British Medical Association
Survey of GPs in England
Full Report
October – November 2016
A report by ICM on behalf of the BMA
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Report prepared by:
Laura Byrne (laura.byrne@icmunlimited.com)
Jennifer Bottomley (jennifer.bottomley@icmunlimited.com)
Alex Turk (alex.turk@icmunlimited.com)
Tel: 020 7845 8300
Address: ICM Unlimited, 4th Floor, Creston House, 10 Great Pulteney St, London, W1F 9NB
Web: www.icmresearch.com

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1. Introduction

This report presents findings from the BMA’s survey of GPs in England 2016.

This 2016 survey was much more focused than in previous years. Only GPs in England were asked to complete the survey, with four main areas for coverage:

- Workload
- Workforce
- Practice Finance
- Working at Scale

The BMA commissioned ICM Unlimited to:

- Host and administer the online questionnaire;
- Report and analyse the results.

1.1 Methodology

- The data presented in this report is based on 5,025 responses to an online survey. A profile of respondents is provided in the report appendix;
- The questionnaire was designed by the BMA, with input from ICM Unlimited;
- The BMA was responsible for contacting respondents to answer the survey;
- ICM Unlimited hosted and scripted the survey, collected data, reported and analysed results;
- Fieldwork ran from 13th October to 6th November 2016.

1.2 Interpreting the data

- We have included any ‘don’t know’ or ‘not stated’ responses in the calculation of percentages in this report.
- All figures in this report are based on unweighted data.
2. Executive Summary

Overall themes

Two themes emerged throughout the survey, and deserve to be considered as general trends rather than just on an issue-by-issue basis.

GPs’ workload has a strong relationship with views and experiences of general practice today. Across a range of questions, GPs describing their workload as excessive (84%) exhibited distinct views from the one in ten GPs (10%) who said their workload is manageable and allows quality and safe care. This was especially pronounced amongst GPs describing their workload as excessive and significantly preventing quality and safe care (27%). The relationship between workload and GPs’ responses is notably strong on the role of hubs, impact of workload on professional development, partners’ perceptions of their role, the ability of a practice to fill GP vacancies, and reasons for hiring locums.

The other consistent theme throughout these results is the distinctive views of GPs working in different roles. It is perhaps not surprising that GPs undertaking different roles with associated distinct experiences, responsibilities, and priorities, are likely to support different options and views to one another. Nevertheless, these results taken as a whole serve as a reminder that GPs are not an entirely homogenous group, with partners especially giving distinctive responses.

Alongside the importance of different roles, some differences emerged by other demographics. These included:

- Older GPs generally give more positive responses – including in terms of their workload being manageable and allowing them opportunity for professional development.

- Gender differences emerge on a handful of questions. Women are more likely than men to describe their workload as excessive and significantly impacting on care. The perceived barriers to becoming a partner are also relevant to gender, with women more likely to cite ‘a workload without limits to demand’ or ‘the onerous responsibilities of running a practice’ as key barriers.

- There is evidence of regional variation in the experiences of GPs across the country. Whilst it is difficult to generalise trends specific to individual regions, the significant differences between regions on issues of workload indicates the diverse range of experiences and challenges facing GPs across the country, and the desire for different measures to address these different issues.
Workload

- Overall, a majority of GPs in England believe that their workload impacts on the safety and quality of care that their patients receive. Only one in ten GPs (10%) describe their workload as manageable and allowing safe and quality care. By contrast, the majority (57%) describe their workload as unmanageable and at times impacting quality and safe care, with over a quarter (27%) reporting that workload is excessive and significantly prevents quality and safe care.

- In order to safely manage practice workload, the most popular consideration is to consider withdrawal of wider non-contractual services that GPs voluntarily provide (61%). Other measures that would be considered include restricting clinical work to contractual services and increasing use of external referrals for non-core services (41%), and withdrawal from local CCG meetings and activities (35%).

- Increased patient self-care/management to reduce demand (23%) is considered to be the single most effective measure to reduce practice workload, followed by increased provision of enhanced community nurses to manage vulnerable housebound patients (15%).

- A majority of GPs agree that locality hubs should provide support for local practices. Specifically, over three in four GPs agree that there should be systems to ensure practices use hubs equitably (78%) and there should be a limit to GP workload with the option for overflow work to be seen in a locality hub (77%). Around two-thirds agree that hubs should be used to provide extended access for evenings and weekends on behalf of practices (70%).

- Overall, a majority of GPs believe that their workload impacts negatively on their professional development, with nearly four in five GPs (78%) disagreeing with the statement that their workload allows them adequate time to keep up to date with continuing professional development.

Workforce

- Three quarters of GP partners (75%) believe that the current roles and responsibilities of being a partner are too onerous, while one in five (19%) partners say they are content with the current role and responsibilities of being a partner. However, non-partners are most likely to be put off becoming a partner because of the workload without limits to demand (75%).

- The most popular reason for working as a locum GP is control over one’s own workload, given by more than three in four locums (76%).

- A majority of salaried GPs give working in one setting / providing continuity of care (54%) and partnership as being too onerous/lacking reward (52%) as reasons for working in their role.
• Looking forward to their work over the next five years, it would appear that most GPs would like to stay in their current broad role type. Whilst almost half of GPs (47%) wish to work as a partner within the current independent contractor model under GMS/PMS in the next five years, this is being driven by the 3 in 5 Partners (60%) who selected this option compared to only 8% of locums. Other popular options include working as a partner within an at scale GP organisation (32%) or as a portfolio GP (30%).

• When it comes to recruiting for GP vacancies (excluding locum cover), three in ten GP partners (31%) have been unable to fill vacancies in the last 12 months. However, almost a quarter (23%) of partners report being able to fill vacancies within a reasonable timeframe.

• When it comes to hiring locum cover, partners are most likely to hire locums to cover infrequent sessions due to short term staff sickness, absence, and leave (39%). Other oft-cited reasons include covering long term employment vacancies (31%) and continuing to provide a full complement of services (30%).

• A clear majority of GPs – nearly four in five (79%) – believe that there should be financial incentives to encourage GPs to work as partners or salaried GPs within practices rather than work as locums. Half of GPs (50%) believe this should be the case if the incentives come from new money, whereas over a quarter (28%) support it as a principle.

Practice Finance

• When asked to specify how any new funding should be invested in general practice, the most popular priorities for any new resources are to support practices, such as increased community nursing support integrated with the practice (46%) and for skill mix (44%).

• More than two in five GPs (42%) would support charging non-UK patients for GP services if fees were set nationally with income paid to the NHS and practices paid for patient registration and administration costs, while more than a third of GPs (35%) believe practices should be allowed to treat such patients privately, set the fees, and retain the income. One in ten (10%) would oppose charging non-UK patients on principle.

• A large majority of GPs (87%) think the Avoiding Unplanned Admission enhanced service should be ended, with almost two thirds of GPs (65%) saying the funding should be added to global sum to support the practice’s care of elderly/vulnerable patients. Just under one quarter (22%) agree that it should be ended, but would prefer that the funding be used locally within the CCG, specifically to improve care for the most vulnerable patients in the practice.

• Whilst eight in ten GPs (81%) think that changes should be made to the formula for calculating global sum allocations, there are a range of views on how it should be changed. Almost half of GPs (47%) feel the new formula should be implemented over
five years through differential uplifts, ensuring no practice loses in cash terms, while over a quarter (27%) believe the new formula should be implemented in a phased way over a number of years to reduce the impact on those who gain and those who lose.

- Indemnity is the area in which most GPs (77%) think costs will increase most significantly over the next 12 months, followed by CQC fees (56%) and locum pay (47%).

**Working at Scale**

- When asked about their preferred models of general practice which should be developed for the future, just under half (47%) believe that the current independent contractor model should be the prime model of general practices and should be supported and invested in, while half of GPs (50%) think the current independent contractor model should be supported and given resources for practices to collaborate in the form of GP federations / networks.

- A range of possible advantages were given for working in a collaborative GP alliance – that it could reduce the bureaucracy of managing a practice was most popular (39%), followed by reducing practice workload (37%), providing a sustainable way of coping with extended access (34%) and greater security and sustainability of practices within a larger organisation (32%).
3. Overall Results

3.1 Workload

Impact of workload on safety and quality of care

Overall, a majority of GPs in England believe that their workload impacts on the safety and quality of care that their patients receive.

Specifically, only one in ten GPs (10%) believe that their workload is manageable and allows them to provide quality and safe care to their patients. This figure is overall highest amongst Trainees (43%) and Locums (34%), and lowest amongst Partners (6%). Older GPs are also more likely to agree with the statement, applying to nearly 1 in 4 (24%) of GPs aged 60+.

The majority (57%) of GPs think that their workload is excessive and at times prevents them from providing quality and safe care to their patients. This is especially the case amongst Salaried (67%) and Partner (59%) GPs, and those aged 30-39 (63%) and 40-49 (62%).

Over a quarter (27%) of GPs selected the most severe statement, that their workload is excessive and significantly prevents them from providing quality and safe care to their patients. GP Partners (31%) were the role type most likely to select this statement. There were also regional and gender divides, with a third (33%) of male GPs agreeing with the statement compared to 20% of females, and those working in the East of England (31%) or East Midlands (31%) significantly more likely to select this response compared to those in the South West (23%) or North East (23%).

Figure 3.1.1

Q1. Which of these best describes the impact of your current workload on the safety and quality of care that your patients receive?  
Base: All participants (n=5025)
Actions considered to safely manage practice workload

When asked to select which actions they would consider in order to safely manage practice workload, three in five (61%) of GPs say they would consider **withdrawal of wider non-contractual services** that GPs voluntarily provide, with two in five (41%) **restricting clinical work** to contractual services and increasing use of external referrals for non-core services. GP Partners are the most likely to consider both options, with two-thirds (67%) considering the withdrawal of non-contractual services and 45% increasing use of external referrals for these non-contractual services. This latter option is most likely to be considered by GPs in the Midlands, with over half of East (52%) and West Midlands (51%) GPs saying they would consider increasing use of external referral for non-contractual services.

Other measures that would be considered by GPs include withdrawal from local CCG meetings and activities (35%), working at scale (34%), withdrawal from enhanced services (34%), temporary suspension of new patient registrations (34%), and application to reduce practice boundary (26%). Just six per cent believe they don’t need to take further measures to manage workload.

Around 1 in 4 GPs (24%) responding to the survey took the option to give a response not already stated in the answer options available. These ‘open’ responses have been thematically coded. The range of responses in answer to this question demonstrates the wide variety of measures that GPs are currently considering in order to safely manage practice workload. Of the options not already listed in the question (and displayed in figure 3.1.2 above), recruiting more staff was the most popular measure, mentioned unprompted by 3% of GPs. This was followed in popularity by stopping the transfer of hospital work into primary care (2%). One in fifty GPs (2%) said they were considering retirement, or early retirement, in order to safely measure practice workload. This was mentioned by GPs of different ages, although was highest amongst those aged 50-59 (4%) and over 60 (5%).

There are further regional differences in the interventions that GPs would consider. For instance, those in the South East are generally more likely to consider temporary suspension of new patient registrations (42%) or an application to reduce practice boundary and remove...
patients from the list (30%), whilst those in the South West are most likely to consider withdrawal from the quality and outcomes framework (28%).

**Effectiveness of measures in reducing practice workload**

When prompted with a list of possible measures to reduce workload, GPs express a broad range of preferences in terms of which would be most effective. The most popular measure is the **increased provision of enhanced community nurses** to manage vulnerable housebound patients, selected by 64% of GPs. Other popular measures include increased **patient self-care/management** (59%) and increased provision for **practice support mental health workers** (53%). However, only 5% said increased use of technology – including Skype consultations, remote electronic consultations, or remote access to the practice clinical system – would be one of the most effective options in reducing practice workload.

**Figure 3.1.3:**

Around one in six GPs (17%) opted to specify a most effective measure not already included in the list presented. Many of these responses emphasised the need to hire more (qualified) GPs. Other themes included increased funding, more nurses, and a reduction in bureaucracy.

As shown in table 1 below, some strong regional differences are apparent in responses to this question, indicative of differing priorities for workload management across the country. Three in five (59%) GPs in the South West thought increased provision for practice support mental health workers would be one of the most effective measures, compared to less than half in London and the South East (both 47%). Around half of GPs in the North East (52%) and Yorkshire and the Humber (48%) say the increased use of trained practice pharmacists would be one of the most effective measures to take, compared to less than a third in the East of England (28%), West Midlands (30%) and East Midlands (31%).
Table 1:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Total</th>
<th>South East</th>
<th>London</th>
<th>North West</th>
<th>East of England</th>
<th>West Midlands</th>
<th>South West</th>
<th>Yorkshire &amp; Humber</th>
<th>East Midlands</th>
<th>North East</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased provision of enhanced community nurses to manage vulnerable housebound patients</td>
<td>64%</td>
<td>67%</td>
<td>63%</td>
<td>64%</td>
<td>62%</td>
<td>64%</td>
<td>63%</td>
<td>61%</td>
<td>64%</td>
<td>69%</td>
</tr>
<tr>
<td>Increased patient selfcare/management to reduce demand</td>
<td>59%</td>
<td>60%</td>
<td>60%</td>
<td>61%</td>
<td>57%</td>
<td>58%</td>
<td>56%</td>
<td>57%</td>
<td>59%</td>
<td>64%</td>
</tr>
<tr>
<td>Increased provision for practice support mental health workers</td>
<td>53%</td>
<td>47%</td>
<td>47%</td>
<td>53%</td>
<td>50%</td>
<td>52%</td>
<td>59%</td>
<td>58%</td>
<td>58%</td>
<td>50%</td>
</tr>
<tr>
<td>Increased use of administrative staff to reduce GP administration (e.g. document workflow)</td>
<td>47%</td>
<td>49%</td>
<td>55%</td>
<td>44%</td>
<td>46%</td>
<td>49%</td>
<td>43%</td>
<td>46%</td>
<td>48%</td>
<td>47%</td>
</tr>
<tr>
<td>Increased signposting/ direct access to extended scope practitioners (e.g. physiotherapists)</td>
<td>43%</td>
<td>43%</td>
<td>39%</td>
<td>44%</td>
<td>41%</td>
<td>44%</td>
<td>43%</td>
<td>50%</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>Increased provision and use of nurse practitioners</td>
<td>40%</td>
<td>40%</td>
<td>34%</td>
<td>41%</td>
<td>44%</td>
<td>37%</td>
<td>43%</td>
<td>41%</td>
<td>47%</td>
<td>37%</td>
</tr>
<tr>
<td>Increased use of trained practice pharmacists</td>
<td>36%</td>
<td>33%</td>
<td>35%</td>
<td>40%</td>
<td>28%</td>
<td>30%</td>
<td>33%</td>
<td>48%</td>
<td>31%</td>
<td>52%</td>
</tr>
<tr>
<td>Increased use of community pharmacists to manage minor ailments and/or certain categories of patients</td>
<td>25%</td>
<td>22%</td>
<td>31%</td>
<td>29%</td>
<td>25%</td>
<td>26%</td>
<td>24%</td>
<td>24%</td>
<td>23%</td>
<td>28%</td>
</tr>
<tr>
<td>Increased use of telephone triage systems to ensure appropriate use of GP appointments</td>
<td>18%</td>
<td>19%</td>
<td>19%</td>
<td>17%</td>
<td>19%</td>
<td>20%</td>
<td>16%</td>
<td>16%</td>
<td>18%</td>
<td>19%</td>
</tr>
<tr>
<td>Increased use of physician assistants</td>
<td>12%</td>
<td>13%</td>
<td>14%</td>
<td>10%</td>
<td>12%</td>
<td>13%</td>
<td>13%</td>
<td>8%</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>Increased use of online resources for patients booking appointments with guided management (e.g. Askmy GP, WebGP)</td>
<td>7%</td>
<td>9%</td>
<td>10%</td>
<td>5%</td>
<td>7%</td>
<td>8%</td>
<td>5%</td>
<td>7%</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Increased use of technology e.g. Skype consultations, remote electronic consultations with patients, remote access to practice clinical system</td>
<td>5%</td>
<td>4%</td>
<td>6%</td>
<td>5%</td>
<td>5%</td>
<td>6%</td>
<td>4%</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>17%</td>
<td>18%</td>
<td>15%</td>
<td>15%</td>
<td>20%</td>
<td>20%</td>
<td>19%</td>
<td>15%</td>
<td>19%</td>
<td>15%</td>
</tr>
</tbody>
</table>
Differences in terms of primary role are also present. Compared to other roles, partners and salaried GPs are significantly more likely to consider increased provision of enhanced community nurses (66% and 64% respectively) and increased patient self-care/management (59% and 64% respectively) to be effective in reducing practice workload.

When asked to prioritise just one of the possible measures to reduce workload, a more nuanced view of desired changes emerged. **Increased patient self-care/management** to reduce demand is the clear preferred single measure to reduce workload, supported by almost a quarter (23%) of GPs. The second most preferred single measure is **increased provision of enhanced community nurses** to manage vulnerable housebound patients (15%). Other popular measures include increased use of administrative staff to reduce GP administration (10%), increased provision and use of nurse practitioners (10%), and increased provision for practice support mental health workers (9%), each of which attracts support from around one in ten GPs.

**Figure 3.1.4:**

Comparing the two sets of results in this section demonstrates that most GPs see a whole package of measures as being desirable to help reduce their workload. Whilst some possible measures are strongly supported even in isolation (e.g. increased patient self-care), there is clear support for a broad range of measures to address this issue.

**Views on hubs**

The GP forward view published by NHS England has committed to developing locality hubs throughout the country in order to provide additional clinical capacity, sustainable support for GPs within practices to work safely, as well as a range of other useful functions. In this survey, GPs were asked about their specific views on locality hubs and their role in supporting individual practices.

Overall, a majority of GPs agree that hubs should provide support for local practices. Specifically, over three in four GPs agree that there should be systems to **ensure practices use hubs equitably** (78%) and there should be a limit to GP workload with the option for
overflow work to be seen in a locality hub (77%). Around two-thirds agree that hubs should be used to provide extended access for evenings and weekends on behalf of practices (70%), practices should be required to provide a number and type of appointments and if they reach a defined capacity can then refer additional patients to the hub (67%). A similar proportion think hubs should offer wider service provision across a range of healthcare professionals (66%), and that hubs should be managed by local practices/network and use local or employed GPs (64%).

Whilst more GPs agreed than disagreed with any one of the statements presented, some proved to be more polarised, attracting a sizable proportion of GPs who disagreed with the statement. The most contentious view is that hubs should provide telephone triage for urgent appointments on behalf of local GP practice; around one third (35%) of GPs disagree. Three in ten GPs (29%) disagree with the view that the management of hubs should be independently procured.

Figure 3.1.5:

Furthermore, it would appear that GPs’ opinion on the role of hubs is in part related to their view of their own workload and its impact on the quality and safety of care. Those who describe their workload as excessive and significantly impacting on care are more likely to agree with a range of measures than those who feel their workload does not impact significantly on care. For instance, they are significantly more likely to agree that:

- There should be a limit to GP workload with the option for overflow work to be seen in a locality hub (83%);
- Practices should be required to provide a number and type of appointments and if they reach a defined capacity can then refer additional patients to the hub (73%);
- Hubs should be responsible for appropriate in-hours urgent home visits on behalf of practices (69%).

**Impact of workload on professional development**

Overall, a majority of GPs believe that their workload impacts negatively on their professional development. Nearly four in five GPs (78%) disagree with the view that their
workload allows them adequate time to keep up to date with continuing professional development, with half (50%) disagreeing strongly with the statement. Those who described their workload as excessive and significantly impacting on care were most likely to disagree with the statement (93%), whilst GP partners were significantly more likely to disagree (82%) than all other primary role types.

Only a minority (14%) agreed that their workload allow them adequate time to keep up to date with continuing professional development. The most likely groups to agree with this statement were those aged 60+ (27% agreeing) and those describing their workload as manageable (57% agreeing).

**Figure 3.1.6:**

My workload allows me adequate time to keep up to date with continuing professional development…

3.2 Workforce

In this section of the survey, GPs were asked about their perceptions of their current role and their reasons for working in this role.

**GP partners’ perception of role**

Three in four GP partners (75%) believe that the current roles and responsibilities of being a partner are in some way too onerous. Two in five (41%) believe that the current roles and responsibilities are excessively onerous, 34% think that the roles and responsibilities are too onerous such that they wish to explore alternative working options. About one in five (19%) partners say they are content with the current role and responsibilities of being a partner.

There is a strong correlation between a partner’s perception of their workload and their overall view of the roles and responsibilities of being a partner. Those who describe their workload as manageable were most likely to be content with the role and responsibilities (65%), whilst those describing their workload as excessive and significantly impacting care
were most likely to think of the role and responsibilities as onerous to the extent that they wish to explore alternative working options (48%).

Figure 3.2.1:

- I believe that the current roles and responsibilities of being a partner are excessively onerous: 41%
- I believe that the current roles and responsibilities of being a partner are too onerous such that I wish to explore alternative working options: 34%
- I am content with the current role and responsibilities of being a partner: 19%
- None of these describe my view: 5%

Q6. Which of the following best describes how you feel about being a partner?  
Base: All GP partners respondents (n=3,567)

Reasons for working as a locum GP

Three in four locum GPs (76%) say that having control over their own workload explains why they work as a locum. Around half cite partnership being too onerous/lacking rewards (53%), locum work suiting their work pattern (49%) and that it gives them more autonomy (48%) as explanations for their career choice. Forty-six percent describe being a locum as a positive career choice, whilst 36% say that they work as a locum because being a salaried GP is too onerous/lacking rewards. Few describe it in the negative terms available – because they couldn’t get a job as a partner (2%) or as a salaried GP (1%).

Figure 3.2.2:

- Control over my own workload: 75%
- Because partnership is too onerous/lacking rewards: 53%
- To suit my work pattern: 49%
- More autonomy: 48%
- A positive career choice: 48%
- Because salaried GP is too onerous/lacking rewards: 36%
- Because I cannot get a job as a partner: 2%
- Because I cannot get a job as a salaried GP: 1%
- None of these apply: 7%

Q7. Which of the following best describe why you work as a GP locum?  
Base: All locum GP respondents (n=382)
Reasons for working as a salaried GP

To explain why they work in their roles, over half of salaried GPs give working in one setting/providing continuity of care (54%) and partnership being too onerous/lacking rewards (52%) as reasons. Approximately two in five explain their role choice in terms of limiting their workload (43%), suiting their work pattern (42%), and providing them with job security (41%). Three in ten describe being a salaried GP as a positive career choice (30%), with only three percent saying it was because they cannot get a job as a partner.

Figure 3.2.3:

Reasons for not working as a partner

All GPs who were not contractors, principals, or partners were asked what puts them off becoming a partner. The most popular response was a workload without limits to demand, with three quarters of responses (75%). Other commonly mentioned reasons include three in five non-partners citing excessive and onerous operational responsibilities of running the practice (62%) and excessive regulatory responsibilities (60%). Fifty-five percent cited the insecurity of practice finances, and half (50%) said excessive and onerous human resource responsibilities put them off becoming a partner. Less than a third (31%) said premises ownership was a barrier to becoming a partner.

There were distinct differences between genders on the barriers to becoming a partner, with female non-partners significantly more likely to cite workload without limits to demand (78%, compared to 70% among men) and the excessive and onerous operational responsibilities of running the practice (65% vs 57%) as reasons.
Looking forward: working in the next five years

When asked to prioritise how they would like to work in the next five years, almost half (47%) of GPs wish to work as a partner within the current independent contractor model under GMS/PMS. Also coming through strongly is the desire to work as a partner within an at scale GP organisation (32%) or as a portfolio GP (30%).

Other commonly desired working arrangements include working as a self-employed freelance locum (22%), as an employed GP in a MCP arrangement if offered adequate terms (19%), as a salaried GP in a single practice (17%) or as a GP with a lead management role (17%). A further 13% wish to work in a practice having a local contract, whilst around one in ten wish to work as an employed GP by a hospital trust if offered adequate terms (11%) or as a self-employed GP in a locum chambers (9%). Of the 16% of GPs who specified a response not already included in the list of options, nearly all mentioned no longer being a GP in the NHS. Many others mentioned retirement, emigration, becoming a private GP or a complete career change.
The strength of preference for working as a partner within the current independent contractor model under GMS/PMS is apparent when GPs are asked to express just one wish for their work in the next five years, with 35% choosing this option. This was almost three times the number of GPs who selected the next most popular option; to work as a portfolio GP (12%). Just over one in nine GPs (11%) prioritise the wish to work as a partner within an at scale GP organisation. The remaining option all attracted the support of less than one in ten GPs, as shown in figure 3.2.6 below.

Figure 3.2.6:

Looking at the breakdown by primary role, it is clear that there is a tendency for GPs to want to remain in a similar role. In the next five years, partners are most likely to wish to continue to work as a partners within the current independent contractor model (46%) or as a partner within an at scale GP organisation (15%). Salaried GPs are most likely to wish to work as a salaried GP in a single practice (34%), whilst locums are most likely to wish to work as a self-employed freelance locum (36%).

**GP partners: recruiting GP vacancies**

When it comes to recruiting for GP vacancies (excluding locum cover), three in ten GP partners (31%) have been unable to fill vacancies in the last 12 months. At the other end of the scale, almost a quarter (23%) of partners report being able to fill vacancies within a reasonable timeframe. Twenty-seven percent of partners selected an interim option – that they were able to eventually fill vacancies but this took up to three months (9%) or between three and six months (18%). Thirteen percent say they have had no need to recruit to fill a vacancy.
The ease of recruitment varies by region, with three in ten (30%) partners in London and the South West having been able to fill vacancies within a reasonable timeframe, compared to only thirteen percent in the East Midlands. The lowest need for recruitment was in the North East, where one in five (20%) said that their practice had not had the need to recruit for a vacancy.

There also appears to be a strong relationship between GPs’ workload and the ability of their practice to fill vacancies. Forty-four percent of partners describing their workload as excessive and significantly impacting on care report being unable to fill vacancies, compared to only fourteen percent of this group who say their practice has been able to fill vacancies within a reasonable timeframe.

GP partners: reasons for hiring locums

When it comes to hiring locum cover, the most frequently cited reason that partners give for hiring locums is to cover infrequent sessions due to short term staff sickness, absence,
and leave (39%). Other oft-cited reasons include covering long term employment vacancies (31%) and continuing to provide a full complement of services (30%). More than a quarter of GPs said they used locums to cover short term vacancies (27%) or maternity/paternity absence (26%), with fewer than one in five recruiting locums to provide cover to enable them to take on other roles (19%), or to cover long term staff sickness or absence (17%). Of the 7% of partners who specified an ‘other’ reason for hiring locums, providing cover for holidays, sabbatical and maternity leave were frequently cited motivations. 8% do not use locums.

Partners who describe their workload as excessive and significantly impacting on care were significantly more likely than others to use locums to cover long term employment vacancies (40%), continue providing a full complement of services (37%), or cover long term staff sickness absence (22%).

Figure 3.2.9:

Financial incentives for locums to work as partners or salaried GPs

A clear majority of GPs –four in five (79%) – believe that there should be financial incentives to encourage GPs to work as partners or salaried GPs within practices rather than work as locums. Half of GPs (50%) believe this should be the case if the incentives come from new money, whereas over a quarter (28%) support it as a principle. Only 12% of GPs think there shouldn’t be such incentives offered to locums – 8% of GPs believing so as a principle, with 4% objecting if the incentives are drawn from practice funds.

Locums themselves are the least receptive to the possibility of being offered financial incentives to change their role. Whilst a majority (58%) of locums thought that financial incentives should be offered for them to work as a partner or salaried GP, this was significantly less than all other major role types, with 84% of partners, 74% of trainees and 70% of salaried GPs agreeing with the financial incentives.

GPs who describe their workload as excessive were more likely to support the incentives, with 85% of those saying their workload significantly impacted on care in favour of
incentives, and 79% whose workload impacted on care at times. This compared with only 68% of those GPs describing their workload as manageable who supported the incentives.

Figure 3.2.10:

3.3 Practice Finance

New investment in general practice

When asked to specify how any new funding should be invested in general practice, just under half of GPs (46%) say resources should be provided to support practices, such as increased community nursing support integrated with the practice. This is closely followed by a call for resources to be provided for skill mix (44%).

Just under two in five GPs think resources should be provided to directly reimburse additional staff (38%) and a similar number feel they should be provided into global sum and others to support practices through external resources (36%). Around three in ten (29%) think all resources should be provided into global sum.

Just over one quarter (27%) would like to see resources provided to develop locality hubs to support practices and just under one quarter (24%) think resources should be provided to help practices develop formal collaborative alliances.

Spending priorities show significant variation by role type. Salaried GPs are more likely to think resources should be provided to support practices (53%), for skill mix (49%), or to directly reimburse additional staff (43%) compared to partners. Conversely, partners are more likely than salaried GPs to support resources being provided into global sum – either in their entirety (33%) or in part with others to support practices through external resources (39%).

Those in the North of England are most likely to support resources being provided for skill mix – with the majority of GPs in Yorkshire and the Humber (54%) and the North East (51%), and 49% in the North West, supporting this spending priority.
Charging non-UK patients for general practice services

GPs were asked under what circumstances they would support a government proposal to charge patients from outside the UK for general practice services. This would exclude patients from countries which have a reciprocal relationship with the UK, as is currently the case in much of Europe.

The most popular response, selected by over two in five GPs (42%), is that they would support this proposal if fees were set nationally with income paid to the NHS and practices paid for patient registration and administration costs. This option was especially popular with GPs across the north of England, with just under half in Yorkshire and the Humber (49%), North East (48%) and North West (47%) supporting it.

The second most popular scenario, chosen by more than a third of GPs (35%), is for practices to be allowed to treat such patients privately, set the fees, and retain the income. GPs describing their workload as excessive and significantly impacting on care were the most likely (44%) to support this option.

Fractionally fewer (33%) chose a situation in which acute urgent problems were provided without charge, but all non-urgent or chronic care appointments were charged.

One in ten GPs (10%) say they would not support this proposal at all on the grounds that all patients should receive free primary healthcare, and 4% claim to have a different view altogether.
Avoiding Unplanned Admission enhanced service

A large majority of GPs surveyed (87%) believe that the **Avoiding Unplanned Admission enhanced service should be ended**. Fewer than one in ten (7%) believe it is worthwhile and should be continued.

Almost two thirds (65%) believe the service should be ended and the **funding added to the global sum** to support the practice’s care of elderly/vulnerable patients. Just over one in five (22%) agree that it should be ended, but would prefer that the **funding be used locally within the CCG**, specifically to improve care for the most vulnerable patients in the practice.

There is a stark and significant difference in views on the enhanced service by role type. Partners are by far the most likely to think the service should be ended and the funding added to global sum to support the practice’s care of elderly/vulnerable patients, with almost three quarters (73%) in support. This compares to almost half of salaried GPs (48%), just over two in five (42%) locums, and only 23% of trainees in favour of this option. Trainees were most likely to think the enhanced service is worthwhile and should be continued, with
one in five (20%) supporting the service, compared to fewer than one in ten partners (7%) and salaried GPs (8%).

**Calculating global sum allocations**

GPs were also reminded that NHS England is undertaking a review of the current formula for calculating global sum allocations, seeking a fairer solution. They were then asked how they thought this new formula should be introduced.

Just 3% feel that there should be **no change to the current formula**, but the four in five (81%) who feel changes should be made are divided on how this could best be introduced.

Almost half of GPs (47%) feel the new formula should **be implemented over five years through differential uplifts**, ensuring no practice loses in cash terms. This is especially strongly supported amongst partners – a majority of whom (51%) support this option. This is significantly higher than among other major role types, with about two in five locums (40%) and salaried GPs (38%) in support.

The next most popular option, selected by over a quarter (27%), is for the **new formula to be implemented in a phased way over a number of years** to reduce the impact on those who gain and those who lose.

Fewer than one in ten (7%) feel it would be best for the **new formula to be implemented as one wholesale change**, accepting that there will be some practices who gain and some that lose.

**Figure 3.3.4**

![Bar chart showing the distribution of responses to Q17](image)

Q17. NHS England is engaged in a review of the current formula for a proposed fairer way of calculating global sum allocations. How do you think a new formula should be introduced?

Base: All participants (n=5,025)

**Expected areas of increased expenditure**

More than three quarters of GPs (77%) think **indemnity** is likely to be the area of expense which will increase most significantly (in percentage terms) over the next 12 months. This was by far the most frequently chosen area of expenditure with the second most likely area – **CQC fees** – chosen by over half (56%).

Confidential. All work in accordance with ISO 27001 and 20252
**Locum pay** is also expected to increase significantly by just under half of GPs (47%). This is followed by **pension contributions** (both employer and employee), mentioned by over one third (35%), and **staff recruitment costs** (including locum recruitment), selected by 30% of GPs.

Several other areas were thought likely to increase in costs by around one quarter of GPs: salaried GP pay (27%), non-clinical staff pay (27%), other clinical staff pay (25%), non-reimbursable premises and infrastructure costs (24%) and legal and professional fees (23%).

Areas considered less likely to increase in expense over the next 12 months include utilities costs (13%), National Insurance contributions (10%), accountancy (8%), and staff training (8%). Fewer than one in twenty consider imminent rise in expenses relating to postage and stationery, travel costs, and dispensing staff pay (all 3%).

Just 1% of GPs say they do not expect any areas of expense to increase over the next 12 months.

The expected areas of increased expenditure vary by role type, potentially indicative of the increased exposure and awareness of GPs in different roles types to different costs. Partners are significantly more likely than salaried, locum, or trainee GPs to include CQC fees (64%), salaried GP pay (33%), other clinical staff pay (29%) or non-clinical staff pay (34%) as one of the areas of expense to increase the most in percentage terms. Salaried GPs are more likely than partners to anticipate indemnity (80%), staff recruitment (including locum recruitment costs) (37%) or legal and professional fees (33%) to be a key area of cost increase.

**Figure 3.3.5**

Q18. Thinking about the next 12 months, which areas of expense do you expect to increase the most (in percentage terms)?

Base: All participants (n=5,025)
3.4 Working at Scale

Preferred models of general practice

When asked about their preferred models of general practice which should be developed for the future, around half of GPs express their support for the current independent contractor model. Specifically, just under half (47%) believe that the current independent contractor model should be the prime model of general practices and should be supported and invested in.

However, there is also support for collaboration among individual practices, with half of GPs (50%) agreeing that the current independent contractor model should be supported, but resources should be allocated for practices to collaborate in the form of GP federations or networks.

Support for the current model is significantly higher among Partners compared to other GPs: 53% believe the current independent contractor model should be the prime model, while the same proportion believe that the current model should be supported, with resources allocated for practices to collaborate.

By contrast, a minority of GPs (17%) feel that the current independent contractor model of individual practices is too onerous and vulnerable, and that alternatives should be explored.

In terms of alternative models of general practice, a sizeable proportion of GPs feel that there should be alliances between individual practices. Around one in three (32%) believe that practices should form collaborative alliances with multi-professional healthcare staff to manage increasing care out of hospital. Similarly, over a quarter of GPs (27%) believe that current independent contractor practices should join to form legal alliances, such as a super partnership with sharing of clinical, management, HR and regulatory responsibilities.

Q19a. What models of general practice would you like to see developed for the future?
Base: All participants (n=5025)

GPs were then asked about their single preferred model of general practice which should be developed in future.
Overall, a majority of GPs continue to support the current independent contractor model. Specifically, one in three (33%) believe it should be the **prime model of general practice and should be supported and invested in**, while a further quarter (27%) believe the current model should be supported, with **additional resources provided for practices to collaborate** in the form of GP federations or networks.

Again, support for the current model is significantly higher among Partners: 38% state that the current independent contractor model should be the prime model for development in future.

By contrast, one in ten GPs (10%) believe that the **current model is too onerous and vulnerable**, and that alternative arrangements should be supported.

In terms of alternative models, around one in seven (14%) express support for a model of **collaborative alliances with multi-professional healthcare staff**, while one in nine (11%) support a model of current independent contractor practices **joining to form legal alliances**.

There are also some regional differences in terms of preferred models for development. GPs based in the North East are most likely to prefer the current model, with additional resources for collaboration between practices (37%), while GPs based in the North West are most likely to express support for a model of collaborative alliances with multi-professional healthcare staff (18%). GPs in the West Midlands (15%) are most likely to express support for current independent contractor practices joining to form legal alliances.

**Figure 3.4.2**

<table>
<thead>
<tr>
<th>Model of General Practice</th>
<th>Support Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current independent contractor model of individual practices should be the prime model of general practices and should be supported and invested in</td>
<td>33%</td>
</tr>
<tr>
<td>Current independent contractor model should be supported and given resources for practices to collaborate in the form of GP federations / networks</td>
<td>27%</td>
</tr>
<tr>
<td>Practices should form collaborative alliances with multi-professional healthcare staff to manage increasing care out of hospital such as MCPs</td>
<td>14%</td>
</tr>
<tr>
<td>Current independent contractor practices should join to form legal alliances, such as a super partnership with sharing of clinical, management, HR and regulatory responsibilities</td>
<td>11%</td>
</tr>
<tr>
<td>The current independent contractor model of individual practices is too onerous and vulnerable, and alternative arrangements should be supported</td>
<td>10%</td>
</tr>
<tr>
<td>None of the above</td>
<td>4%</td>
</tr>
</tbody>
</table>

Q19b. And which one model of general practice would you most like to see developed for the future?
Base: All participants (n=5025)

**Advantages of working in a collaborative GP alliance**

When asked about the advantages of working in a collaborative GP alliance, GPs highlight a range of potential benefits, including the sharing of management, clinical and regulatory responsibilities.
For instance, two in five (39%) believe that collaborative alliances could **reduce the bureaucracy of managing a practice**, through sharing of management and administrative functions. Similarly, 37% believe alliances could help **reduce practice workload**, e.g. by providing locality hubs for overflow work, and sharing of clinical staff and services.

Around one in three believe that collaborative alliances provide a **sustainable way of coping with extended access** (34%) and **greater security and sustainability of practices** within a larger organisation (32%), while a quarter believe they provide **greater opportunities for integrated working** with multi-professional community staff (26%) and a reduced burden on individual practices for **preparing and complying with regulatory obligations** (25%).

**Figure 3.4.3**

Other perceived advantages of working in a collaborative GP alliance include: creation of locality services and diagnostic services for practices (20%), potential to share in joint education and continuing professional learning (19%), and a way of absorbing and providing “out of hospital” care with movement of secondary care services into the community (17%).

Just one in nine (11%) do not believe that there are any advantages to working in a collaborative GP alliance.
### 4.1 Sample profile

<table>
<thead>
<tr>
<th>Current status</th>
<th>No. of respondents</th>
<th>% of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP contractor or principal or partner</td>
<td>3567</td>
<td>71%</td>
</tr>
<tr>
<td>Practice-employed salaried GP</td>
<td>789</td>
<td>16%</td>
</tr>
<tr>
<td>Freelance GP (locum)</td>
<td>382</td>
<td>8%</td>
</tr>
<tr>
<td>GP trainee</td>
<td>92</td>
<td>2%</td>
</tr>
<tr>
<td>NHS organisation-employed salaried GP</td>
<td>48</td>
<td>1%</td>
</tr>
<tr>
<td>Retired</td>
<td>36</td>
<td>1%</td>
</tr>
<tr>
<td>Out-of-hours GP</td>
<td>18</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Private sector-employed salaried GP</td>
<td>16</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Part of the GP retainer scheme</td>
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<td>&lt;1%</td>
</tr>
<tr>
<td>On a career break</td>
<td>13</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Part of the GP flexible careers scheme</td>
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<td>&lt;1%</td>
</tr>
<tr>
<td>Part of a GP returner or induction or refresher</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>scheme</td>
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<td></td>
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<tr>
<td>Prison GP</td>
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</tr>
<tr>
<td>Other</td>
<td>51</td>
<td>1%</td>
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<table>
<thead>
<tr>
<th>Gender</th>
<th>No. of respondents</th>
<th>% of sample</th>
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<tbody>
<tr>
<td>Male</td>
<td>2489</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>2469</td>
<td>49%</td>
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<tr>
<td>Unanswered</td>
<td>63</td>
<td>1%</td>
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<tr>
<th>Age</th>
<th>Number of respondents</th>
<th>% of sample</th>
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</thead>
<tbody>
<tr>
<td>29 and under</td>
<td>315</td>
<td>6%</td>
</tr>
<tr>
<td>30 to 39</td>
<td>883</td>
<td>18%</td>
</tr>
<tr>
<td>40 to 49</td>
<td>1372</td>
<td>27%</td>
</tr>
<tr>
<td>50 to 59</td>
<td>2026</td>
<td>40%</td>
</tr>
<tr>
<td>60+</td>
<td>429</td>
<td>9%</td>
</tr>
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<table>
<thead>
<tr>
<th>Region</th>
<th>Number of respondents</th>
<th>% of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>East of England</td>
<td>508</td>
<td>10%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>388</td>
<td>8%</td>
</tr>
<tr>
<td>London</td>
<td>475</td>
<td>9%</td>
</tr>
<tr>
<td>North East</td>
<td>296</td>
<td>6%</td>
</tr>
<tr>
<td>North West</td>
<td>606</td>
<td>12%</td>
</tr>
<tr>
<td>South East</td>
<td>892</td>
<td>18%</td>
</tr>
<tr>
<td>South West</td>
<td>736</td>
<td>15%</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>568</td>
<td>11%</td>
</tr>
<tr>
<td>Unanswered</td>
<td>24</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>
### 4.2 Guide to statistical reliability

The respondents to the questionnaire are only samples of the total “population”, so we cannot be certain that the figures obtained are exactly those we would have if every single GP in the UK had been interviewed (the “true” values). We can, however, predict the variation between the sample results and the “true” values from knowledge of the size of the samples on which the results are based and the number of times that a particular answer is given. The confidence with which we can make this prediction is usually chosen to be 95% - that is, the chances are 95 in 100 that the “true” value will fall within a specified range. The table below illustrates the predicted ranges for different sample sizes and percentage results at the “95% confidence interval”.

<table>
<thead>
<tr>
<th>Size of sample on which survey result is based</th>
<th>Approximate sampling tolerances applicable to percentages at or near these levels</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Statistical Reliability</td>
</tr>
<tr>
<td></td>
<td>10% / 90%</td>
</tr>
<tr>
<td>100 interviews</td>
<td>5.9</td>
</tr>
<tr>
<td>500 interviews</td>
<td>2.6</td>
</tr>
<tr>
<td>1,000 interviews</td>
<td>1.9</td>
</tr>
<tr>
<td>5,025 interviews</td>
<td>0.8</td>
</tr>
</tbody>
</table>

* For example, with a sample of 5,025 where 30% give a particular answer, the chances are 19 in 20 that the “true” value (which would have been obtained if the whole population had been interviewed) will fall within the range of plus or minus 1.3 percentage points (+/-1.3%) from the sample result.

### Comparing percentages between subgroups and the overall totals

When results are compared between separate groups within a sample, different results may be obtained. The difference may be “real”, or it may occur by chance (because not everyone in the population has been interviewed). To test if the difference is a real one - i.e. if it is “statistically significant”, we again have to know the size of the samples, the percentage giving a certain answer and the degree of confidence chosen. If we assume the “95% confidence interval”, the differences between the two sample results must be greater than the values given in the table below:

<table>
<thead>
<tr>
<th>Size of samples compared</th>
<th>Differences required for significance: percentages at or near these</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statistical Reliability</td>
</tr>
<tr>
<td></td>
<td>10% / 90%</td>
</tr>
<tr>
<td>500 and 500</td>
<td>3.7</td>
</tr>
<tr>
<td>500 and 1,000</td>
<td>3.2</td>
</tr>
<tr>
<td>1,000 and 1,000</td>
<td>2.6</td>
</tr>
<tr>
<td>2,500 and 2,500</td>
<td>1.7</td>
</tr>
</tbody>
</table>
* For example, when comparing a sample of 500 with the population of 1,000 where 30% give a particular answer, the chances are 19 in 20 that the “true” value (which would have been obtained if the whole population had been interviewed) will fall within the range of plus or minus 4.9 percentage points (+/-4.9) from the sample result.