice nursing leads, and LMCs may also be able to support.

Support for GPs, practices and systems: A lesson from the focus groups and the survey analysis was that individual GP support alone is not sufficient to address workload issues, which were identified as the greatest job stressors. Hence there needs to be interventions aimed at improving practice systems as well as the interface between general practice and other parts of the health economy. For example for CCGs to enforce elements of the NHS 2017-19 Acute Contract aimed at reducing administrative burden for GPs.

Support at different career stages: Local areas should assess the individual needs of GPs at different career stages, but also learning from the GPRISS sites in terms of what worked well, the focus groups

explained that portfolio careers, for example were equally of interest at various career stages, that GPs approaching retirement had much to give back to the system by way of coaching and mentoring, and that small things in relation to facilitating HR processes and raising awareness of local housing and other options made a big difference for retaining GP trainees.

Communicating and engaging locally: It was important to take account of local GPs and other stakeholders in designing and implementing local solutions and also that particular stakeholders such as local GP federations, LMCs, the RCGP, STPs and CCGs were instrumental in championing and supporting GP retention initiatives but that the local landscape is different in each area and needs careful and thorough navigation to identify those who occupy key local roles across large system footprints. Communicating with the general practice workforce needs to be through multiple channels and requires regular communication, but caution was also given by the GPRISS sites in terms of ensuring that messages are 'fresh' and that they take advantage of existing mechanisms for communicating.

Creating capacity for change: All areas shared that this was a key issue that required time and investment. In some areas there were resources already in place, but where this was not the case it took significant lead time to find the right people. Developing people on the ground with the capacity and capability to drive retention initiatives was seen as critical to the success of the GPRISS programme, in most cases this included local stakeholder partners.

10. Strengths and limitations

10.1 Strengths

This evaluation has employed a mixed method approach to triangulate findings from quantitative and qualitative research activities. A key advantage of this approach is both analysis of known factors and exploration of unidentified factors can be achieved in the same study, offsetting common disadvantages encountered if quantitative and qualitative methods were used independently. The role of an independent evaluator has allowed for an impartial assessment of factors affecting all levels of the primary care system. Moreover, the evaluation team's knowledge of the primary care system has ensured that relevant stakeholders have been engaged: from the different types of GPs, to practice managers, system leaders, members of LMCs and representatives of the RCGP. This was particularly useful when quota-sampling was used to ensure important stakeholders were represented in focus groups. The evaluation team's communications approach, along with active engagement of implementation teams at each site, were key advantages in this study. By having a single point of contact who regularly visited each site, the evaluation team were able to develop and nurture relationships that facilitated responsive and open dialogue between evaluators, NHSE and GPRISS implementation teams.

10.2 Limitations

One key limitation noted is the fact that some interventions had not been fully implemented at the time of this evaluation. This means that some participants were only able to proffer their perceptions of future benefits as opposed to actual realised benefits. With this in mind, it was recommended that a subsequent evaluation should take place once interventions are embedded

and recipients have had sufficient exposure to them. A follow-up would allow for the medium- to longer-term benefits to be established.

In relation to the online survey, the snow-balling sampling technique poses a potential risk of sampling bias; since participants were chosen by individuals who had already been selected, it is possible that most participants shared similar characteristics or opinions. The fact that respondents were self-selecting also poses the risk of selection bias: i.e. those with strong positive or negative opinions may have been more likely to respond. To minimise the effect of these biases, subsequent assessments will ensure that all recipients of interventions will be contacted and given the opportunity to respond. The small sample size of respondents for the survey (overall and at each site) precluded any assessment of statistical significance. As a result, the reported findings illustrate trends. It is expected that, in a future evaluation, a larger sample size would allow assessors to establish which types of interventions work best, and for which subgroups of GPs.

With respect to the qualitative assessments, the timing of the focus groups (mid-implementation of some interventions) may have impacted on stakeholder's ability to reflect and comment on the progress and success of interventions. Another limitation is the fact that the focus groups comprised a mixed group of stakeholders, including only a handful of GPs; some of which were involved with implementation of interventions. The underrepresentation of GPs who received interventions was mainly driven by a lack of availability due to pressures associated with activities performed during the end of the financial year. Ideally, future assessments could involve additional focus groups made up of GPs at different stages of their careers. This would permit more in-depth discussion and exploration of the GP perceptions.

11. Appendices

Appendix A: GP retention intensive support site profiles

Informed by narrative description from initial interviews (site descriptors document – pulled from initial interviews) and quantitative data.

The Black Country											
<ul style="list-style-type: none"> • Locality type: Sustainability and Transformation Partnership (STP) • Population: 1,456,506 • IMD score: 31.1 (Quintile four, second most deprived) 	<p>Local population age profile</p> <table border="1"> <caption>Local population age profile data</caption> <thead> <tr> <th>Age Group</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>0 to 19 years</td> <td>25%</td> </tr> <tr> <td>20 to 39 years</td> <td>29%</td> </tr> <tr> <td>40 to 59 years</td> <td>26%</td> </tr> <tr> <td>60+ years</td> <td>20%</td> </tr> </tbody> </table>	Age Group	Percentage	0 to 19 years	25%	20 to 39 years	29%	40 to 59 years	26%	60+ years	20%
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<p>General practice statistics</p> <p>At the start of the GPRISS initiative, in October 2018, there were 802 GPs working in 217 practices across the Black Country. This equates to an average of 3.7 GPs per practice, less than the national average of 5.4. In some areas within the STP workforce deficits are stark: Up to 28% of practices have 1.5 Full-Time Equivalent (FTE) GP roles or fewer. With a quarter (24.5%) of GPs in the region over the age of 55, it is considered that workforce deficits will get considerably worse over the next decade.</p> <p>Average list sizes within the STP are generally smaller than other practices in the country, but the average number of patients per GP is approximately 200 more than national estimates (1589 pts. per GP). Using the monthly rate of practice appointments as an indicator of workload, data highlights that general practices in the Black Country have fewer patient appointments per month compared to the rest of the country. However, individual GPs have more appointments per month than their counterparts elsewhere (451 vs. 394 appointments).</p>											
<p>Site-reported factors affecting retention</p> <ul style="list-style-type: none"> • CCGs are very good at training GPs but are not able to keep them in the medium-to-long term due to the pull of big cities (such as Birmingham) • Burnout is cited as an issue, especially in Wise5s who are often single-handed GPs. GPs in the middle of their careers (in salaried and partner roles) are finding it difficult balancing work with family commitments, and feel that locuming provides a better balance. • Many older GPs are approaching retirement. • Communication and collaborative working are yet to be established throughout federations: patients can encounter different approaches and directories of services between practices within federations 											
<p>Interventions</p> <table border="1"> <thead> <tr> <th>Intervention Type</th> <th>Interventions</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td> <ul style="list-style-type: none"> • One-to-one coaching • One-to-one peer mentoring • Pre-retirement coaching • Peer Support </td> </tr> <tr> <td>Practice</td> <td> <ul style="list-style-type: none"> • Team-based coaching </td> </tr> </tbody> </table>		Intervention Type	Interventions	Individual	<ul style="list-style-type: none"> • One-to-one coaching • One-to-one peer mentoring • Pre-retirement coaching • Peer Support 	Practice	<ul style="list-style-type: none"> • Team-based coaching 				
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	<ul style="list-style-type: none"> • Portfolio career roles • Learning in Action • Productive General Practice (PGP) Quick Start
System	<ul style="list-style-type: none"> • Development of new models of care (including primary care at scale) • Transitioning to Primary Care Networks and Integrated Care systems • Primary and secondary care interface toolkit • GP recruitment programme • Participation in a range GP Forward View projects

Isle of Wight											
<ul style="list-style-type: none"> • Locality type: Clinical Commissioning Group (CCG) • Population: 144,464 • IMD score: 23.1 (Quintile four, second most deprived) 	<p>Local population age profile</p> <table border="1"> <caption>Local population age profile data</caption> <thead> <tr> <th>Age Group</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>0 to 19 years</td> <td>19%</td> </tr> <tr> <td>20 to 39 years</td> <td>20%</td> </tr> <tr> <td>40 to 59 years</td> <td>27%</td> </tr> <tr> <td>60+ years</td> <td>34%</td> </tr> </tbody> </table>	Age Group	Percentage	0 to 19 years	19%	20 to 39 years	20%	40 to 59 years	27%	60+ years	34%
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60+ years	34%										

General practice statistics

In October 2018, there were 77 GPs working in 16 practices on the Isle of Wight, equating to 4.8 GPs per practice. This is not too far below the national average of 5.4 GPs per practice. Of the 62.5 FTE roles on the island, 42% of GPs have indicated that they intend to leave or retire from the profession in the next five years.

Average patient list sizes in the CCG (9050 patients) are larger than the country's average (8534 patients), and the average number of patients per GP is approximately 300 more than national estimates (1589 pts. per GP). Using the monthly rate of GP-led appointments as an indicator of workload, GPs in the locality have an average of 14 more appointments per month than their counterparts on the mainland (408 vs. 394 appointments per month). It has been projected that the elderly demographic will contribute to a 35.5% increase in demand for appointments by 2022, requiring an additional 35.5 FTE GP roles.

Site-reported factors affecting retention

- Geography: The island is not readily accessible from the mainland and has some of the highest ferry fares in Europe. This affects both recruitment and retention of both permanent and locum GPs.
- Tier 2 recruitment: Practices are finding it increasingly difficult to get the right visa/sponsorship support. In the end practices and prospective GPs give up.
- Pressure on acute trusts is transferred to primary care to pick up the excess workload. For instance, a deficit in hospital beds means that patients invariably have to be looked after by primary care services.
- Previous criticism about the schooling system has made the island less appealing to families.

Interventions

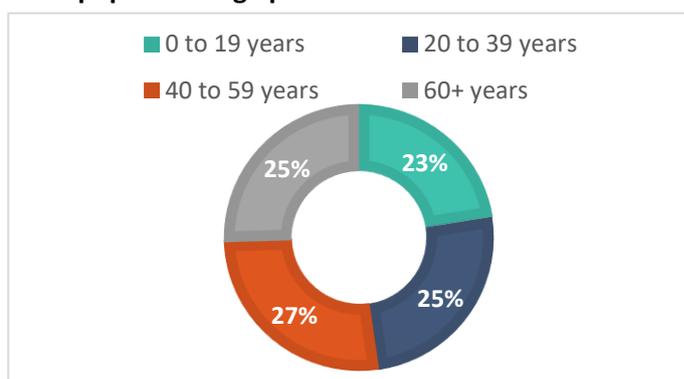
Individual	<ul style="list-style-type: none"> • One-to-one coaching • Mentorship training • Peer support networks
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	<ul style="list-style-type: none"> • Educational programmes • Portfolio career roles • Options for GPs approaching retirement
Practice	<ul style="list-style-type: none"> • Team coaching • IT equipment for out of hours working • e-consultation systems • IT solutions for booking locums • Career development roadmaps • Acute visiting service • Protocols for management of patients in care homes • The Time for Care programme or GP Quick Start
System	<ul style="list-style-type: none"> • GP recruitment • Primary and secondary care interface toolkit

Lancashire & South Cumbria

- Locality type: STP
- Population: 1,759,774
- IMD score: 25.4 (Quintile four, second most deprived)

Local population age profile



General practice statistics

At the beginning of the GPRISS initiative, there were 1,024 GPs working in 199 practices across Lancashire & South Cumbria, equating to 5.1 GPs per practice. This is close to the national average of 5.4 GPs per practice. Overall, 21.1% of GPs in the STP are over the age of 55, and CCGs like Blackpool have reported a 13.2% reduction in numbers of GPs from this age group. In Morecambe, a well-established federation is already participating in the national GP Career Plus initiative in order to support local practices.

List sizes across the STP are generally smaller than the national average, but each GP in the area has approximately 477 more patients to manage compared to other GPs in the rest of England (1589 pts. per GP). Using the monthly rate of GP-led appointments as an indicator of workload, GPs in the two CCGs have an average of 51.5 more appointments each month than their counterparts (445.5 vs. 394 appointments per month). The demand for GPs is so great, it is estimated that 46 additional GPs are needed, year on year, to meet wider STP targets.

Site-reported factors affecting retention

- Staff development: There is a need to offer training and development opportunities to existing practice staff to invest, develop and 'grow our own'.
- Overall practice staff need more training and development
- Difficulties retaining GPs once trained: Positives in terms of available places and numbers on training courses, however limited success in maintaining or securing GPs to stay in the local area.

- Recruitment: Some practices have had vacancies open for long periods of time, despite persistent advertising there has been limited interest and posts which remain unfilled.
- Ageing workforce: Across the intensive support site geographical area, there are a high percentage of GPs who are over the age of 55, as well as other staff within the wider practice workforce who are of a similar age. This is in part due to the rural nature of the area, where GPs and the wider primary care workforce tend to settle for many years.

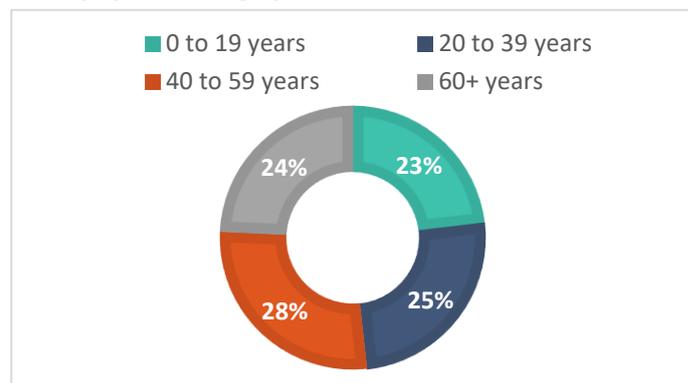
Interventions

Individual	<ul style="list-style-type: none"> • Leadership programmes for GPs • Leadership offers for admin/managerial staff • Clinical supervision and other training • One-to-one coaching • NHS Collaborate events • Portfolio career roles • Support for Allied Health Professionals • Lead GP roles to support employment and placement of physician associates • Engagement of Female GPs
Practice	<ul style="list-style-type: none"> • Practice-based workforce support • The Time for Care programme
System	<ul style="list-style-type: none"> • Organisational Development sessions • Workforce modelling tools • Health and wellbeing navigator roles (social prescribing signposting) • Implementation of the NHS standard contract • National NHSE initiatives (such as GPFV training, Resilience programme or Practice manager development programme)

Mid & South Essex

- Locality type: STP
- Population: 1,219,651
- IMD score: 18.7 (Quintile three, in the middle)

Local population age profile



General practice statistics

Mid and South Essex had 603 GPs working in 159 practices across at the beginning of the GPRISS initiative. This equates to 3.8 GPs per practice; considerably lower than the national average (5.4 GPs per practice). The average practice list sizes in the STP are, approximately 1,000 patients lower than the national average, but each GP in the area has, on average, 396 more patients to manage compared to their counterparts the rest of England (1589 pts. per GP). Using the monthly rate of GP-led appointments as an indicator of workload, each GP in the STP has an average of 70 more appointments each month than their counterparts (464.5 vs. 394 appointments per month).

Site-reported factors affecting retention

- It is becoming increasingly difficult to recruit GPs in rural areas. Locum GPs fill the shortfall locum but there is no incentive for them to become partners.
- In urban areas, there is high turnover due to burnout. Some GPs are leaving or retire early because they feel that there is not enough time to do the job justice. Those who remain are made to work harder.
- Decreasing numbers of partners is leading to increasing numbers single-handed GPs. At times, single-handed practices have had to close their lists.
- Training vacancies are easily filled but as soon as trainees qualify, they leave due to the allure of big cities like London. Additionally increasing numbers of trainees view being a locum as akin to becoming an independent contractor and having a more flexible lifestyle.

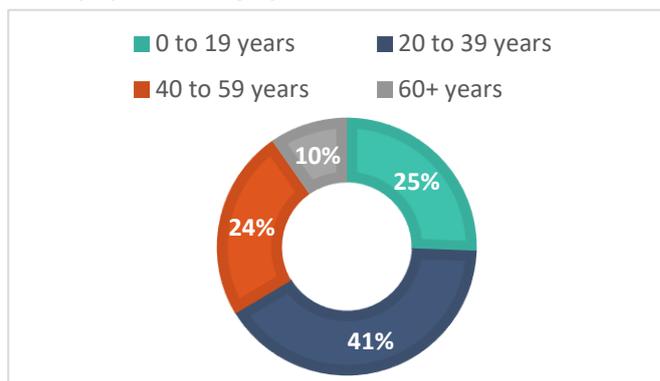
Interventions

Individual	<ul style="list-style-type: none"> • Portfolio and other GP extended roles • One-to-one coaching • Support for newly-qualified and trainee GPs (e.g. The Next Generation GP programme) • Peer support networks • Improving training infrastructure for trainees
Practice	<ul style="list-style-type: none"> • Use of 15-minute GP appointments • GP Quick Start
System	<ul style="list-style-type: none"> • Primary and secondary care interface toolkit • Marketing and promotion of the area • Marketing and promotion of national retention initiatives • National NHSE initiatives (such as GPFV training, Resilience programme or Practice manager development programme)

Newham

- Locality type: CCG
- Population: 399, 366
- IMD score: 32.9 (Quintile four, second most deprived)

Local population age profile



General practice statistics

Between 2015 and 2018, Newham experienced a 6% reduction of GP numbers (equating to a loss of 11 FTEs). At the start of the GPRISS initiative (October 2018), there were 202 GPs working in 51 practices across Newham. This means that the CCG has an average of 1.4 less GPs per practice than the rest of the country (Newham, 4.0; National average, 5.4). In relation to the average age of GPs, Newham is ranked in the top quartile: approximately 33% of the workforce are over 55, and 23% are over 60. According to information gathered by the CCG, up to 50% of GPs are actively considering leaving.

Average practice list sizes in Newham are generally smaller than other practices in the country (7943 vs. 8533 patients), but the average number of patients per GP is approximately 417 more than national estimates (1589 pts. per GP). This puts Newham in the six top boroughs in London. In relation to workload, data highlights that GPs in the CCG have more patient appointments per month compared to the rest of the country (469 vs. 394).

Site-reported factors affecting retention

- Over the past five years, the population has grown by approximately 50,000 people but GP numbers have remained relatively static, making it difficult to manage workloads.
- Numerous vacancies are unfilled across the CCG.
- The locality struggles to hold on to younger GPs post qualification. They often cite more challenging roles, better family life, and shorter commutes as reasons for leaving.
- Older GPs are leaving for other London boroughs, countries or professions that offer a more appealing work-life balance.
- Pay in Newham is lower due to the fact that it is outside the inner London supplement area.

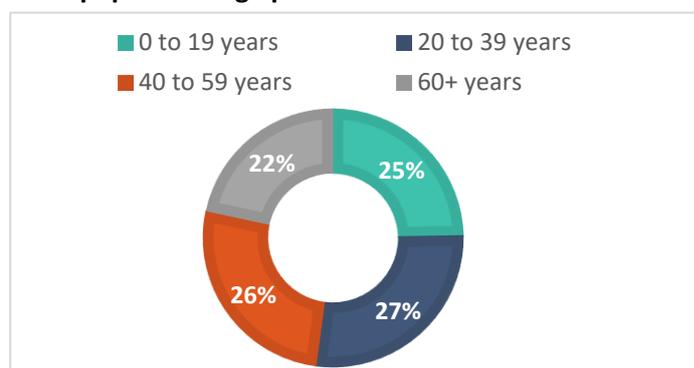
Interventions

Individual	<ul style="list-style-type: none"> • Practice manager coaching and mentoring • 1:1 Coaching Offer for GPs • GP mentoring schemes • Primary Care Leadership programme • Quality Improvement (QI) programme
Practice	<ul style="list-style-type: none"> • GPTeamNet intranet portal or Clarity Appraisal software • Data Quality Improvement • Practice Policy Support
System	<ul style="list-style-type: none"> • Digital engagement • A Shared Learning steering group • Provision of the NHS standard contract (QI Champions)

North Kirklees and Greater Huddersfield

- Locality type: two adjacent CCGs
- NB: unless otherwise stated, all figures refer to the combined totals or averages across the 2 CCGs
- Population: 442,214
- IMD score: 24.7 (Quintile four, second most deprived)

Local population age profile



General practice statistics

At the beginning of the GPRISS initiative, there were 215 GPs working in 64 practices across the two CCGs, equating to 3.4 GPs per practice. This is the lowest rate of all GPRISS sites, with the average practice in the area having 2 less GPs than other practices in the country. In North Kirklees, 33% of the GP workforce is over the age of 55. This is 11% higher than the Yorkshire and Humber region average.

List sizes across the two CCGs are generally smaller than the national average, but each GP in the area has approximately 477 more patients to manage compared to other GPs in the rest of England (1589 pts. per GP). Using the monthly rate of GP-led appointments as an indicator of workload, GPs in the 2 CCGs have a combined average of 51.5 more appointments each month than their counterparts (445.5 vs. 394 appointments per month). The demand for GPs is so great, it is estimated that 46 additional GPs are needed, year on year, to meet wider STP targets.

Site-reported factors affecting retention

- Small number of GP training practices across the North Kirklees and Greater Huddersfield CCGs areas, therefore limited opportunity to train and retain new GPs in the local area.
- Perceived attractive opportunities in cities or towns nearby, such as Leeds, York, Bradford or Harrogate.
- Suitability of premises is an issue: some practices are located in premises that are not ideal for modern primary care.

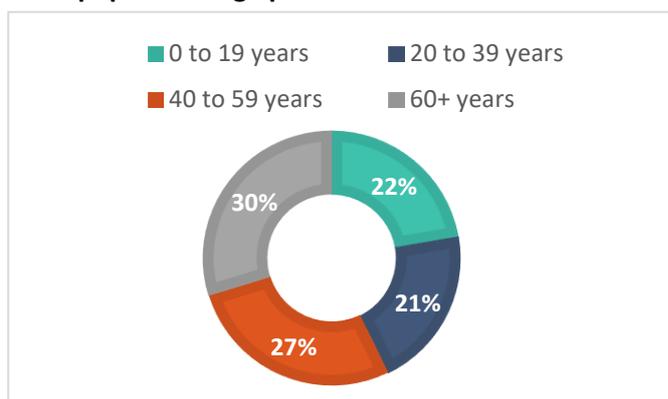
Interventions

Individual	<ul style="list-style-type: none"> • Next Generation GP programme • Individual coaching • Leadership development programme • Mentorship programme Peer networks
Practice	<ul style="list-style-type: none"> • Practice- or team-based coaching • Support for training practices • Funding for practice-led interventions
System	<ul style="list-style-type: none"> • Stakeholder engagement

Weston and Worle

- Locality type: an area comprising 11 practices in Weston, Worle, Banwell and Winscombe.
 - These practices fall within the North Somerset Upper Tier Local Authority (LA). The North Somerset Upper Tier Local Authority falls within the Bristol North Somerset & South Gloucester CCG
- North Somerset Upper Tier LA Population: 459,252
- North Somerset Upper Tier LA IMD score: 15.8 (Quintile three, in the middle)

Local population age profile



General practice statistics

At the beginning of the GPRISS initiative, there were 600 GPs working in 79 practices across the Bristol, North Somerset and South Gloucester CCG. This is the highest rate of all GPRISS sites; higher than the national average (7.6 vs. 5.4). The ageing GP workforce in Weston is masked by a younger demographic across the wider CCG. Within Weston, 35% of GPs are over 50 years and 25% are over 55 years. In two practices, 100% of GPs are over the age of 55.

Practice list sizes across the North Somerset are higher than national average but each GP in the area has marginally (approximately 23) more patients to manage compared to other GPs in the rest of England (1589 pts. per GP). GPs in the area have a combined average of 40.2 more appointments each month than their counterparts (434.2 vs. 394 appointments per month).

Site-reported factors affecting retention

- There are challenges managing appointments due to a high patient-to-GP ratio. This often results in more appointments than slots/sessions. Challenges are exacerbated by GPs reducing their sessions and an overreliance on locums.
- Apart from appointments, prescriptions, lab results, and letters compete for GPs' time and attention.
- Property management is an issue as all but 2 practices in Weston are converted Victorian buildings.

Interventions

Individual	<ul style="list-style-type: none"> • Apprenticeships and portfolio career roles • One-to-one coaching • Training on personal effectiveness and change management • Change facilitation support • Change roles for GPs approaching retirement
Practice	<ul style="list-style-type: none"> • Care Homes Project • EMIS (electronic patient record system) optimisation • Workflow optimisation • Practice team coaching
System	<ul style="list-style-type: none"> • GP Team Net • Home visiting service business case • New front-end website and launch of askmyGP • Development of a prescribing hub

Appendix B: Survey question outline

Demographic Questions

1. What is your GPRISS location?
2. What is your gender?
3. What is your age?
4. Are you part of the GPRISS implementation team?
5. What is your role within primary care?
6. In what capacity are you employed in general practice for the majority of your sessions?
7. At what stage are you in your career as a GP?
8. Please estimate the size of the current/most recent practice you have worked in?

Questions for GPs

Note: GPRISS aims to address local challenges facing GP retention. As a result, national factors such as pensions and indemnity are out of the scope of the initiative.

9. Please rank the 5 biggest local factors that have a negative impact on your job satisfaction over the past year (1 being the factor with the biggest impact; and 5, the factor with the smallest impact).
10. Please select all the interventions that you or your practice have taken (or will take) part in?
 - For each intervention that you or your practice have taken (or will take) part in, please rate whether you feel it will have a positive impact on your job satisfaction (0 no impact, and 10, a significant impact).
11. Overall, I feel that the combined impact of all interventions I have received (or will receive) will improve my job satisfaction.
12. Is there anything that you would change about the interventions you have received?
13. Apart from the support you have received, are there other types of support that would be helpful in improving your job satisfaction?
14. As a result of the GPRISS initiative, I feel more supported in my role compared to this time last year.
15. I feel that practices have benefited (or will benefit) as a result of the GPRISS initiative.
16. I feel that the wider primary care system has benefited (or will benefit) as a result of the GPRISS initiative.
17. I feel working relationships and collaborative working have improved (or will improve) in my local area as a result of the GPRISS initiative.
18. I feel patients have benefited as a result of the GPRISS initiative.
19. Overall, I feel more optimistic about general practice.
20. After participating in the GPRISS initiative, are you more or less likely to stay in general practice in the next 6 to 12 months?
21. After participating in the GPRISS initiative, are you more or less likely to stay in the area in the next 6 to 12 months?
22. After participating in the GPRISS initiative, are you more or less likely to scale back your working hours in the next 6 to 12 months?

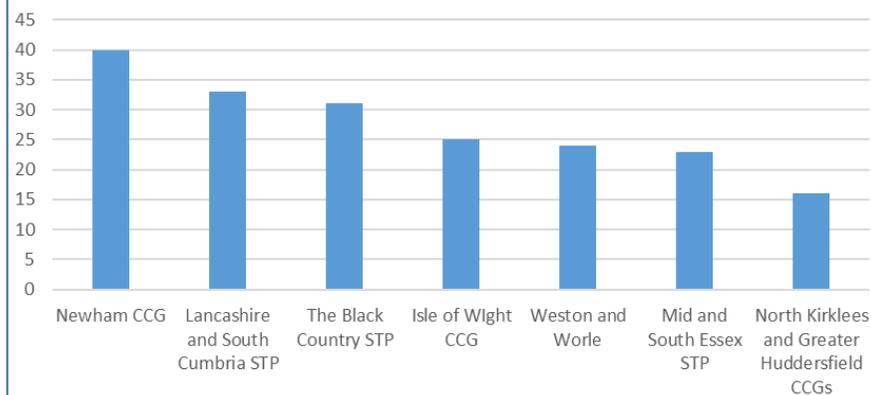
Questions for wider primary care (e.g. practice managers, CCG leads etc.)

23. Please select all the interventions that you have taken (or will take) part in?
24. The GPRISS initiative has had a positive impact on GPs since this time last year.
25. I feel that practices have benefited (or will benefit) as a result of the GPRISS initiative.
26. I feel that the wider primary care system has benefited (or will benefit) as a result of the GPRISS initiative.
27. I feel working relationships and collaborative working have improved (or will improve) as a result of the GPRISS initiative.
28. I feel the GPRISS initiative has created (or will create) a positive momentum for change.
29. I feel patients have benefited (or will benefit) as a result of the GPRISS initiative.

Appendix C: Detailed survey results

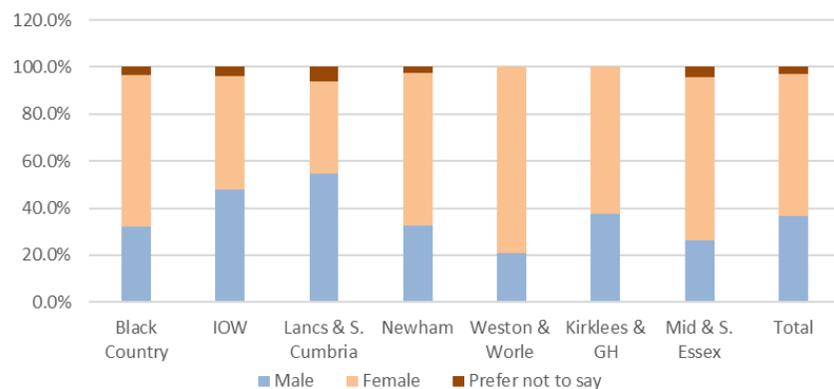
All Participants

What is your GPRISS location?



Newham CCG	40
Lancashire and South Cumbria STP	33
The Black Country STP	31
Isle of Wight CCG	25
Weston and Worle	24
Mid and South Essex STP	23
North Kirklees and Greater Huddersfield CCGs	16

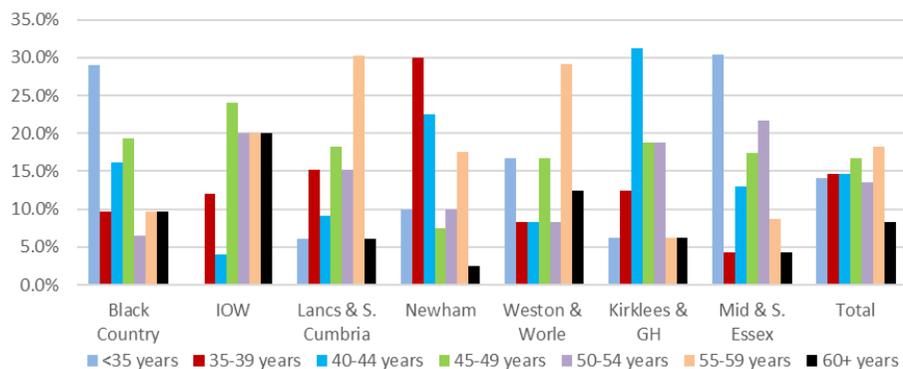
What is your gender?



	Percentage (n)							Total
	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirlees & GH	Mid & S. Essex	
Male	32.3% (10)	48.0% (12)	54.5% (18)	32.5% (13)	20.8% (5)	37.5% (6)	26.1% (6)	36.5% (70)
Female	64.5% (20)	48.0% (12)	39.4% (13)	65.0% (26)	79.2% (19)	62.5% (10)	69.6% (16)	60.4% (116)
Prefer not to say	3.2% (1)	4.0% (1)	6.1% (2)	2.5% (1)	0.0% (0)	0.0% (0)	4.3% (1)	3.1% (192)

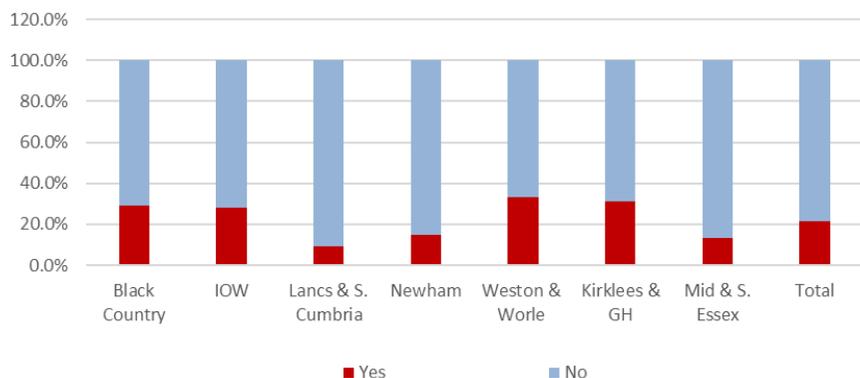
All Participants

What is your age?



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
<35 years	29.0% (9)	0.0% (0)	6.1% (2)	10.0% (4)	16.7% (4)	6.3% (1)	30.4% (7)	14.1% (27)
35-39 years	9.7% (3)	12.0% (3)	15.2% (5)	30.0% (12)	8.3% (2)	12.5% (2)	4.3% (1)	14.6% (28)
40-44 years	16.1% (5)	4.0% (1)	9.1% (3)	22.5% (9)	8.3% (2)	31.3% (5)	13.0% (3)	14.6% (28)
45-49 years	19.4% (6)	24.0% (6)	18.2% (6)	7.5% (3)	16.7% (4)	18.8% (3)	17.4% (4)	16.7% (32)
50-54 years	6.5% (2)	20.0% (5)	15.2% (5)	10.0% (4)	8.3% (2)	18.8% (3)	21.7% (5)	13.5% (26)
55-59 years	9.7% (3)	20.0% (5)	30.3% (10)	17.5% (7)	29.2% (7)	6.3% (1)	8.7% (2)	18.2% (35)
60+ years	9.7% (3)	20.0% (5)	6.1% (2)	2.5% (1)	12.5% (3)	6.3% (1)	4.3% (1)	8.3% (16)

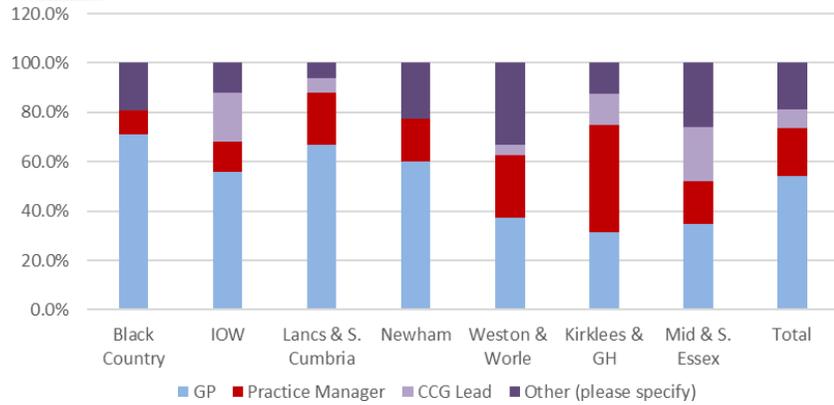
Are you part of the GPRISS implementation team?



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Yes	29.0% (9)	28.0% (7)	9.1% (3)	15.0% (6)	33.3% (8)	31.3% (5)	13.0% (3)	21.4% (41)
No	71.0% (22)	72.0% (18)	90.9% (30)	85.0% (34)	66.7% (16)	68.8% (11)	87.0% (20)	78.6% (151)

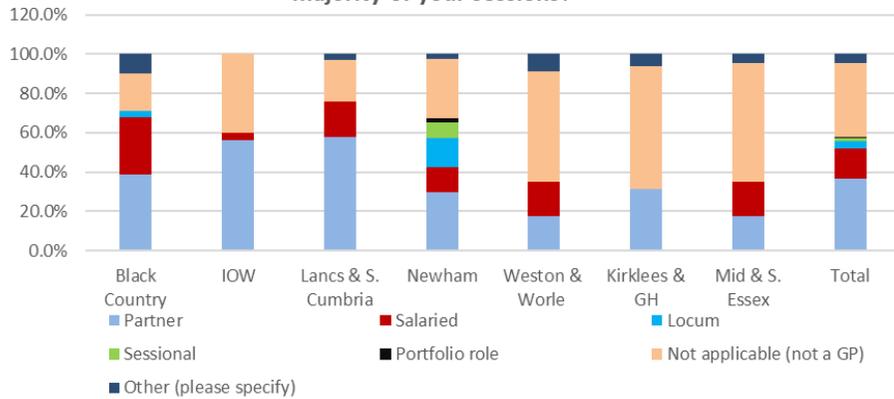
All Participants

What is your role within primary care?



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
GP	71.0% (22)	56.0% (14)	66.7% (22)	60.0% (24)	37.5% (9)	31.3% (5)	34.8% (8)	54.2% (104)
Practice Manager	9.7% (3)	12.0% (3)	21.2% (7)	17.5% (7)	25.0% (6)	43.8% (7)	17.4% (4)	19.3% (37)
CCG Lead	0.0% (0)	20.0% (5)	6.1% (2)	0.0% (0)	4.2% (1)	12.5% (2)	21.7% (2)	7.8% (15)
Other	19.4% (6)	12.0% (3)	6.1% (2)	22.5% (9)	33.3% (8)	12.5% (2)	26.1% (6)	18.8% (36)

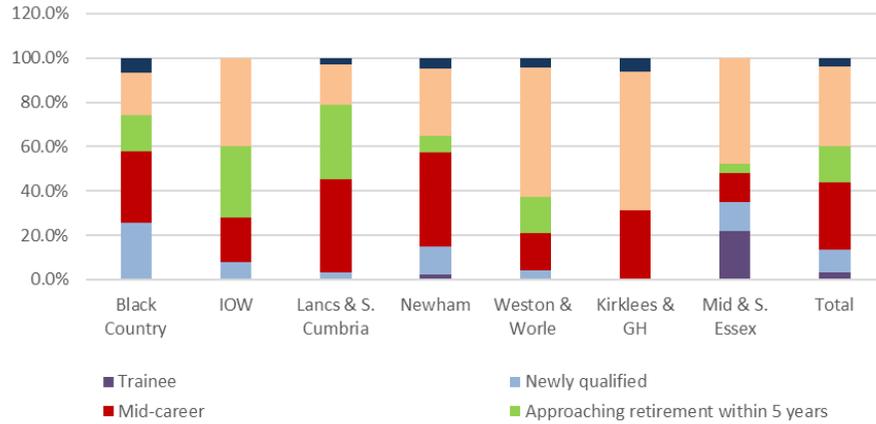
In what capacity are you employed in general practice for the majority of your sessions?



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Partner	38.7% (12)	56.0% (14)	57.6% (19)	30.0% (12)	17.4% (4)	31.3% (5)	17.4% (4)	36.6% (70)
Salaried	29.0% (9)	4.0% (1)	18.2% (6)	12.5% (5)	17.4% (4)	0.0% (0)	17.4% (4)	15.2% (29)
Locum	3.2% (1)	0.0% (0)	0.0% (0)	15.0% (6)	0.0% (0)	0.0% (0)	0.0% (0)	3.7% (7)
Sessional	0.0% (0)	0.0% (0)	0.0% (0)	7.5% (3)	0.0% (0)	0.0% (0)	0.0% (0)	1.6% (3)
Portfolio role	0.0% (0)	0.0% (0)	0.0% (0)	2.5% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.5% (1)
Not applicable	19.4% (6)	40.0% (10)	21.2% (7)	30.0% (12)	56.5% (13)	62.5% (10)	60.9% (14)	37.7% (72)
Other	9.7% (3)	0.0% (0)	3.0% (1)	2.5% (1)	8.7% (2)	6.3% (1)	4.3% (1)	4.7% (9)

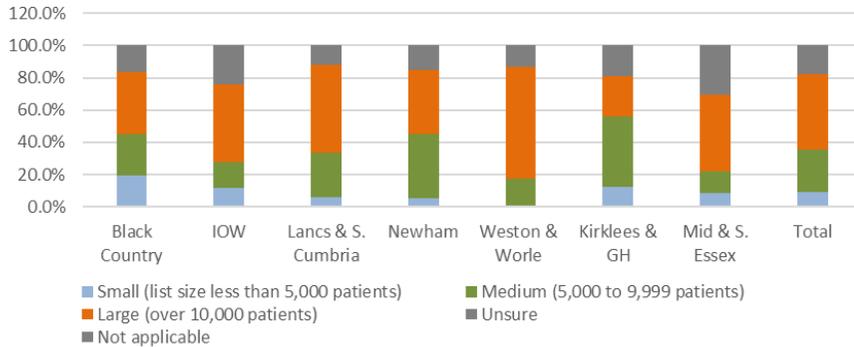
All Participants

At what stage are you in your career as a GP?



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Trainee	0.0% (0)	0.0% (0)	0.0% (0)	2.5% (1)	0.0% (0)	0.0% (0)	21.7% (5)	3.1% (6)
Newly qualified	25.8% (8)	8.0% (2)	3.0% (1)	12.5% (2)	4.2% (1)	0.0% (0)	13.0% (3)	10.4% (20)
Mid-career	32.3% (10)	20.0% (5)	42.4% (14)	42.5% (17)	16.7% (4)	31.3% (5)	13.0% (3)	30.2% (58)
Approaching retirement within 5 years	16.1% (5)	32.0% (8)	33.3% (11)	7.5% (3)	16.7% (4)	0.0% (0)	4.3% (1)	16.7% (32)
Not applicable	19.4% (6)	40.0% (10)	18.2% (6)	30.0% (12)	58.3% (14)	62.5% (10)	47.8% (11)	35.9% (69)
Other	6.5% (2)	0.0% (0)	3.0% (1)	5.0% (2)	4.2% (1)	6.3% (1)	0.0% (0)	3.6% (7)

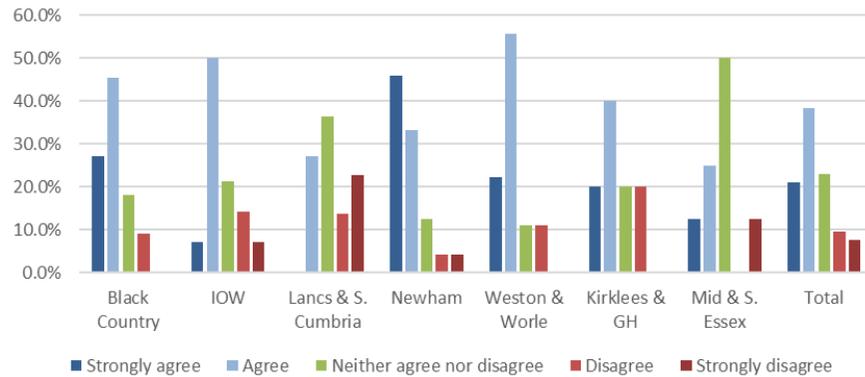
Practice size



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Small (<5,000 patients)	19.4% (6)	12.0% (3)	6.1% (2)	5.0% (2)	0.0% (0)	12.5% (2)	8.7% (2)	8.9% (17)
Medium (5,000-9,999 patients)	25.8% (8)	16.0% (4)	27.3% (9)	40.0% (16)	17.4% (4)	43.8% (7)	13.0% (3)	26.7% (51)
Large (>10,000 patients)	38.7% (12)	48.0% (12)	54.5% (18)	40.0% (16)	69.6% (16)	25.0% (4)	47.8% (11)	46.6% (89)
Unsure	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	4.3% (1)	0.0% (0)	0.0% (0)	0.5% (1)
Not applicable	16.1% (5)	24.0% (6)	12.1% (4)	15.0% (6)	8.7% (2)	18.8% (3)	30.4% (7)	17.3% (33)

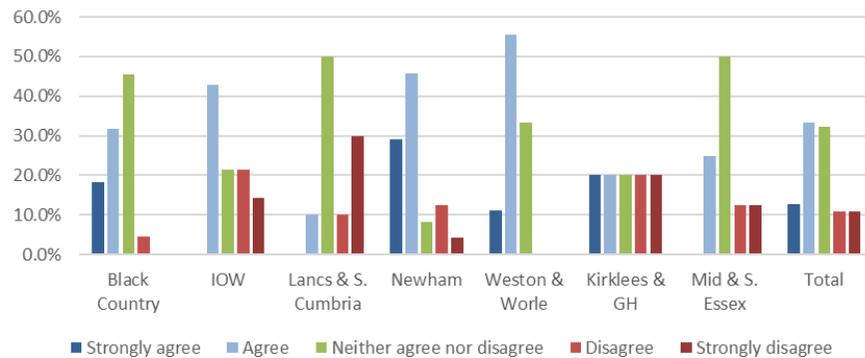
GPs only

Overall, I feel that the combined impact of all interventions I have received (or will receive) will improve my job satisfaction.



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	27.3% (6)	7.1% (1)	0.0% (0)	45.8% (11)	22.2% (2)	20.0% (1)	12.5% (1)	21.2% (22)
Agree	45.5% (10)	50.0% (7)	27.3% (6)	33.3% (8)	55.6% (5)	40.0% (2)	25.0% (2)	38.5% (40)
Neither agree nor disagree	18.2% (4)	21.4% (3)	36.4% (8)	12.5% (3)	11.1% (1)	20.0% (1)	50.0% (4)	23.1% (24)
Disagree	9.1% (2)	14.3% (2)	13.6% (3)	4.2% (1)	11.1% (1)	20.0% (1)	0.0% (0)	9.6% (10)
Strongly disagree	0.0% (0)	7.1% (1)	22.7% (5)	4.2% (1)	0.0% (0)	0.0% (0)	12.5% (1)	7.7% (8)

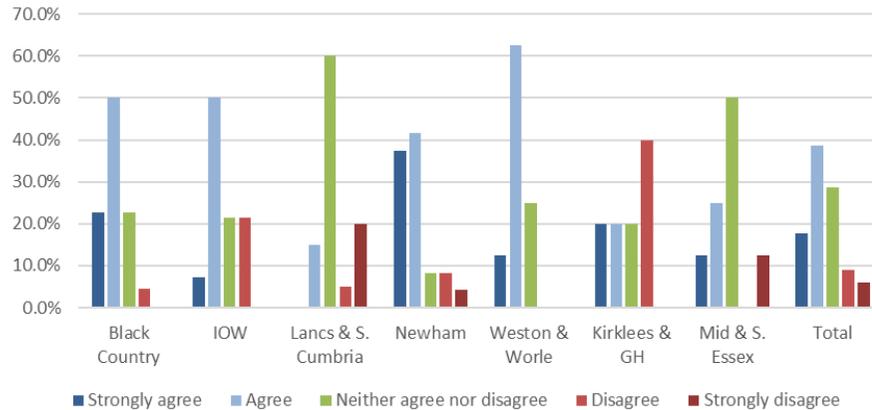
As a result of the GPRISS initiative, I feel more supported in my role compared to this time last year.



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	18.2% (4)	0.0% (0)	0.0% (0)	29.2% (7)	11.1% (1)	20.0% (1)	0.0% (0)	12.7% (13)
Agree	31.8% (7)	42.9% (6)	10.0% (2)	45.8% (11)	55.6% (5)	20.0% (1)	25.0% (2)	33.3% (34)
Neither agree nor disagree	45.5% (10)	21.4% (3)	50.0% (10)	8.3% (2)	33.3% (3)	20.0% (1)	50.0% (4)	32.4% (33)
Disagree	4.5% (1)	21.4% (3)	10.0% (2)	12.5% (3)	0.0% (0)	20.0% (1)	12.5% (1)	10.8% (11)
Strongly disagree	0.0% (0)	14.3% (2)	30.0% (6)	4.2% (1)	0.0% (0)	20.0% (1)	12.5% (1)	10.8% (11)

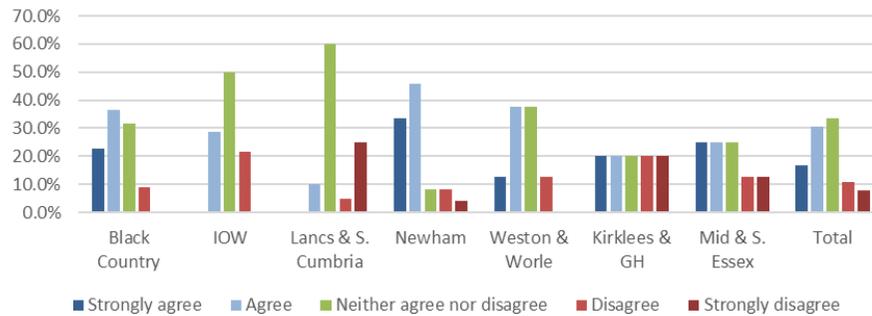
GPs only

I feel that practices have benefited (or will benefit) as a result of the GPRISS initiative.



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	22.7% (5)	7.1% (1)	0.0% (0)	37.5% (9)	12.5% (1)	20.0% (1)	12.5% (1)	17.8% (18)
Agree	50.0% (11)	50.0% (7)	15.0% (3)	41.7% (10)	62.5% (5)	20.0% (1)	25.0% (2)	38.6% (39)
Neither agree nor disagree	22.7% (5)	21.4% (3)	60.0% (12)	8.3% (2)	25.0% (2)	20.0% (1)	50.0% (4)	28.7% (29)
Disagree	4.5% (1)	21.4% (3)	5.0% (1)	8.3% (2)	0.0% (0)	40.0% (2)	0.0% (0)	8.9% (9)
Strongly disagree	0.0% (0)	0.0% (0)	20.0% (4)	4.2% (1)	0.0% (0)	0.0% (0)	12.5% (1)	5.9% (6)

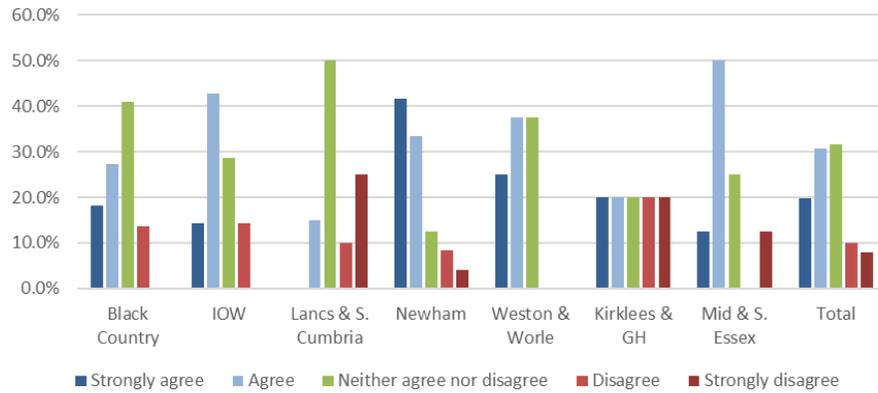
I feel that the wider primary care system has benefited (or will benefit) as a result of the GPRISS initiative



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	22.7% (5)	0.0% (0)	0.0% (0)	33.3% (8)	12.5% (1)	20.0% (1)	25.0% (2)	16.8% (17)
Agree	36.4% (8)	28.6% (4)	10.0% (2)	45.8% (11)	37.5% (3)	20.0% (1)	25.0% (2)	30.7% (31)
Neither agree nor disagree	31.8% (7)	50.0% (7)	60.0% (12)	8.3% (2)	37.5% (3)	20.0% (1)	25.0% (2)	33.7% (34)
Disagree	9.1% (2)	21.4% (3)	5.0% (1)	8.3% (2)	12.5% (1)	20.0% (1)	12.5% (1)	10.9% (11)
Strongly disagree	0.0% (0)	0.0% (0)	25.0% (5)	4.2% (1)	0.0% (0)	20.0% (1)	12.5% (1)	7.9% (8)

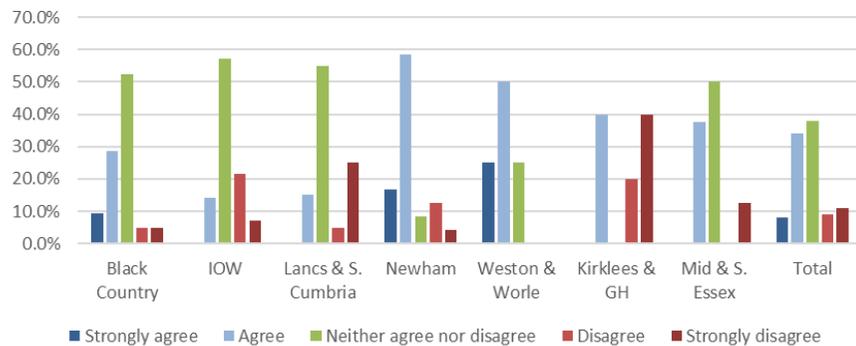
GPs only

I feel working relationships and collaborative working have improved (or will improve) in my local area as a result of the GPRISS initiative.



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	18.2% (4)	14.3% (2)	0.0% (0)	41.7% (10)	25.0% (2)	20.0% (1)	12.5% (1)	19.8% (20)
Agree	27.3% (6)	42.9% (6)	15.0% (3)	33.3% (8)	37.5% (3)	20.0% (1)	50.0% (4)	30.7% (31)
Neither agree nor disagree	40.9% (9)	28.6% (4)	50.0% (10)	12.5% (3)	37.5% (3)	20.0% (1)	25.0% (2)	31.7% (32)
Disagree	13.6% (3)	14.3% (2)	10.0% (2)	8.3% (2)	0.0% (0)	20.0% (1)	0.0% (0)	9.9% (10)
Strongly disagree	0.0% (0)	0.0% (0)	25.0% (5)	4.2% (1)	0.0% (8)	20.0% (1)	12.5% (1)	7.9% (8)

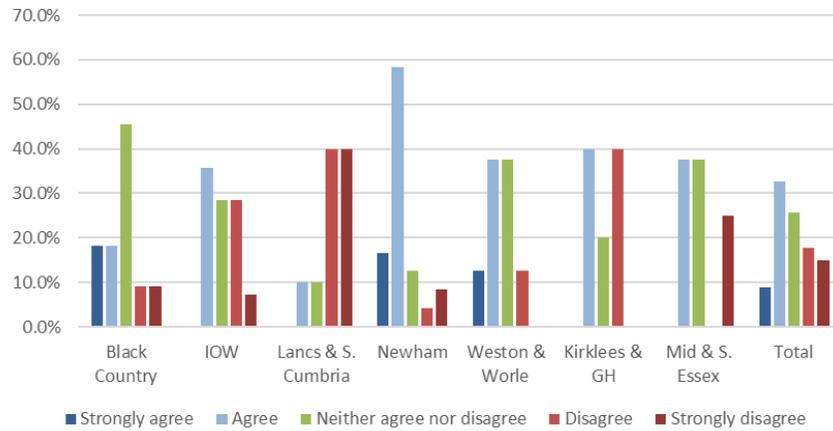
I feel patients have benefited as a result of the GPRISS initiative.



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	9.5% (2)	0.0% (0)	0.0% (0)	16.7% (4)	25.0% (2)	0.0% (0)	0.0% (0)	8.0% (8)
Agree	28.6% (6)	14.3% (2)	15.0% (3)	58.3% (14)	50.0% (4)	40.0% (2)	37.5% (3)	34.0% (34)
Neither agree nor disagree	52.4% (11)	57.1% (8)	55.0% (11)	8.3% (2)	25.0% (2)	0.0% (0)	50.0% (4)	38.0% (38)
Disagree	4.8% (1)	21.4% (3)	5.0% (1)	12.5% (3)	0.0% (0)	20.0% (1)	0.0% (0)	9.0% (9)
Strongly disagree	4.8% (1)	7.1% (1)	25.0% (5)	4.2% (1)	0.0% (0)	40.0% (2)	12.5% (1)	11.0% (11)

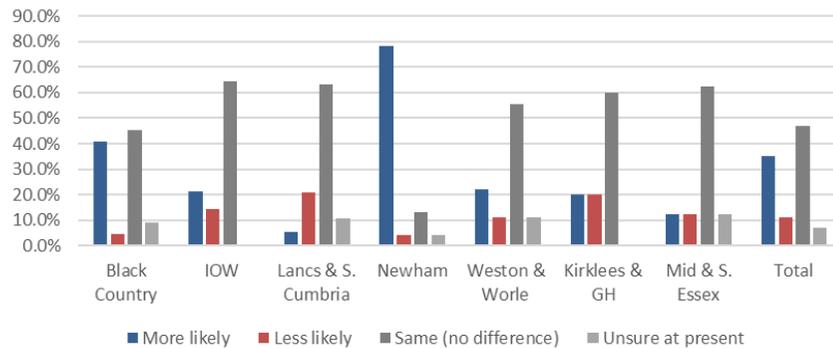
GPs only

Overall, I feel more optimistic about general practice.



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	18.2% (4)	0.0% (0)	0.0% (0)	16.7% (4)	12.5% (1)	0.0% (0)	0.0% (0)	8.9% (9)
Agree	18.2% (4)	35.7% (5)	10.0% (2)	58.3% (14)	37.5% (3)	40.0% (2)	37.5% (3)	32.7% (33)
Neither agree nor disagree	45.5% (10)	28.6% (4)	10.0% (2)	12.5% (3)	37.5% (3)	20.0% (1)	37.5% (3)	25.7% (26)
Disagree	9.1% (2)	28.6% (4)	40.0% (8)	4.2% (1)	12.5% (1)	40.0% (2)	0.0% (0)	17.8% (18)
Strongly disagree	9.1% (2)	7.1% (1)	40.0% (8)	8.3% (2)	0.0% (0)	0.0% (0)	25.0% (2)	14.9% (15)

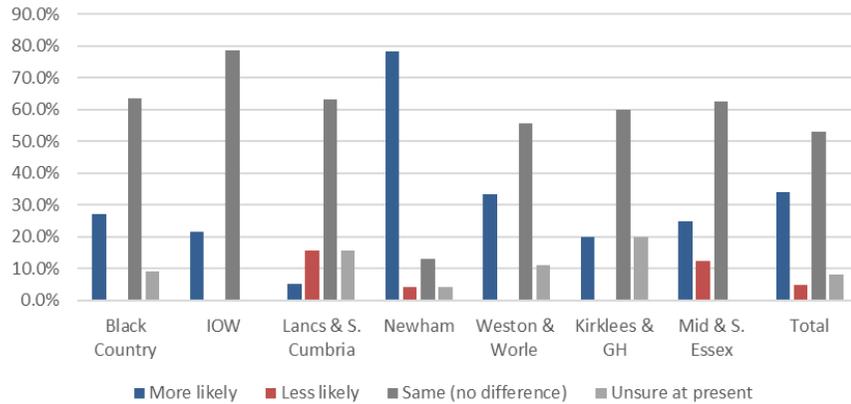
After participating in the GPRISS initiative, are you more or less likely to stay in general practice in the next 6 to 12 months?



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
More likely	40.9% (9)	21.4% (3)	5.3% (1)	78.3% (18)	22.2% (2)	20.0% (1)	12.5% (1)	35.0% (35)
Less likely	4.5% (1)	14.3% (2)	21.1% (4)	4.3% (1)	11.1% (1)	20.0% (1)	12.5% (1)	11.0% (11)
Same (no difference)	45.5% (10)	64.3% (9)	63.2% (12)	13.0% (3)	55.6% (5)	60.0% (3)	62.5% (5)	47.0% (47)
Unsure at present	9.1% (2)	0.0% (0)	10.5% (2)	4.3% (1)	11.1% (1)	0.0% (0)	12.5% (1)	7.0% (7)

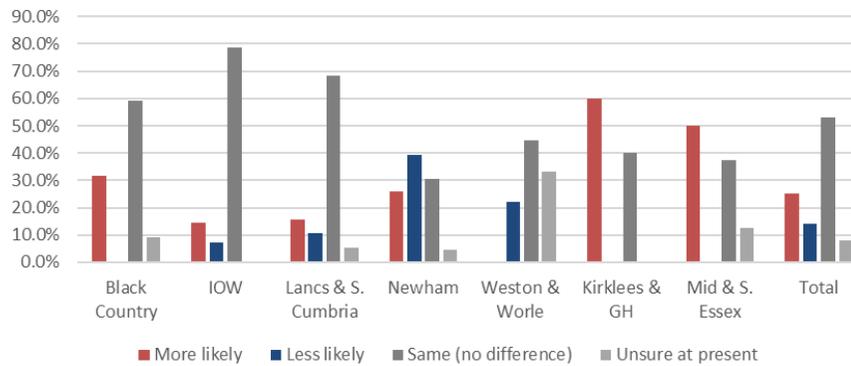
GPs only

After participating in the GPRISS initiative, are you more or less likely to stay in your area in the next 6 to 12 months?



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
More likely	27.3% (6)	21.4% (3)	5.3% (1)	78.3% (18)	33.3% (3)	20.0% (1)	25.0% (2)	34.0% (34)
Less likely	0.0% (0)	0.0% (0)	15.8% (3)	4.3% (1)	0.0% (0)	0.0% (0)	12.5% (1)	5.0% (5)
Same (no difference)	63.6% (14)	78.6% (11)	63.2% (12)	13.0% (3)	55.6% (5)	60.0% (3)	62.5% (5)	53.0% (53)
Unsure at present	9.1% (2)	0.0% (0)	15.8% (3)	4.3% (1)	11.1% (1)	20.0% (1)	0.0% (0)	8.0% (8)

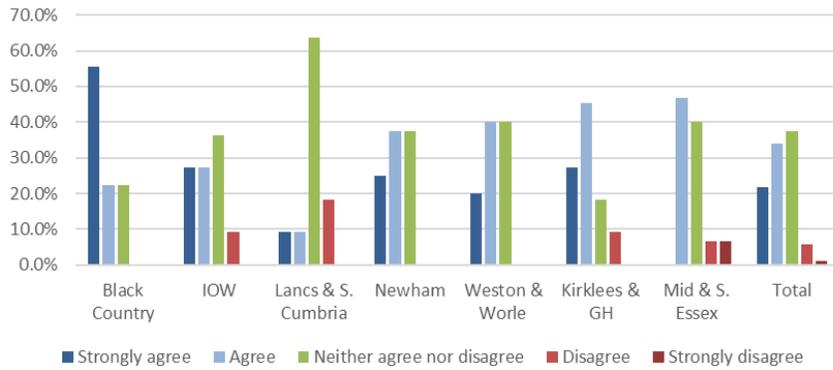
After participating in the GPRISS initiative, are you more or less likely to scale back your working hours in the next 6 to 12 months?



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
More likely	31.8% (7)	14.3% (2)	15.8% (3)	26.1% (6)	0.0% (0)	60.0% (3)	50.0% (4)	25.0% (24)
Less likely	0.0% (0)	7.1% (1)	10.5% (2)	39.1% (9)	22.2% (2)	0.0% (0)	0.0% (0)	14.0% (14)
Same (no difference)	59.1% (13)	78.6% (11)	68.4% (13)	30.4% (7)	44.4% (4)	40.0% (2)	37.5% (3)	53.0% (53)
Unsure at present	9.1% (2)	0.0% (0)	5.3% (1)	4.3% (1)	33.3% (3)	0.0% (0)	12.5% (1)	8.0% (8)

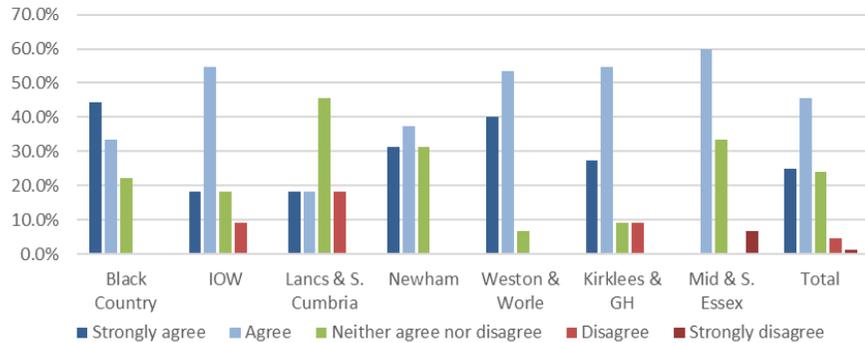
Non-GPs

The GPRISS initiative has had a positive impact on GPs since this time last year.



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	55.6% (5)	27.3% (3)	9.1% (1)	25.0% (4)	20.0% (3)	27.3% (3)	0.0% (0)	21.6% (19)
Agree	22.2% (2)	27.3% (3)	9.1% (1)	37.5% (6)	40.0% (6)	45.5% (5)	46.7% (7)	34.1% (30)
Neither agree nor disagree	22.2% (2)	36.4% (4)	63.6% (7)	37.5% (6)	40.0% (6)	18.2% (2)	40.0% (6)	37.5% (33)
Disagree	0.0% (0)	9.1% (1)	18.2% (2)	0.0% (0)	0.0% (0)	9.1% (1)	6.7% (1)	5.7% (5)
Strongly disagree	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	6.7% (1)	1.1% (1)

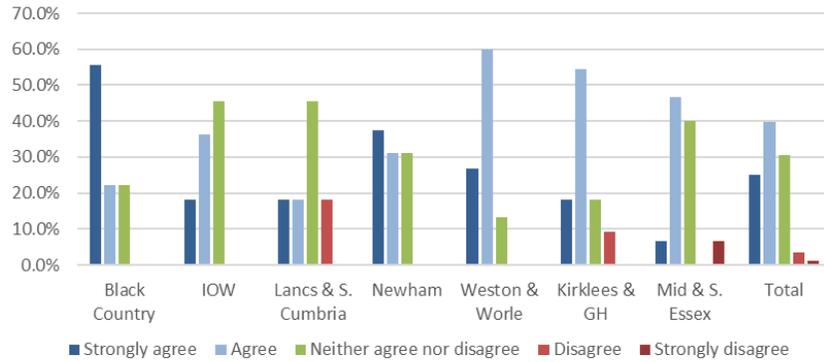
I feel that practices have benefited (or will benefit) as a result of the GPRISS initiative.



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	44.4% (4)	18.2% (2)	18.2% (2)	31.3% (5)	40.0% (6)	27.3% (3)	0.0% (0)	25.0% (22)
Agree	33.3% (3)	54.5% (6)	18.2% (2)	37.5% (6)	53.3% (8)	54.5% (6)	60.0% (9)	45.5% (40)
Neither agree nor disagree	22.2% (2)	18.2% (2)	45.5% (5)	31.3% (5)	6.7% (1)	9.1% (1)	33.3% (5)	23.9% (21)
Disagree	0.0% (0)	9.1% (1)	18.2% (2)	0.0% (0)	0.0% (0)	9.1% (1)	0.0% (0)	4.5% (4)
Strongly disagree	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	6.7% (1)	1.1% (1)

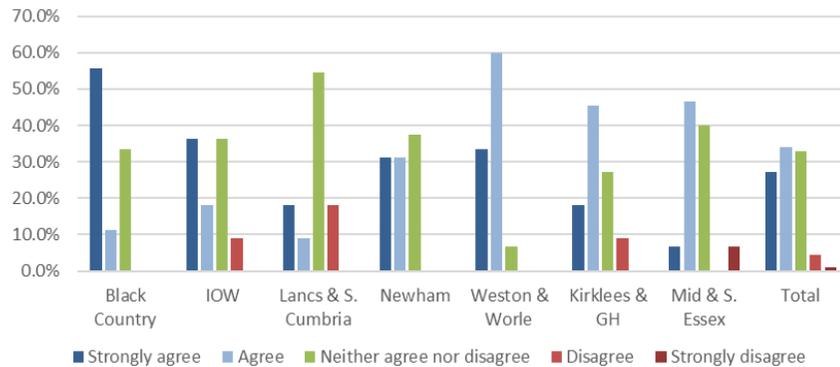
Non-GPs

I feel that the wider primary care system has benefited (or will benefit) as a result of the GPRISS initiative.



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	55.6% (5)	18.2% (2)	18.2% (2)	37.5% (6)	26.7% (4)	18.2% (2)	6.7% (1)	25.0% (22)
Agree	22.2% (2)	36.4% (4)	18.2% (2)	31.3% (5)	60.0% (9)	54.5% (6)	46.7% (7)	39.8% (35)
Neither agree nor disagree	22.2% (2)	45.5% (5)	45.5% (5)	31.3% (5)	13.3% (2)	18.2% (2)	40.0% (6)	30.7% (27)
Disagree	0.0% (0)	0.0% (0)	18.2% (2)	0.0% (0)	0.0% (0)	9.1% (1)	0.0% (0)	3.4% (3)
Strongly disagree	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	6.7% (1)	1.1% (1)

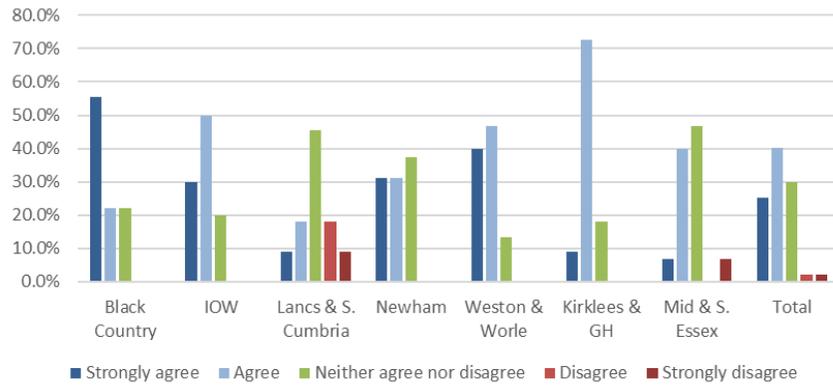
I feel working relationships and collaborative working have improved (or will improve) as a result of the GPRISS initiative.



	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	55.6% (5)	36.4% (4)	18.2% (2)	31.3% (5)	33.3% (5)	18.2% (2)	6.7% (1)	27.3% (24)
Agree	11.1% (1)	18.2% (2)	9.1% (1)	31.3% (5)	60.0% (9)	45.5% (5)	46.7% (7)	34.1% (30)
Neither agree nor disagree	33.3% (3)	36.4% (4)	54.5% (6)	37.5% (6)	6.7% (1)	27.3% (3)	40.0% (6)	33.0% (29)
Disagree	0.0% (0)	9.1% (1)	18.2% (2)	0.0% (0)	0.0% (0)	9.1% (1)	0.0% (0)	4.5% (4)
Strongly disagree	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	6.7% (1)	1.1% (1)

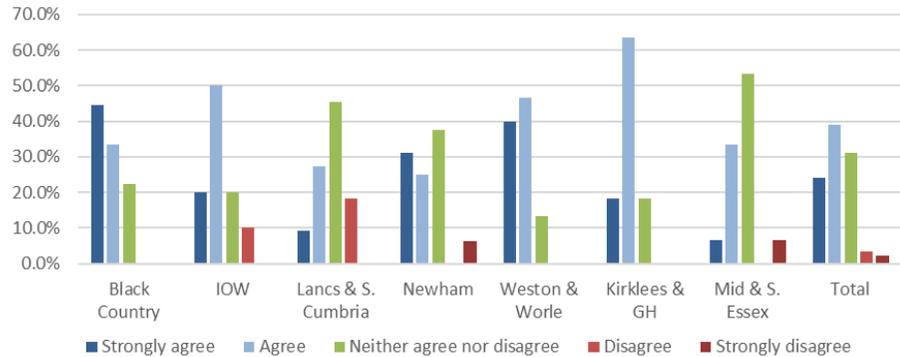
Non-GPs

I feel the GPRISS initiative has created (or will create) a positive momentum for change.

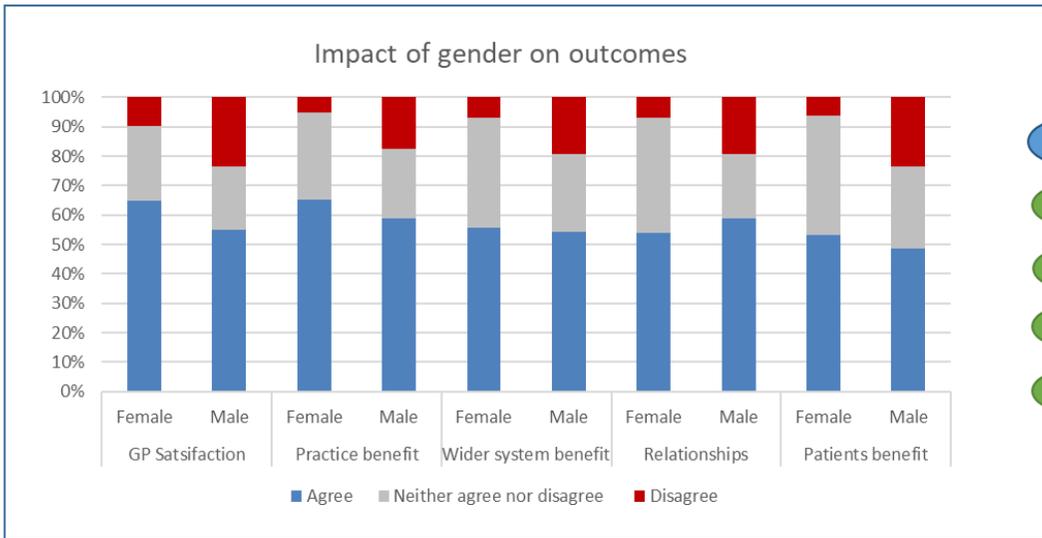


	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	55.6% (5)	30.0% (3)	9.1% (1)	31.3% (5)	40.0% (6)	9.1% (1)	6.7% (1)	25.3% (22)
Agree	22.2% (2)	50.0% (5)	18.2% (2)	31.3% (5)	46.7% (7)	72.7% (8)	40.0% (3)	40.2% (35)
Neither agree nor disagree	22.2% (2)	20.0% (2)	45.5% (5)	37.5% (3)	13.3% (2)	18.2% (2)	46.7% (7)	29.9% (26)
Disagree	0.0% (0)	0.0% (0)	18.2% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	2.3% (2)
Strongly disagree	0.0% (0)	0.0% (0)	9.1% (1)	0.0% (0)	0.0% (0)	0.0% (0)	6.7% (1)	2.3% (2)

I feel patients have benefited (or will benefit) as a result of the GPRISS initiative.

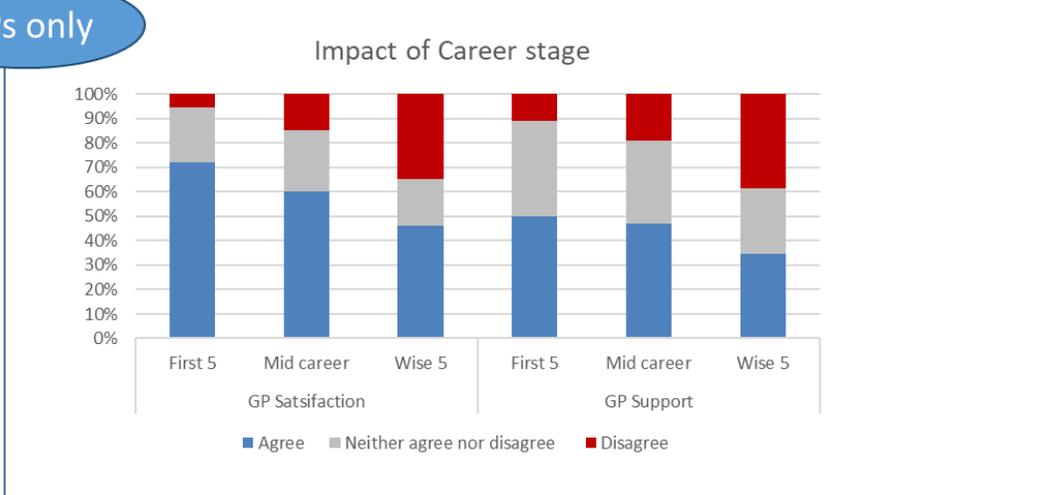


	Black Country	IOW	Lancs & S. Cumbria	Newham	Weston & Worle	Kirklees & GH	Mid & S. Essex	Total
Strongly agree	44.4% (4)	20.0% (2)	9.1% (1)	31.3% (5)	40.0% (6)	18.2% (2)	6.7% (1)	24.1% (21)
Agree	33.3% (3)	50.0% (5)	27.3% (3)	25.0% (4)	46.7% (7)	63.6% (7)	33.3% (5)	39.1% (34)
Neither agree nor disagree	22.2% (2)	20.0% (2)	45.5% (5)	37.5% (6)	13.3% (2)	18.2% (2)	53.3% (8)	31.0% (27)
Disagree	0.0% (0)	10.0% (1)	18.2% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	3.4% (3)
Strongly disagree	0.0% (0)	0.0% (0)	0.0% (0)	6.3% (1)	0.0% (0)	0.0% (0)	6.7% (1)	2.3% (2)



		Agree	Neither agree nor disagree	Disagree	
GPs	GP Satisfaction	Female	64.7% (33)	25.5% (13)	9.8% (5)
		Male	54.9% (28)	21.6% (11)	23.5% (12)
All	Practice benefit	Female	65.2% (75)	29.6% (34)	5.2% (6)
		Male	58.8% (40)	23.5% (16)	17.7% (12)
All	Wider system benefit	Female	55.7% (64)	37.4% (43)	6.9% (8)
		Male	54.4% (37)	26.5% (18)	19.1% (13)
All	Relationships	Female	53.9% (62)	39.1% (45)	7.0% (8)
		Male	58.8% (40)	22.1% (15)	19.1% (13)
All	Patients benefit	Female	53.1% (60)	40.7% (46)	6.2% (7)
		Male	48.5% (33)	27.9% (19)	23.5% (16)

GPs only

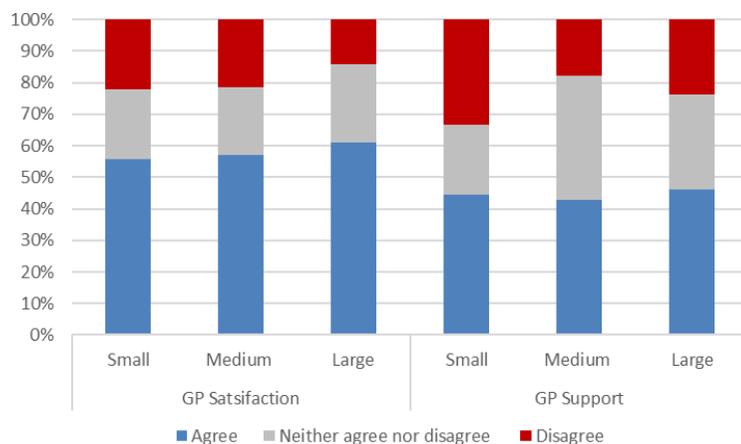


		Agree	Neither agree nor disagree	Disagree
GP Satisfaction	First 5	72.2% (13)	22.22% (4)	5.6% (1)
	Mid career	60.0% (33)	25.5% (14)	14.6% (8)
	Wise 5	46.2% (12)	19.2% (5)	34.6% (9)
GP Support	First 5	50.0% (9)	38.9% (7)	11.1% (2)
	Mid career	47.2% (25)	33.9% (18)	18.8% (10)
	Wise 5	34.6% (9)	26.9% (7)	38.5% (10)

NB: "GP support" refers to the following question which was asked to GPs: "As a result of the GPRISS initiative, I feel more supported in my role compared to this time last year"

GPs only

Impact of practice size

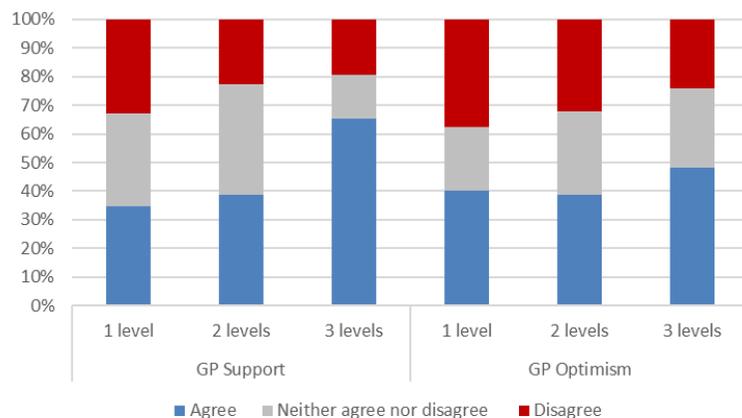


		Agree	Neither agree nor disagree	Disagree
GP Satisfaction	Small	55.6% (5)	22.2% (2)	22.2% (2)
	Medium	57.1% (16)	21.4% (6)	21.4% (6)
	Large	60.9% (39)	25.0% (16)	14.1% (9)
GP Support	Small	44.4% (4)	22.2% (2)	33.3% (3)
	Medium	42.9% (12)	39.3% (11)	17.9% (5)
	Large	46.0% (29)	30.2% (19)	23.8% (13)

NB: "GP support" refers to the following question which was asked to GPs: "As a result of the GPRISS initiative, I feel more supported in my role compared to this time last year"

GPs only

Impact of receiving levels



		Agree	Neither agree nor disagree	Disagree
GP Support	1 level	34.6% (18)	32.7% (17)	32.7% (17)
	2 levels	38.7% (12)	38.7% (12)	22.6% (7)
	3 levels	65.4% (17)	15.4% (4)	19.2% (5)
GP Optimism	1 level	40.0% (18)	22.2% (10)	37.8% (17)
	2 levels	38.7% (12)	29.0% (9)	32.2% (10)
	3 levels	48.0% (12)	28.0% (7)	24.0% (5)

NB: The graphs show the impact of receiving any combination of the different levels: 1 level refers to any level; 2 levels refers to any combination of individual, practice and system; 3 levels refers to all levels.

Appendix D: Qualitative fieldwork

D1: Initial interview guide

1. Role & GPRISS Site Description (*Rapport building questions*)

- What is your perception of the role of GPRISS and its key aims?
- Please describe your role in the GPRISS project?
Who do you work with on the project/interventions? Which staff do you work with on a daily basis?
- Can you describe area and population that your GPRISS site serves? (*Prompt: opportunity to understand the local area, its population and healthcare challenges faced*)
- What is the current state, context or evolution of general practice in your locality? (*Prompt: what challenges around GP retention are you facing?*)

2. Theory of change, planning phase and interventions chosen

- Who are your interventions targeted at and what do they entail?
- What is the rationale for you choosing these interventions? (*Prompt: Opportunity to explore factors underpinning choice of interventions. Reason for specific interventions at different scales – individual/practice/system?*)
- What else is going on which is similar in your locality? (*Prompt: Opportunity to compare and contrast other similar things with GPRISS funded interventions*)
- How have your GPRISS plans progressed over time/during set up?

3. Implementation

- What progress has been made with the implementation of your chosen interventions, thus far? (*Prompt: opportunity to outline early achievements / successes*)
- What factors have enabled or acted as a barriers to the implementation/progress with these interventions? (*Prompt: identify influencing factors*)

4. Closing remarks

- Anything further which the interview has not covered?
- Any questions or concerns?

D2: Focus group discussion guide

1. GPRISS sites

- **To GPRISS implementation team member:** [XXXX] could you please give a brief summary of your site and range of interventions.
- **Open to group** – What has GPRISS meant for general practice in your locality? (*Prompt: what changes, if any, have they witnessed/observed in primary care? Mood/atmosphere*)

2. GPRISS interventions

- What feedback have you had from GPs or other members of the primary care workforce about the effectiveness of the interventions and the impact on job satisfaction (*Prompt: Invite feedback from the group*)
- **To GPs** – what is your perception of the impact of GPRISS on you and your colleagues?
- Which interventions do you think have worked best, and for which GP groups? (*Prompt: Most effective intervention?*)
- Is there anything missing? Are there any important areas or issues that GPRISS does not address?

3. NHSE/GPRISS Approach – The Hot House

- What has been the impact or effect of doing initiatives across three levels (individual/practice/system) on GP retention? (*Prompt: multi-level approach - individual/practice/system*)
- What do you think have been the strengths and weaknesses of combining interventions at 3 different levels?
- To what extent has this approach been effective and produced a combined or collective impact?

4. Implementation, Outcomes & Impact

- Reflecting on your initial expectations, do you think your GPRISS site has achieved its goals?
- What factors do you think have helped you to or hindered you from achieving your goals? (*Prompts: challenges faced & solutions, explore where things have not quite stuck or worked, why has this happened?*)
- What have been your local success factors and what does good look like (in terms of infrastructure, relationships and engagement)?
- Overall, what lessons have you learned during implementation of your GPRISS project? (*Alternative wording: what are the key lessons from your GPRISS project?*)
- On a larger scale, how can these lessons be applied to other retention projects across the UK?

5. Relationships, partnerships and engagement

- What relationships and partnerships have been developed during implementation of the GPRISS project? (*Prompt: Individual connections, practice relationships or inter-organisational partnerships: [e.g. Feds, Networks, LMCs, between practices, etc.]*)
- In your opinion, what has the role of the national team (NHSE) been? And have there been any particular challenges or benefits working with them? (*Prompts: Have they been helpful in pushing things through, making things happen or posed challenges?*)

6. Survey results

- From the online survey, we sent out to clinicians/healthcare professionals in your area, there were the following themes – X, Y & Z.
- (*Prompt: I would like to open these themes up to group as points to discuss/seek clarification on, look to bring the data to life...*)

7. Future plans

- Based on your experience being involved with GPRISS, what would you recommend should be done to ensure that GPRISS and other GP retention initiatives are sustainable in the future? (*Prompt: Opportunity to identify the actions that should be done everywhere; the must do's*)
- What do you think the future impacts of the GPRISS project will be? (*Prompts: On different aspects...e.g. GP retention, atmosphere in general practice, GP wellbeing etc.*)

8. Closing remarks

- Anything further which our discussion today has not covered?
- Any questions or concerns?
Prompt: If questions or concerns are not for this forum, focus group members are invited to contact evaluation team separately (contact details on information sheet given to all participants)