GPs' views on The Future of General Practice – Focus Group Findings

Contents

Health Policy and Economic Research Unit

BMA

Key findings

- The attendees were divided as to whether the traditional partnership model of general practice provision is sustainable in the long-term.

- Although some attendees showed a preference to one or more alternative models of general practice, the general consensus was that there is no one ideal model of general practice in the future. Different populations and geographies may be better suited to alternative models of general practice including the existing traditional partnership model. Attendees were insistent that any new "imposed" model of general practice would ultimately lead to large numbers of GPs leaving the profession.

- All models would be sustainable in the long-term if general practice was resourced properly and out of hours care was adequately coordinated.

- There was a feeling that no matter what form future models of general practice took, it is essential for general practice models to have one or more GP partners at the top of the management hierarchy as clinical credibility is essential to any business negotiations.

- In general, younger GPs still aspire to become partner GPs in the long-term. However, younger GPs are increasingly deferring taking on this responsibility until later on in their careers compared to previous cohorts. Deteriorating remuneration for partner GPs and diminishing terms and conditions, such as access to maternity leave, were also seen as barriers to recruiting new partner GPs.

- Working as a salaried or locum GP remains an attractive alternative option to working as a partner GP for some, as these roles are primarily devoid of management and financial responsibilities. Working as a salaried GP was perceived as taking 'more personal responsibility' by partner GPs than working as a locum. However, some attendees said that salaried GPs can be at risk of being "dumped on" as a result.

- Increasing numbers of general practitioners are choosing to work part-time. It was communicated that one of the main reasons for this trend is the intensity of working as a GP is tremendous and that GPs' workloads are eroding opportunities for GPs to integrate with other colleagues.

- The need for a good work-life balance continues to be one of the main attractions to general practice although the demands of this specialty are not proving "family friendly" for some attendees.

- The majority of GPs who attended the focus groups currently work in a number of different roles. It was generally felt that it was not sustainable to work as a GP full-time and that working in different roles fulfilled the need for "variety" that typically attracted the attendees into general practice in the first place.

- The continuity of patient doctor relationship was a theme that was prevalent in every focus group. Whilst the attendees were strongly in favour of maintaining continuity and developing long-term patient relationships, it became apparent that the value of patient-doctor continuity depends on the patients' circumstances and that older patients are particularly wed to seeing the same GP. The GP attendees seemed to derive job satisfaction from long-term relationships as well as from following patients' journeys.

- One of the most common factors that attracted the attendees into general practice was being able to be "their own boss" as a partner GP. The recent contract imposition and the level of bureaucracy involved in sustaining funding for a practice is threatening this motivation.

- It was felt that the current level of change and the demands currently put on general practice are barriers to practices increasing efficiency and that the uncertainty about future funding makes it very difficult for a practice to undertake long-term strategic planning which could alleviate some of the pressures on practices.

- There are substantial differences in the way that urban and rural practices work and therefore these practices face very different challenges when attempting to optimise performance.

Background

The demographic of the general practice workforce is changing. In the last decade there has been a 400 per cent rise in the number of salaried GPs in the UK medical workforce.[1] In contrast, the number of contractor or partner GPs fell by 5 per cent in the same timeframe. Whilst the number of partner GPs has remained relatively stable over the last few years, the number of single handed GP partnerships has nearly halved in the last 10 years.[2] In addition, there are also predictions of a shortage of GPs in the future.[3]

In April 2013 the formal transfer of clinical commissioning responsibility to Clinical Commissioning Groups (CCGs) took effect in England. All practices are now accountable to CCGs and this has further compounded the workload of an already stretched general practice workforce.

More recently, in October 2013, the Government[4] announced new plans to extend general practice hours. The Government outlined proposals that would see a change in the hours that most GP practices currently open; office hours from Monday to Friday, to seven days a week and out of office hours. In order to resource this a £50 million pilot fund was unveiled with opportunities for practices to competitively apply for funding to resource extended hours. This new funding initiative is currently only being trialled at this time; however, if extended hours are imposed on all GP practices, this could have a significant impact on all GP practices and GP workloads.

It is not surprising then, that one solution for struggling small practices is to collaborate or merge with other practices to share or optimise resources. A recent report by the King's Fund and the Nuffield Trust acknowledges that increasingly larger scale primary care provision is emerging.[5] Furthermore, in March 2013 the Centre for Workforce Intelligence (CfWI)[3] reported that primary care commissioners would seek better coordinated patient care through more collaborative delivery and effective use of skill mix in multidisciplinary teams in alternative primary care delivery service models. The CfWI suggested that general practice would benefit from practices adopting a different skill mix, more effective demand management, better out-of-hours (OOH) services, and measures to improve operational efficiency and productivity and thus forecasted growing numbers of very large GP practices with the aim of coordinating a broader range of primary care services across multiple sites and extended hours.

Whilst larger-scale primary care models have the potential to reduce outgoings and optimise assets, little investigation has been undertaken to establish the effect any change in primary care provision might have on the general practice workforce. The BMA's Health Policy and Economic Research Unit has undertaken some qualitative research into the 'Future of General Practice' to gauge if the traditional model of general practice; where the majority of the medical workforce in a practice are contractor or partner GPs, who employ salaried or locum GPs when necessary, is sustainable in the future.

Methodology

An invitation to attend a BMA facilitated focus group on 'The Future of General Practice' and 'General Practice Workload' was sent to all 708 GPs who were signed up to the BMA's 'InTouch' research panel as of July 2013. 120 GPs responded to the invitation. All BMA 2006 cohort doctors who were working or training in general practice were also invited to attend one of the focus groups as younger GPs were not adequately represented within these 120 respondents. Based on the respondents' availability, three focus groups were scheduled on three dates in August and September 2013.

The three focus groups contained between five to 11 attendees. The participants were aged between 31 and 66, thus, the GPs were at varying stages of their careers. One of the aims of this research was to gain an insight into younger and newly qualified GPs' perceptions and expectations of general practice in the future. However, this criterion was not entirely satisfied due to a poor take-up by younger or less-experienced GP invitees.

The attendees in the focus groups were asked a series of questions about factors that affect their career aspirations, whether these influences change over time and the influence of a good work-life balance on career choices. In order to encourage discussion on what general practice could look like in the future, the attendees were then presented with information about four potential different models of general practice[5] and were asked whether the group could reach a consensus on the future model of general practice.

Results

The themes that emerged as a result of the analysis of the three focus groups are detailed in the results below. Verbatim quotes to support these findings are included where appropriate. An infographic of the key themes and interactions between themes that arose from the analysis of the focus group content is illustrated in Appendix 2.

Factors behind career aspirations

Analysis of the focus group transcripts revealed a variety of factors that influenced the attendees to choose general practice as their chosen medical specialty. However, the most common themes to emerge are listed below with illustrative supporting quotes:

"I didn't want to do hospital work; that was the ivory tower. I liked the variety that general practice had. I've never wanted to do anything else, I think you have to be omni-competent and be jack of all trades still."
Female GP Partner

The attraction of variety

"I became a GP because I didn't want to specialise."
Male GP Partner

"Variety [attracted me to general practice]; when I first worked in general practice, I thought it was amazing that I saw an 80-year old lady, and then we saw a 27-year old who was a drug addict and then we saw a six-week old baby. I saw people who were very, very ill and the next minute, I saw someone who was totally healthy and I was not going to intervene at all."
Female GP Locum

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Female GP Partner

Being able to develop long-term patient relationships/patient continuity

"I loved the patients and really enjoyed that one to one relationship and the feeling that they'll come back to you. I really like that idea of being with people on a journey for a long time… and I liked the fact that GPs are involved in their communities and can seemingly know everything about everyone. I felt that they made very good decisions on that basis due to treating each person as an individual."
Female GP Locum

"Back on my medical school placement, I really felt like GPs made a difference and that having a level of continuity, being a coordinator in all things really, not just medical care, but in social care and all sorts of things was really appealing and I think that it's really the continuity and stability that inspired me to become a GP."
Female GP Partner

"I went into general practice to practice high quality medicine but also to do it in a people orientated way and I really value the long-term relationships that I have with my patients. I would actually say that was one of the key factors that influenced my career choice."
Male GP Partner

The flexibility that general practice affords to work in more than one role

"I think it's very important to have interests and other things outside of your day to day work, that help to sustain your career and give you a bit of freedom and a bit of flexibility and a bit of stimulation from other things."
Female GP Partner

"General practice is not just about providing NHS care to NHS patients. It is in itself a portfolio of everything from seeing the patients, doing a variety of non-NHS medically orientated work, be it medicals, or be it occupational health work that comes in, or work outside the practice, such as education."
Male GP Partner

"Working as a GP has provided me with the most incredible flexibility to do what I've done and be where I've been. I've controlled my own destiny."
Female GP partner

The opportunity to have a good work-life balance/regular working hours

"For me, I [chose] general practice as it was going to have boundaries and regular working hours that I could control and therefore have a family."
Female GP Locum

"It's about work-life balance, that's important to me. I've got a family; I've got a young child. The [full-time] job is 8am to 6pm; you can't do that five days a week."
Female Partner GP

The attraction of autonomy and being able to be your own boss

"[Unlike my experience of hospital medicine] I'm not having to beg people to get things done, I deal with the patients directly and you get a 'thank you' as well."
Female GP Partner

In addition to these motivational factors, some GP attendees, particularly those who were further on in their career admitted that they initially *'fell into general practice'* through *"serendipity" and "indecision led to me going into general practice"*. Older GPs also commented that in the past, working as a general practitioner was seen as a *"good profession"* for life. Some GPs commented that working in general practice now is not necessarily seen as a *"job for life"* as GPs do not always want to take on partnerships immediately post qualification.

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Female GP partner

"Only three of the 12 of the GPs I qualified with are now working full-time… Four don't work in medicine at all in this country, five are part-time".
Female GP Partner

How have these influences on career aspirations changed over time?

Analysis of the verbatim recordings of the focus groups reveals a shift of attitudes over time about general practice. Increasingly GPs seem to find the experience of working as a GP as too intense to work full-time in a practice.

Indeed, the vast majority of the GPs who attended these focus groups worked as a GP on a part-time basis. This trend might be symptomatic of the availability of these respondents; however the lack of robust workforce data for general practice (current workforce data does not include locum GPs) does not easily facilitate testing the hypothesis that participation rates in general practice are depreciating.

"Only three of the 12 of the GPs I qualified with are now working full-time… Four don't work in medicine at all in this country, five are part-time."
Female GP Partner

"The workload is just so intense, that the only way to balance that is to work less sessions. A lot of GPs are doing that, but because of the nature of the work, it is possible to do other things [as well as being a full-time GP]."
Female Portfolio GP

"I don't see an average general practitioner any longer, everyone's doing different things. Portfolio careers, combining a wide variety of roles and some really innovative things are happening. I see the younger generation, very few of them are considering a career as a full-time doctor, whether salaried, locum or a partner… Part of the reason I think, is that few people can sustain the challenge, the pace and the complexity of being a full-time general practitioner."
Male GP Partner

Other factors that have changed as GPs careers have progressed are:

Work as a GP is increasingly isolating

" I think part of the reason why people want to do other things, is that it can be quite isolating being a GP. Being sat in that room from 8:30am to 6:30pm or 7:00pm at night, you have interaction with the patients, but you don't really tend to have much interaction with anyone who is not a patient. That's why it's important for you to be able to go to things like LMCs and just have a little bit more interaction with your peer group."
Female Salaried GP

"You would all go and sit in the big office to go through your paperwork and the results. The receptionists were there and there would be lots of interaction. I would know everything that is going on… You've lost the contact. It's much more efficient in many ways, sitting in your room; you get through letters and results much quicker, but you've lost the family within the practice along the way."
Female GP Partner

"Its sometimes nice [within the practice] to have that break and an opportunity to rant about things and get some feedback from other people and I think that is something that is very important, to our mental wellbeing as well."
Female Salaried GP

There are now more opportunities for GPs

"Once you've trained you can work anywhere. You can work in this country, you can work abroad, you can work in different practices and younger GPs strike me as not wanting to be tied down anymore."
Female GP Partner

"Now doctors can afford to choose. Now you can actually afford to be a salaried doctor, you can afford to pick and choose."
Male GP Partner

"When I started, there were basically partnerships and that was it. There wasn't anything else. Nowadays there are lots of different roles and models."
Female GP Partner

GP Partner earnings have deteriorated as have their terms and conditions

"GP partners are not earning more in some places, than they would have done as a salaried doctor."
Male GP Partner

"It is uncertain whether being a GP in the future will continue to be a high earning career or not because everything has been cut."
Male Locum GP

General practice is now seen as more 'business-like' – this demands a different skill set

"I think general practice has changed. It's much more business-like and, how I see it is, the bigger the better. There are more of you, you can spread your skills base. If you can organise yourselves to spend less [on staff] you can become better organised. Its becoming more of a business model, it has to."
Female GP Partner

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Female GP Partner

The importance of a good work-life balance when choosing general practice

The majority of focus group attendees indicated that work-life balance is important to them as a general practitioner. When explicitly asked if money was a driver to choosing to work in general practice, the common feeling was that money was not an important factor when choosing this career path.

"The hours aren't family friendly anymore, or even child-care friendly."
Female GP Partner

Increasing numbers of women are now working as a GP

"We're a training practice so I have medical students and GP trainees. I admit, I've not been doing it long but so far they've mainly been female and they are looking for some part-time work in the future because they want to have a family. They often want to do other things too... None of them seem to want to just be a GP and jump into a practice; whether as a salaried GP or in a partnership. They seem to want to float around for a while and that's what suits them."
Female Salaried GP

"Now about 60 per cent of GP trainees are female. Obviously it's a whole different situation. Tying yourself down isn't necessarily practical anymore."
Female GP Partner

Work-life balance isn't possible as a GP partner

"When I first started my career, I envisaged a very long rewarding, happy career where I valued my job as a GP and I was able to give good clinical care, with patients that respected me etc. I still want all of that and I still think that's achievable, but for me, at the moment it's not achievable as a full-time partner."
Female GP Partner

"Since the new contract [in 2004], the intensity and complexity and challenge of the workload has radically altered so that an average day is now 11 hours… I'm just knackered… In terms of the quality of the interaction with my family, it's affected my work, even though I probably worked more hours years ago."
Male GP Partner

"The hours aren't family friendly anymore, or even child-care friendly."
Female GP Partner

The impact of generation Y: the need for a good work-life balance and not settling at a young age

"I think one of the main reasons that my children have not chosen medicine [as a career], is because of the impact on your work-life balance."
Female GP Partner

"I do see a division at the moment in general practice. My generation is very different to the generation of GPs who are coming up. From what I see the younger GPs are not engaging, they don't want partnerships; they don't want the commitment, they don't go to meetings, they're not involved in anything. We [older GPs] have to take it all on."
Female GP Partner

A good work-life balance is more achievable working as a Salaried or Locum GP

"At the moment, I'm not going to be in line for partnerships in the next year or two, I want to just wait and see what is happening with the NHS. I think being a salaried GP provides the security of being in a practice, having that continuity with patients, having a relationship with colleagues without going from practice to practice but it also does not have the headache and responsibilities that partners have, like constantly having to battle with all these things that's pulling general practice in all directions with regards to the changes in the NHS."
Female GP Locum

"I don't think working as a salaried GP is flexible as you have very little control over the hours you need… A lot of people I know, salaried GP is what you do for the first few years and then you just do freelance [or locum] in order to have that flexibility."
Female Portfolio GP

Some practices are struggling to recruit GPs into partnerships

"There have been two partnerships recently that were both advertised as full-time. Both of them ended up going to two doctors sharing a job. People just don't want full-time partnerships anymore as it's just too intense."
Male GP Partner

"I know of one practice that has advertised nationally three times and have had no applicants. Another practice in a very nice area, have had no applicants [for partnerships]. Another practice has just appointed three new partners, but they went out and head-hunted them... Three part-time partners have been appointed."
Male Salaried GP

The majority of younger GPs still aspire to work as a partner but they also want variety and the opportunities to work in different roles

"As a salaried GP, I would still like to work as a GP partner and I have that aspiration because of the vision of being in charge of my work, but at the moment, it doesn't look like a very pleasant or comfortable place to be so its not something I currently see working in my life."
Female Salaried GP

"We have GP trainees; we've had four in the last three years. We've had three female trainees and one male trainee. The last female GP was brilliant… Though she does not want to tie herself down for a period of time, she wants to do a lot of locums, earn some money, travel... I think most younger GPs aspire to become partners… But, it's not like it used to be when you'd finish your training and then go into a partnership. They want to work in different places and see what its like."
Female GP Partner

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Male GP Partner

Areas of dissonance or discontent within general practice

The focus groups revealed a number of areas of dissonance which are at risk of becoming increasingly prevalent amongst the general practice workforce.

One of the main attractions of working as a general practitioner, particularly for the younger generation of GPs, is the prospect of having a good work-life balance; however, a common theme within the focus groups was that increasingly GPs' workloads are unmanageable and that GPs are working long hours with often no breaks.

Further to this disparity, there has been much media coverage about the pressure accident and emergency departments are under and some critics suggest that the provision of Out of Hours (OOH) care should be transferred back from being the responsibility of CCGs to being the responsibility of individual practices. This subject caused much disgruntlement within the focus groups with one or two attendees stating that GPs would leave in droves if OOH care were to return to being the responsibility of practices.

Indeed, many of the older generation of GPs reflected on the number of hours they worked and the impact this had on their families when GP practices were responsible for OOH care. These focus groups were held prior to the Government announcement[4] on extending practice hours to weekends and out of office hours; therefore there were no discussions relating to this possibility specifically.

"I can remember before 2003 when the new contract came in, I was 32 weeks pregnant and I'd just done a night on-call and I went into premature labour. Fortunately, I took that day off and the labour pains stopped, and I was back to work the next day. I paid a locum to do the rest of my on-call out of my own pocket... [When the contract changed] it was great at the beginning and you actually had a reasonable work-life balance but the workload has increased. The concern I have now is the workload becoming more and more and I'm seeing less and less of my kids and that's not why I went into general practice."
Female GP Partner

"GPs are no longer looking after health and illness, we're actually now [taking on the responsibility of] health prevention and long-term management of conditions which previous cohorts of GPs did not have to cope with [like obesity and diabetes]. I've seen general practice workload change over and over again. It is unsustainable to go back and provide out of hours in any way, shape, or form, not just because of the change of demographics and workforce, but because of the workload during the day."
Male GP Partner

"You did a lot more visits [before the contract changed in 2004] but you did get home for lunch sometimes. I don't visit now, the only visits I do are urgent visits out of surgery."
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Although some GPs are attracted to working as a salaried or locum GP; without the management responsibilities or financial commitments required of a GP partner, there were also concerns from some focus group attendees that some salaried GPs and locum GPs are not always treated well. It was felt that salaried and locum GPs had limited control over their salary, workplace or autonomy over patients and even having some restrictions placed on practice software. Whilst it was felt that while there are some "super locums", it was felt that most locums did not want to take on responsibilities beyond seeing patients and indeed, some partners routinely checked the work of the locums they employed. This was manifested through reviewing referrals and allocating locums routine work such as undertaking emergency surgeries.

The practice of checking locums' work could be having negative consequences on working relationships. This also adds to GP partners' workloads. The reason behind this 'checking' is to save money for the practice and the CCG; however, this finding also undermines the 'professionalism' of some locum GPs and points to possible tensions between GPs.

"Some salaried GPs are very valued in their practice. They go to the practice meetings, have additional responsibilities, but others are just treated as workhorses. The work is palmed off on them and they feel very disillusioned. I was only a partner GP for a short time, but I would say that in the current climate, being a salaried GP is still a good option."
Female GP Locum

"I know a salaried GP who sits down at their desk at eight o'clock in the morning and gets up from their desk at six o'clock in the evening, without moving, barring going to the toilet. They certainty don't have lunch and during that 10 hour period, all they have done is see patients. That has to be unsafe practice."
Male GP Partner

"I have been working over the last three years and doing clinical sessions [as a GP locum]. But, it's really frustrating, I can treat all of the patients, do all of the paperwork and do all of the visits but I find that I'm only doing half of the job. I can't look at patients' results, I can't look at all of the letters as it's all electronic; I can't take that holistic partnership view. I feel really hamstrung and I feel that I can do more. Its really difficult, the more electronic things are, as a locum, you can't access the forms etc… All the results go to the partners…This makes you isolated in a practice."
Male Locum GP

"It is my belief that being a salaried GP and not being in control of your workplace undermines professionalism and I think that undermines the effectiveness of a GP as an advocate for patients."
Male GP/Medical Director

"We end up putting our locums onto duty sessions where you end up seeing the emergency patients but you see that they don't make brave decisions or a decision that a partner would make because they are undertaking safe medicine and therefore more people end up coming back in when we have a locum in, than when we have a partner doing the same session."
Male GP Partner

"I know a salaried GP who sits down at their desk at eight o'clock in the morning and gets up from their desk at six o'clock in the evening, without moving, barring going to the toilet. They certainty don't have lunch and during that 10 hour period, all they have done is see patients. That has to be unsafe practice."
Male GP Partner

One of the main attractions of general practice as mentioned above is the opportunity to work for yourself and "*be your own boss"*. Another theme that emerged from the focus groups was that intrinsically working as a GP partner provides professional autonomy; however, increasingly partner GPs' autonomy and control is being diminished. The reasons tabled for this included that it is progressively more difficult to adapt to, often imposed, Government changes. These changes include the recent GP contract imposition and having to meet with Government targets to optimise the income of the practice, whist delivering the care that patients need. Other reasons include the real-terms deterioration of general practice funding and uncertainty in future funding and Government priorities which are perceived barriers to practices developing a "*practice strategy"* to optimise practice performance.

"I couldn't bear hospital medicine in the end, I wanted to be my own boss and actually, being a partner [GP] does achieve some of that. Although I think with the new contract, you're going along with someones else's agenda so much that it's demoralising. I'm actually trying locally to re-write the rules so that I can actually be a bit more in control of my job."
Female GP Partner

"If you want to maintain a career in general practice, you have to at some point, come to the realisation that the profession is no longer in charge and it hasn't been for some time You've got two choices, you can agree with it [that the government are in charge] and go along with it, or you can disagree, vote with your feet and get out. If you choose not to get out, then you have to adapt to the changes they [government] are making. You have to find ways of maintaining your goals within the practice while delivering what you're being asked to deliver because that is what they [the government] has been given the mandate to do. It is becoming increasingly difficult to do that [adapt]. "
Male GP Partner

"Because of the changes, it is very difficult to invest in the long-term. It is very difficult to invest in staffing, so probably, employing a salaried GP for me at the moment is a better option. If we knew what was going to happen in three or five years time, I wouldn't mind funding staff and expanding."
Male GP Partner

"I think a [GP partner] has the worst of both worlds, you are so-called self-employed but you're really a state employee of sorts without the protection of being employed. "
Male GP/Medical Director

Although the focus groups did not reach an absolute consensus that patient continuity is essential for the wellbeing of patients as some patients would choose rapid access to a GP appointment over continuity, the attendees did generally agree that a lot of job satisfaction comes from building relationships with patients. It was also felt that knowing a patient's history can be highly beneficial in terms of improving clinical outcomes. Attendees took great satisfaction from improving patients' health and seeing families expand and develop over time. However, some attendees said that having opportunities to form or maintain patient relationships are under threat.

There are a number of reasons for this including the effect of working part-time and patients seeing a number of different GPs as a result, not being able to take time to talk to patients and develop these relationships due to work pressures. Themes that emerged during the focus groups included GPs having to increasingly act more as care coordinators and less as clinical physicians and also dealing with more than one presented problem during appointments which results in less opportunities to take time to build interpersonal relationships with patients. The attendees of the focus groups suggested that GPs are increasingly supporting patients with mental health problems and that GPs are also now coordinating a number of aspects of care and support for patients who have multiple morbidities such as diabetes and heart disease. It was generally felt that general practice workload and acting as a care coordinator has been compounded by the shortage of community and practice nurses, a shortage of community care teams and significantly reduced mental health resources. Arguably, if GPs are required to adopt more of a social support coordination role in the future, this could negatively impact on some GPs' job satisfaction.

"We have a huge elderly population and the social side of things is an enormous problem. We have all these 90 plus patients who left their families... They call out the doctor saying they're not feeling well and their light bulb needs changing…You go there, and you can be there an hour because you're trying to coordinate social services etc. and the job has switched into that. The medicine is not enough, and all of the time, you're on the phone, waiting for people to answer, waiting for them to get back to you, and I'm thinking 'that's not what I trained for'."
Female GP Partner

"We seem to absorb everything that no one else [other agencies] want [to do]."
Male GP Partner

The community care teams should be doing [some things GPs are doing]… I've had a huge amount of long-term conditions that the nurses should be dealing with. I should be concentrating on medical presentations or presentations that patients choose to bring me, and sorting out the medicine within that, signposting them on for things that are non-medical. Otherwise it's a complete waste of resources."
Male GP Partner

"We are desperately short of nurses, we have posts unfilled. These are things I think that the Government need to put attention to because there is a crisis out there in terms of support for GPs."
Female GP Partner

In one focus group concerns were raised about female GPs accessing maternity remuneration in general practice. It was raised that younger women are increasingly being deterred from entering GP partnerships as there are no guarantees of maternity pay as a GP partner due to problems of practices accessing Government funding to pay for maternity cover. This finding is concerning and aside from the ethical and equality concerns this raises, this factor is clearly a barrier to female GPs wanting to work as GP partner.

"They've completely taken away maternity leave. As a woman, when GP registrars come in [to training], they're being told [have] your kids while you're in hospital medicine because you may not get maternity leave, and that's what they're doing. They're not coming into general practice until they've had their children because there's no guarantee they're going to get their maternity leave covered."
Female GP Partner

"Our salaried doctors have contracts, the BMA contract, and it [maternity leave] is written into their contract...the practice has to pay it, whereas its just GP partners who aren't necessarily covered [for maternity pay]."
Female GP Partner

"If I ever employed a doctor, I would be very careful about what I wrote in a new contract about what rights they had and I don't think I would use the BMA contract because I couldn't guarantee to cover that [maternity leave] because I wouldn't want to put myself out of business by paying for maternity leave."
Female GP Partner

"Because of the changes, it is very difficult to invest in the long-term. It is very difficult to invest in staffing, so probably, employing a salaried GP for me at the moment is a better option. If we knew what was going to happen in three or five years time, I wouldn't mind funding staff and expanding."
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Future models of general practice

In order to facilitate detailed discussions on the future of general practice the attendees of the focus groups were split into groups of between four to five participants. These smaller groups were presented with an adapted extract from the King's Fund and Nuffield report 'Securing the future of general practice: new models of primary care' (see Appendix 1).[5] The groups were asked to consider the following questions:

- Is the current general practice model sustainable?
- What do you see as the pros and cons of the different models illustrated (in the extract)?
- Will these models provide continuity of care/a 'named physician'?
- Which model do they think will be most likely? Why?
- Which would be your preferred model?
- Do you think these models will change future GPs' career aspirations? Why?

Is general practice sustainable?

Although this question was not directly posed to the attendees of the focus groups, analysis revealed a number of issues facing all models of general practice. Analysis suggested that general practice is under considerable strain and as such, may not be sustainable in the long-term due to the following reasons.

- GPs' workloads and levels of work related stress are not sustainable.
- There are no definitions of "core [general practice] services". As such, there are geographical differences in patient experience and treatments and services available from practices.
- There are shortages of GPs in many areas in the UK resulting in a shortage of GP partners, salaried GPs and locum GPs in some regions.
- There are not enough resources including skilled nursing staff, to cope with shifting care provision from secondary to primary care.
- The uncertainty of future Government funding pose a considerable threat to all models of general practice.
- The current workload and levels of bureaucracy required of a practice takes GPs away from seeing patients.
- GPs are at risk of burnout due to workload, difficulties taking rest breaks and not having enough time in the day to offload or undertake reflective practice with other colleagues.
- There has been an increase in patient expectations which can result in a patient being disgruntled if they do not receive the outcome they expected.
- Patient expectations and demands have resulted in a shift in practice culture in some places. There were suggestions that some GPs now practise "defensively" with the aim of avoiding legislative action from patients.
- The pace of change due to Government policies, interventions and incentives are proving difficult for practices to implement or adapt to.

Conversely, examination of the focus group transcripts suggested that general practice is sustainable in the future as:

- General practice remains an attractive speciality for doctors as it generally offers regular working hours, variety and opportunities to develop and forge long-term doctor-patient relationships.
- GPs can chose to work as a locum, salaried GP or partner GP. These different roles may prove more attractive than others at different times of a GP's life.
- Working as a GP provides many different opportunities to work in multiple roles, thus, optimising job satisfaction.
- Most of the focus group attendees were extremely enthusiastic about general practice and showed a great degree of commitment to the specialty.
- All models would be sustainable in the long-term if general practice was resourced properly and OOH care was adequately coordinated.

Is the current model of general practice sustainable?

There were opposing views regarding the current model of general practice. Analysis of the group activity suggested that the traditional partnership model is at risk due to the following factors:

- Government austerity measures have resulted in real-terms cuts in general practice funding. This has generally resulted in deteriorating partner GP remuneration and restrictions on recruiting other practice staff. These cuts have also placed a strain on meeting the costs of practice properties.
- Therefore, the current funding of the partnership model was not deemed as financially sustainable as practices are not remunerated for the work that is completed, but by patient population and other financial incentives and targets (e.g. QOF) that do not always reflect practices' workloads.
- Younger GPs do not necessarily want to take on the responsibility of partnership until later on in their careers. This means that some practices have difficulties recruiting new partners.
- There was a feeling that there are too many Governmental priorities within general practice and that this does not facilitate practices in prioritising and strategising within the parameters of the traditional model.
- The time slots allocated to patient appointments do not allow for any unexpected emergencies. In addition, patients are routinely attending appointments with a list of problems. Due to GPs' workload, there is no 'buffer' within the traditional model of general practice to accommodate these incidents.
- The traditional model does not inherently nurture career development opportunities for practice staff.
- The current model fosters competition between GP practices; this means that at times, the profession can lack *"cohesion or a common purpose for GPs or a willingness to work together"*.

Conversely, the advantages of the traditional partnership model are:

- This model has historically proved adaptable to suit the needs of patients and practices in both rural and urban areas.
- The partnership model, in theory, provides the benefit of providing a named doctor and continuity of care.
- The partnership model encourages ownership of and commitment to *"the business"* and fosters shared leadership by clinicians.
- The partnership model can benefit from having a non-clinical partner with business and management expertise.
- Historically, the traditional model fostered a practice-wide sense of team.
- Most GPs ultimately still aspire to be a partner GP.
- The traditional model may be more effective if there was more innovative commitment across primary and secondary care.
- The traditional model allows a degree of flexibility for partner GPs who wish to work part-time hours and/or work in different roles. However, this flexibility is dependent on the other partner GPs within the practice.
- Management decisions are ultimately taken by GPs not by managers.
- A hierarchy of managers can create obstructions to delivering care. The partnership model can be quick to implement change as it does not have multiple layers of bureaucracy.
- The conventional model can be successful if there is a strategic practice development model in place.

What are the pros and cons of different models?

The attendees were asked to identify the pros and cons of different models of general practice provision.

In general the advantages of different models of general practice included:

- Increased efficiency; if different practices share back office functions/sharing staff this removes potential duplication and could result in staff becoming 'experts' through exposure to repeated tasks or the development of specific in-depth knowledge.
- It was felt that working in larger practice organisations might make it easier to work together to solve practice-wide problems such as issues with CQC.
- For those attendees who felt that the current model of general practice provision is not sustainable, the different models presented provided an array of alternatives dependent on the needs of the population the existing practice(s) served.

It was felt that the disadvantages of other models of general practice provision included:

- The potential to increase bureaucracy due to multiple levels of management – it was felt that increasing the hierarchies within general practice could have ambiguous outcomes.
- It was felt that merging or partnering with other practices could diminish the corporate identity of the practice. There are concerns as to whether *"my voice would be heard"*. There were also concerns relating to clinical autonomy.
- There were concerns that those models which rely heavily on a salaried GP workforce, such as regional and multi-national practice organisations, are not sustainable in the long-term. The attendees suggested that these practices were more likely to have a large turnover of salaried GPs due to the nature of short-term contracts and that this would have negative implications for the morale of the entire practice as there could be a shift in the proportion of GPs who are committed long-term to the practice.
- There were particular concerns regarding the governance of a 'Super Partnership' with questions about how decisions get made and who ultimately makes decisions.
- The attendees felt that autonomy is very important to GPs and that independence and self-governance might be diminished in larger organisations.
- It was felt that the move to larger practices is politically driven and that there are *"simple solutions"* to problems in the current model of general practice such as the option of providing longer appointments. These solutions are likely to be difficult to resource however.
- It was felt that some walk-in centres and community services which are integrated in models such as Networks and Community Health Organisations are beneficial to some patients.

Will these models provide continuity of care/a 'named physician'?

There was a debate about the importance of a named physician to general practitioners and patients. Whilst it was felt that some patients; particularly the elderly, placed a lot of importance on having a named GP, it was also felt that some patients placed a greater onus on being able to quickly get access to a GP.

Some attendees felt that when patients are ill, continuity is very important to the patient and that in the long-run, it is more efficient. Aside from the reassurance of seeing the same doctor for the patient, it was generally agreed that knowing a patients' history was beneficial when diagnosing and prescribing, as well as the time that was saved reading a patient's medical history.

Which model is most likely?

The attendees tended to agree that the cheapest model of general practice is likely to be more prevalent in the future. There were also opinions that different models would "naturally evolve" dependent on the needs of the population and the priorities of those driving any change.

Which would be your preferred model?

Although some attendees showed a preference to an alternative model of general practice provision, the general consensus was that the future of general practice is likely to include a variety of models. The attendees felt strongly that no one model of general practice fits all populations or geographies as it was felt a 'Super Partnership' would not geographically suit rural areas as the shared resources and facilities would be too dispersed. Thus, attendees strongly resisted the idea of having any new model imposed on all practices.

It was felt that the traditional model of general practice could be sustainable if more planned resources were dedicated to general practice provision. Attendees placed a heavy emphasis on the length of appointments and said that currently the length of appointments is compounding the intensity of working as a GP as often, appointment lengths can be too short. Some attendees felt that the option to offer longer appointments are essential to making general practice sustainable as this would enable more health promotion and provide opportunities for GPs to make better diagnoses, reducing the number of consultations in the long-run.

In addition, it was also conveyed that a greater integration of services; good information sharing and effective personal relationships across different services is crucial to the success of general practice. A common theme to emerge across the groups was that primary and secondary care need to communicate better. There were also suggestions that the location of services is less important than sharing information and that opportunities to network within the clinical community are imperative to general practice.

Other suggestions as to how to improve the efficiency of general practice in any form included increased investment for community and practice nursing staff.

How will different models of general practice change future GPs' career aspirations?

The overarching theme that arose from these three focus groups was that any model of general practice would only be successful if the ownership of any change is retained by GPs. It was felt that any change should be driven from the ground-up, which would be dependent on the needs of the patient population and the geography of the practice area. The attendees felt strongly that any imposed changes to the way that general practice is delivered in the future would result in GPs leaving the profession in large numbers and that this would also discourage doctors choosing to work in general practice in the UK in the future.

In terms of considering the influence that future models of general practice might have on GPs' career aspirations in the future, the younger generation of GPs will increasingly place more weight on being able to have a good work-life balance, therefore, this reinforces the suggestion that any model of general practice provision will need to provide opportunities for GPs to work in roles that have varying levels of responsibility and bureaucracy. If this is the case, it is possible that models that provide a clear career progression to GP partner or models that rely on salaried GPs for the majority of care provision, such as regional and national multi-practice organisations, could be more attractive places to work for GPs in the future.

It was felt that regardless of the model of general practice provision, GPs would increasingly want to work part-time in the future. It is not obvious at this stage if any alternative models of general practice would provide this level of flexibility which arguably attracts and retains doctors to work in general practice.

One of the themes that emerged in the focus groups was the high workload and intensity of work that GPs are currently experiencing. GPs are at risk of burnout and are already reporting high levels of work-related stress. As such, ideally any future models of general practice provision should actively seek to provide sufficient support, reflective practice and structured rest opportunities.

In addition, one of the common themes that arose in the focus groups was that any further deterioration of GP partners' remuneration could lead to significant numbers of GPs leaving the profession. As previously mentioned, currently GP partners also have no guarantee of accessing maternity pay. These factors combined suggest there are significant barriers to female GPs taking on a GP partnership. As the majority of medical graduates are now female these issues could prevent females choosing to specialise in general practice, or indeed, this could lead to increased numbers of female GPs choosing to start their family when undertaking general practice training in order to benefit from maternity remuneration. This trend would cause problems for local and national medical workforce planning.

Conclusions

A number of attendees conveyed that they are increasingly under insurmountable pressure as a GP. This is symptomatic of funding cuts, patient expectations, rising workloads, Government initiatives and goals and, in the extreme, Government impositions.

A clear finding that emerged was that any enforced change would meet great resistance by the existing general practice workforce. Ultimately, if change to the model of general practice was to be imposed, a likely result would be significant numbers of GPs leaving the profession.

There were mixed opinions as to whether the current traditional partnership model of general practice is sustainable. For those attendees who felt that the existing model is not sustainable, the alternatives presented in '*The Future of General Practice: New Models of Primary Care*' provide viable alternatives of general practice provision, provided that practices themselves are able to choose the best model suited to the needs of their patient population and geography. However, further it was felt only time would reveal any significant disadvantages of these models. For many attendees, the feeling was that the existing model is still sustainable; however, the uncertainty of future government funding, shortages of practice and community nursing staff, cuts to other core care services, dealing with long-term conditions and multiple morbidities, increasing numbers of referrals, and a rise in general practice workload means that general practice is now under significant strain.

The general consensus within these focus groups was that young GPs still aspire to eventually take on the responsibility of working as a GP partner. This finding is supported by existing BMA research.[6] Nonetheless, there were also suggestions that younger GPs are now taking on the responsibility of entering a GP partnership later on in their careers compared with GPs from previous cohorts. A number of reasons for this trend were suggested including the current workload of GP partners deterring potential candidates, problems with female GPs accessing maternity remuneration and generational changes in attitudes and priorities. This finding would benefit from further exploration, due to the relatively small numbers of newly qualified and younger GPs who attended these focus groups.

Work-life balance is particularly important for younger GPs; however, analysis of these focus group transcripts revealed increasing numbers of GPs of every age are choosing to work on a part-time basis. Large numbers of GPs are working in multiple roles and time away from working in a practice is often considered as respite.

The vast majority of attendees of these focus groups were hugely passionate about general practice and there are many concerns about what general practice will look like in the future. When discussing alternative models other than the traditional model of general practice provision however, it became apparent that most attendees had very little knowledge of the wider implications of adopting alternative models of care provision. It was generally felt that general practice models would evolve in time.

Another important finding relates to the concerns raised about the professionalism and responsibility adopted by, and placed on, salaried and locum GPs. Whilst there was a general consensus that working as a salaried GP came with significant responsibilities to patients and managing the resources of the practice including careful referral management and taking on additional roles, there were also many examples of salaried GPs being exploited; having to work long sessions without breaks and at times, being the only full-time GP in a practice.

In addition, whilst it was felt that while there are some "super locums", it was felt that most locums did not want to take on responsibilities beyond seeing patients and indeed, some partners routinely checked the work of the locums they employed. This was manifested through reviewing referrals and allocating locums routine work such as undertaking emergency surgeries.

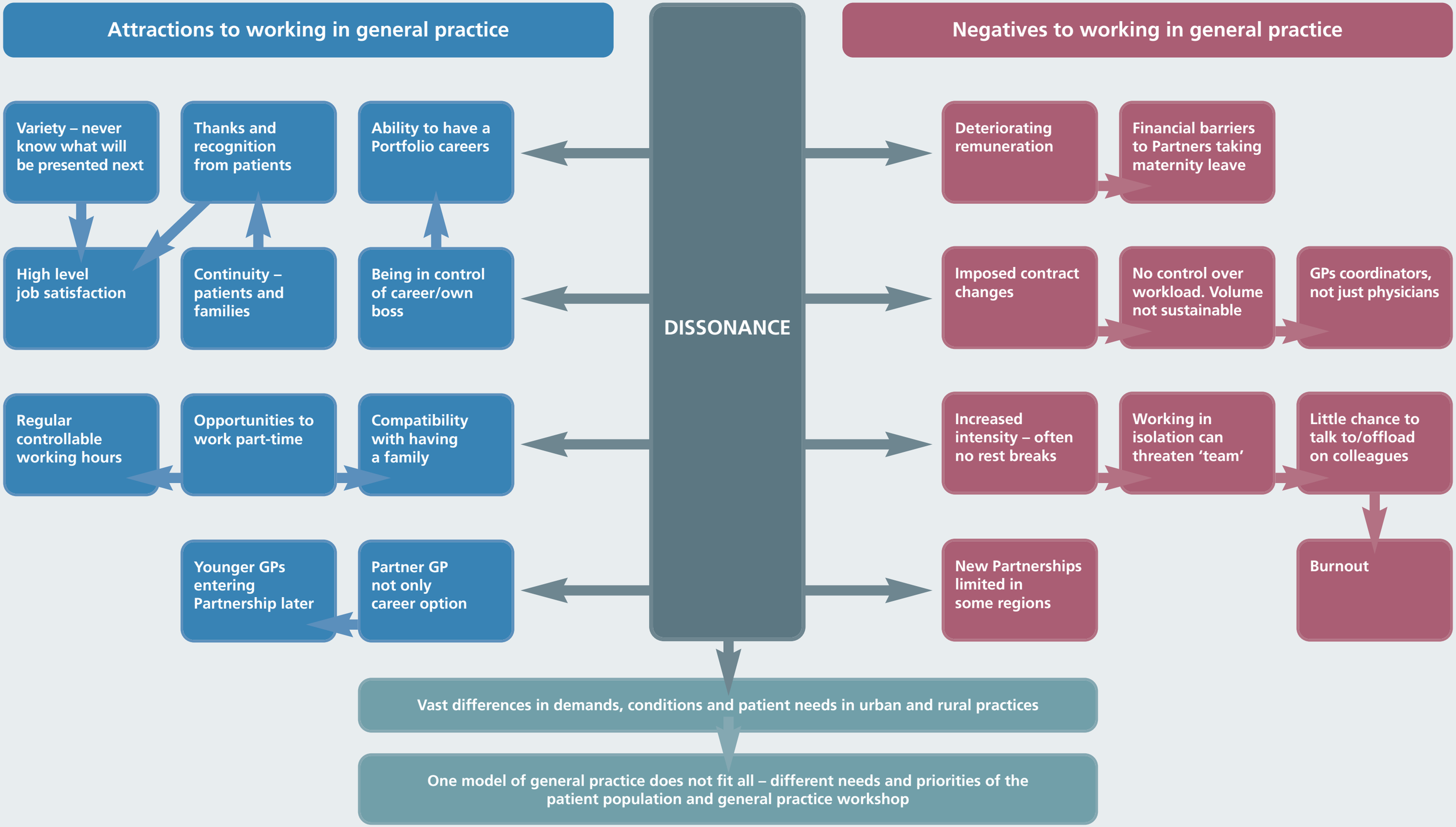
In light of previous themes which have highlighted the workload pressures of general practitioners, this finding suggests that some GP partners are conflating their own workloads by taking on the additional tasks of reassessing the work of locum GPs in order to save money for the practice and the CCG. This finding also undermines the 'professionalism' of some locum GPs and points to possible tensions between GPs.

In summary, there are many obstacles facing general practice. Many GPs are uncertain as to what form general practice will take in the future and as such, some GPs are reluctant to commit to taking on partnership roles or developing a long-term strategy for their practice which ultimately could help alleviate some of the current pressures being faced by GPs. There is no one ideal model of general practice for the future; however, some GPs will require an evidence base before effecting any significant change. The recent contract imposition, Government changes, targets and initiatives are creating an air of distrust about the future and as such, the general practice workforce is becoming increasingly resistant to any change which is perceived as being imposed, as *"one size does not fit all"*.

Appendix 1 – Extract from *'Securing the future of general practice: new models of primary care'*. The King's Fund and Nuffield Trust

	Networks or federations (terms often used interchangeably)	Super-partnerships	Regional and national multi-practice organisation	Community health organisations
Legal status	• Collaboration between multiple practices. • Can be informal in nature or linked as a legal entity e.g. limited liability partnership, community Interest company or limited company.	• Large-scale single partnership structure • Created through formal partnership mergers.	• Small-scale GP partnership or other organisational/legal entity led by GPs. • Scale and scope of primary care on a more regional basis is similar to some physician model groups in America.	• Range from collaborative groups of organisations to single legal entities such as charities or not for profit organisations. • Practices involved retain their independent status.
Governance	• Informally or formally established organisational structures with management teams funded by member practices.	• Executive board accountable to shareholders' group (membership is all partners of the merged practice).	• Corporate-style management structure combining GP Partners with CEO and director team. • Lead salaried GPs located in each practice – much smaller ratio of partners to other employed clinicians. • Typically hold APMS contracts.	• Various models: Elected members from each organisation; Volunteer boards of directors; Clinical management team.
Scope	• In addition to general medical services provided by member practices, may also provide enhanced services and some examples of specialist services. • May share back-office functions, safety and clinical governance.	• General medical services, population management and prevention, enhanced diagnostics, specialist services, community services.	• Multi-practice model delivering range of general medical services, enhanced diagnostics, and community and specialist services. • Partnership centralises management and back-office functions on behalf of its multiple constituent practices. • Smaller mass of patients in a specific locality means the model is limited in change it can make compared to primary care providers focussed in geographical locations.	• Primary care and community services with or without diagnostics and minor surgery. Some examples include inpatient care and specialist services.
Main purpose	• Use organisational scale to achieve economies. • Create local organisational infrastructure to expand scope of primary care provision. • Creating a legal entity to hold non-PMS or GMS contracts.	• Use organisational scale to achieve economies. • Create an integrated care organisation built on general practice as a viable alternative to aspects of hospital care. • Improve quality of local primary care • Improve career opportunities for GPs and practice staff. • Potential to diversify income streams.	• Use organisational scale to achieve economies. • Improve quality of local primary care. • Growth and diversification of income stream through multiple contracts. • Increased opportunities for career development, education and training for staff.	• A different model of provision rather than organisation. • Seeks to develop an extended range of local services defined by a population health focus, taking into account wider social and health needs. • Aims to improve integration of general practice with community and specialist services. • Takes on a role of community development alongside that of a healthcare provider. • Philosophy typically brings services to underserved areas, often marginalised groups, providing for needs holistically dependent on population needs.
Potential strengths	• Retains local practice location and identity, which can help to ensure services are geographically accessible, as well as enabling person-centred care. • Enables the provision of a more comprehensive range of services which are coordinated and community-based. • The extent of integration of services is affected by the purpose of the local federation. • Networks/federation of practices work together on a locality basis to plan and deliver new or extended forms of care e.g. managing long-term conditions. • Also collectively support public health priorities e.g. immunisations.	• Based on multiple sites. • Offer a wider range of services – not only offer primary care but a range of community-based specialist services. • Can offer out-patient services e.g. x-rays, MRIs. • Facilitates quality improvement through peer review and learning.	• Retains local practice location. • Can enable the development of consistent safety and quality assurance systems.	• Often focuses on a large single health centre with community and health organisations. • Can promote the provision of comprehensive care, attending to welfare and wellness, prevention and treatment services for physical and mental health care needs. • Potential to offer better coordinated care which is person-centred, through providing connections to an extended range of specialist and community services. • Often engage community members in governance of the service, which can inform the development of a more population-oriented service. • This model of provision is more prevalent in more deprived or remote areas where the population typically suffers poor access to services.

Appendix 2 – Interaction of themes emerging from the Future of General Practice Focus Groups



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