

Greater Manchester Primary Care Workforce Project (GMWF)

Report for Work Package 2C: Recruitment and
Retention of GPs in Greater Manchester
(Interviews with local, regional and national
key informants)



Working in collaboration with:

**Greater
Manchester
Health and
Social Care
Partnership**



The 10 Clinical Commissioning Groups across Greater Manchester

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<https://www.arc-gm.nihr.ac.uk/projects/addressing-long-term-workforce-challenges-general-practice-greater-manchester>

This study/project is funded by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care Greater Manchester. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

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1. Executive Summary

This report presents a study of the factors influencing the supply, recruitment and retention of GPs across Greater Manchester, prepared in September 2018 by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care Greater Manchester (CLAHRC GM) on behalf of the Greater Manchester Health and Social Care Partnership (GMHSCP).

1.1. Background

The number of GPs in England has declined in recent years and GP practices are facing continuing challenges to recruit and retain doctors while providing care for an ageing population living with increasingly complex health needs.

Regionally, the GMHSCP workforce strategy is prioritising the delivery of an integrated health and care model in primary care involving a multi-skilled, multi-professional workforce. One key aim is to improve the recruitment and retention of a number of key roles and skills across primary care.

To inform the development of their primary care workforce strategy (and in particular the recruitment and retention of GPs), GMHSCP engaged NIHR CLAHRC GM to investigate strategic-level stakeholder views (i.e. individuals in lead policy, research and development/service roles) about factors influencing the supply, recruitment and retention of GPs both nationally and across Greater Manchester (GM).

1.2. Methods

The study was an in-depth qualitative exploration of strategic-level stakeholder views (i.e. individuals in lead policy, research and development/service roles) about factors influencing the supply, recruitment and retention of GPs both nationally and across GM. It was informed by a rapid scoping review of the literature on the recruitment and retention of GPs and involved thematic analysis of semi-structured interviews with 39 participants (14 national/regional GP and primary care policy leads and 25 CCG/provider leads for each of the 10 areas across the region of GM).

1.3. Findings

1.3.1. Recruitment of GPs

- Recruitment into Foundation Programmes (FP) and GP training was reportedly rising, but there were concerns about how far this would result in a corresponding rise in qualified GPs entering general practice.

- GM training programmes were reportedly filling at rates above the national level. While GM was viewed as a desirable place to train, work and live, this was geographically dependent on proximity to the city of Manchester's more affluent suburbs and perceived commutability. Newly qualified GPs were said to be less likely to choose to work in areas of high deprivation.
- GPs were seen to be prioritising work-life balance and working part-time/in portfolio roles to protect against professional burnout, meaning workforce gaps could not be completely filled without full time equivalent GPs (or larger numbers of part-time GPs).
- The need for flexibility and work-life balance was reportedly becoming equally important to both female and male GPs so that the trend for greater part-time working was becoming a generational rather than a gender issue.
- General practice remained less popular than other specialties due to negative perceptions of general practice (i.e. that it involved a lack of career progression, low levels of intellectual stimulation and GPs being undervalued).
- A key strategy to overcome negative perceptions was the promotion of new models of working which underlined the flexibility, work-life balance and wider career options that appeared to be attractive to trainees.
- It was hoped that mandatory rotation of FPs through general practice and longer placements would encourage consideration of general practice as a career choice. However, it was noted that this could only have a positive effect if trainees had positive placement experiences.
- International recruitment was perceived not to be performing as well as hoped. However, regionally, international recruitment funding was seen to enable wider improvements to learning environments.

1.3.2. Retention of GPs

- The loss of existing GPs (both of retirement age and younger) despite a range of measures to retain them was seen as a crisis both nationally and regionally. The main reasons for GPs leaving early or reducing their working time were burnout from heavy workload and a lack of work-life balance, feeling undervalued, encountering barriers to returning after career breaks and the pension ceiling.
- Some perceived this to be exacerbated by fragmented allocation of funding for schemes and a sense of disconnection from policy-makers and fundersⁱ. A lack of succession planning within GP partnerships was highlighted as a growing problem in GM.
- Retention efforts were focused on widening GP skills (e.g. in clinical supervision) or enabling GPs to work differently, often by extending roles/working part-time.

ⁱ Beginning 2019, these concerns are being addressed by GMHSCP via a consultative approach to supporting and evaluating regional and local initiatives

- While some of these schemes were said to have increased the number of returning GPs, better promotion was needed to reach both doctors thinking of leaving and those who had already left.
- The introduction of a range of new roles professionals was viewed by some as helping to reduce GP workload and encourage them to stay, though this increased the time needed for training and supervision which could be a further strain.

1.4. Discussion

- Positive clinical placement experiences in general practice can influence doctors' choice of specialty; this emphasises the importance of support for GM general practices to become positive and attractive training environments.
- Undergraduate experiences in medical school can influence career choice and the reports of a lack of respect for general practice during education and training that have been found in other research were also heard in this study. GP involvement in undergraduate medical student selection and clinical teaching to counteract negative attitudes is one strategy that has been suggested to address this, but this approach has not been evaluated.
- A key challenge is designing a GP role that doctors wish to do. Future GP job design could ensure that the GP workforce has opportunities to widen or improve their skills and that these offerings are communicated effectively to undergraduates and FP doctors. Creating flexible employment opportunities to sustain recruitment will therefore be important; however, planning must take into account these part-time working plans in any estimation of GP workforce capacity/requirements.
- GM was viewed as a desirable place to live, train and work but this was geographically dependent. Ensuring that trainees and working doctors have the opportunity to serve mixed populations (rather than working intensively in areas of socio-economic deprivation) could be a component to consider in future GM training offers.
- Reasons for GPs retiring, leaving the profession early or failing to return after a career break reflect those identified in previous literature, including dissatisfaction with organisational churn, increasing workload, negative portrayal in the media, lack of support and feeling undervalued.
- Schemes to address retention and return to work (such as enabling existing GPs to develop portfolio careers or sub-specialisations) are in place but have yet to be evaluated. The recent national toolkit issued by NHSE and NHSI on GP retention, emphasises portfolio working as a positive aspect of the GP role though time is needed to assess its effectiveness.
- Some schemes (i.e. the Retainer Scheme and the Induction and Refresher scheme) have been evaluated, with indications that subsequent GP working years can result in good value for money. Uptake of the Retainer scheme, however, has been slow, suggesting a need for increased promotion of these types of initiatives among doctors.

- Additionally, this study highlights a number of other concerns in relation to retention. There were general concerns about finding no guaranteed way of retaining the existing GP workforce and a reported sense of disconnection in GM from regional policy-makers and funders in relation to retention scheme planning and resource allocationⁱⁱ.
- There were also concerns that introducing non-GP new roles professionals to help with GP workload may not be time-saving in the long-run.
- More specifically, an urgent need for succession planning across GM for GPs retiring or leaving was highlighted.
- The study highlights a number of other solutions being pursued by different areas e.g. supporting GPs with personal finances or online/Skype working; however, these were being trialled in particular areas of GM in isolated pockets of activity without evaluationⁱⁱⁱ.
- The NHS Long Term Plan is seeking to increase the number of GPs through the Fellowship Scheme for new GPs; however, time is needed to assess whether these measures have any effect on the retention of existing GPs in the general practice workforce.

1.5. Key Messages

- Recruitment into GP training places has increased but may not translate into a corresponding increase in qualified GPs entering general practice to fill gaps completely.
- Negative perceptions of general practice persist; work to tackle this continues by promoting the job as flexible with a range of working options/contracts and opportunities for research, teaching and other skills improvement.
- Positive clinical placement experience can influence decisions to choose general practice but negative experiences can be a deterrent; general practices need support to become positive and attractive training environments.
- GPs of the future (both female and male) intend to work largely part-time or in portfolio roles; flexible employment opportunities to sustain recruitment are needed but planning must take part-time working intentions into account.
- GM is viewed as a desirable place to live, train and work but preferences were for serving mixed patient populations rather than intensive working in areas of high socio-economic deprivation.
- Factors that are influencing GPs to retire, leave the profession early or fail to return reflect those found previously.
- Schemes to address retention and return to work across the working lifespan have focused on widening skills or enabling GPs to work differently.

ⁱⁱ GMHSCP report that, beginning in 2019, these concerns are being addressed by via a consultative approach to supporting and evaluating regional and local initiatives

ⁱⁱⁱ Ditto above

- While some schemes were perceived to be having positive effects, uptake could be slow, suggesting a need for increased promotion of these types of initiatives among doctors.
- The lack of a systematic approach to GP succession planning was seen to be a growing problem in GM.
- There was a reported sense of disconnect between regional policy-makers/funders and GM areas in relation to the planning and resource allocation of retention schemes; isolated pockets of activity suggested the need for a more consistent regional approach to GP recruitment and retention.

2. Background

GP practices are facing challenges to recruit and retain their doctors and capacity is not meeting demand¹. The number of GPs in England has declined over the last decade, with more recent estimates showing that in September 2018, England had 2,500 fewer full time equivalent (FTE) GPs than required, a number which could rise to 7,000 by 2024 if the current decline continues².

The 2016 General Practice Forward View (GPFV) recognised the challenges faced by general practice in providing care for an ageing population living with increasingly complex health needs alongside a corresponding shortage of GPs, and signalled a new national policy focus on addressing workforce pressures in general practice³. Priorities were the recruitment and retention of GPs (and practice nurses), along with the introduction of new roles professionals into the primary care workforce to relieve workload pressure. The GPFV aspired to increasing the number of GPs by an extra 5,000 by the year 2020. However, it now seems unlikely that this goal will be attained⁴.

Workforce challenges are taking place against a rapidly changing primary care system. The NHS Long Term Plan (LTP)⁵ and a new GP Contract Five Year Framework⁶ aspire to build on the GPFV by further increasing the number of doctors working in general practice (a more detailed workforce implementation plan is awaited and expected to be issued in late 2019). From 1 July 2019, primary care networks (PCNs) made up of groups of general practices in the same geographical area, were expected to be providing care to populations of between 30,000 and 50,000 patients each. PCNs will be part of larger Integrated Care Systems (ICSs) that are planned to be in place by 2021 across the country⁷. ICSs will, among other things, be tasked with developing five-year workforce plans to inform national workforce planning including the number and mix of roles needed to deliver the NHS LTP⁸. Key promises in the LTP are: guaranteed funding for up to 20,000+ additional new non-GP roles staff by 2023/24 in primary care (i.e. social prescribers, clinical pharmacists, physician associates, first contact physiotherapists and first contact community paramedics); the creation/part-funding of a new primary care Fellowship Scheme for newly qualifying GPs (and nurses); creation of Training Hubs; a continuation of current NHS England recruitment and retention schemes⁶.

Almost 500 more trainees entered the 3-year GP training programme in 2018 compared to 2015/16 (up from 2,769 to 3,250)² which is a positive upturn, though the extent of their entry to substantive GP work on completion of training remains to be seen. It is known that fewer newly qualified doctors are choosing to enter primary care and existing GPs are leaving the profession early in greater numbers^{9,10}. Our NIHR CLAHRC GM literature review on GP recruitment and retention¹¹ highlighted a range of factors that are discouraging trainee doctors from considering general practice. These included a perception of general practice as a lower status medical specialty with increased workload, lack of career progression, poor pay and an

associated lack of respect. The review also highlighted factors that are leading existing GPs to leave, including an unmanageable workload with poor support and constant organisational change, a perception that the profession is not valued and a perceived lack of autonomy and support. A number of strategies are being employed to increase the recruitment and retention of GPs but the effects are unknown.

2.1. The Greater Manchester workforce strategy

In GM, a third of GPs intend to leave the medical profession and/or direct patient care in the next 5 years¹² and a fifth of current GP trainees plan to move abroad¹³. Regionally the GMHSCP 5-year plan identifies the need for the primary care workforce to change to enable reform to happen in a way that is sustainable for the future^{14,15}. The GM Workforce Strategy is seeking to explore new models of care that utilise the breadth of skills across primary care and put patients at heart of services, requiring changes in how the future workforce is developed and sustained¹³. Key priorities for delivering an integrated health and care model in primary care involving a multi-skilled, multi-professional workforce are to¹³:

- improve the recruitment and retention of a number of key roles and skills across all primary care;
- support the development of system leaders across all primary care;
- create a range of career pathways which cross boundaries and sectors;
- ensure that all staff feel valued and have access to opportunities for development;
- ensure that primary care is seen as the 'career of choice'.

2.2. Study aim

To inform the development of their primary care workforce strategy (and in particular, plans for the recruitment and retention of GPs), GMHSCP engaged NIHR CLAHRC GM to investigate the factors influencing the supply, recruitment and retention of GPs across GM.

3. Methods

We conducted a qualitative study to examine factors affecting the supply, recruitment and retention of GPs across GM. Ethical approval was obtained from a University of Manchester ethics committee. To gain a range of strategic-level stakeholder views (i.e. from individuals in lead policy, research and development/service roles), purposive and 'snowball' sampling was used to select potential participants in the following groupings: 1) National/regional GP and primary care policy leads and 2) CCG/Provider leads for each of the 10 areas across the region of GM.

These individuals were identified and invited to participate in the study. With consent, semi-structured interviews were conducted between August 2018 and May 2019 with

contacts agreeing to take part, either face-to-face or by telephone for the convenience of participants. Interviews aimed to identify challenges faced in the recruitment and retention of GPs and how these issues were being addressed. Broad topics for discussion in interviews (informed by the abovementioned NIHR CLAHRC GM literature review on GP recruitment and retention), are presented in Table 1. Interviews/focus groups were transcribed and anonymised, before being analysed thematically using NVivo software¹⁶ and applying a combination of pre-determined and emergent codes¹⁷.

Additionally, Appendix 1 presents a brief diagrammatic representation of the basic pathway through medical training and Appendix 2 provides a list of definitions for the main GP roles.

Table 1. Interview topic guide

Topics
Recruitment
<ul style="list-style-type: none"> • <i>What factors are influencing the decision-making process of FP doctors when selecting specialism?</i> • <i>What factors are influencing the decision-making process of GP trainees when selecting location to practise (including choice of GM locality)?</i> • <i>Are there any initiatives with the potential to influence the career decisions of FP doctors and GP trainees to encourage them to choose/remain in general practice?</i>
Retention
<ul style="list-style-type: none"> • <i>What factors are influencing the decisions of practising GPs nationally and across GM areas to retire or leave the profession?</i> • <i>What initiatives if any have the potential to influence the decision-making of GPs intending to retire or leave the profession?</i>

4. Findings

4.1. Participants

A total of 39 participants took part in 31 interviews (see Table 2 for final study sample).

Table 2. Final study sample (national and regional participants)

Participant role	Number of participants
National and regional GP/policy leads	14
Regional CCG/Provider leads	25
Total	39

Findings from the interviews are presented in two main themes mirroring the 'pipeline' analogy¹⁸ where 'increasing the flow' relates to recruitment and 'plugging the gaps' relates to retention and return to work.

4.2. Increasing the flow

4.2.1. Recruitment of undergraduates to foundation programmes and GP training

Nationally it was reported that recruitment into GP training had recently risen. Concerns remained, however, over whether this upturn would see a corresponding increase in qualified GPs entering general practice. Some national leads expressed doubt about whether general practice was viewed as an attractive career option and felt there was a need to promote the specialty more:

From what I can see from the data, the recruitment into GP training, there's been some impressive work there, so we've gone up... this year, so that's good, so we're getting people into the training schemes. We don't know how many of those we'll hang on to and then most importantly we don't know how many will then go into the workforce and stay in the workforce. And our biggest concern is that you can train as many people as you like, but if the job doesn't look attractive, then people will vote with their feet. (National GP Lead 1, Interview 8)

There are more people going into GP training than ever before, which is great, but in terms of numbers of GPs on the ground at the moment we're not really seeing a positive impact on that... it's sort of like a vicious circle... because understandably the professional feels under pressure, is overworked... you can't say it's not hard work... but it's also selling what's really good about being a GP as well. (National Policy Lead 1, Interview 27)

Within GM, a relatively positive but geographically mixed picture was presented in relation to recruitment of undergraduates into Foundation Programmes (FP) and FP doctors into GP training. The perception was of an overall increase in the uptake of places for both, as well as a view that within GM training programmes fill at rates above the national average.

Although trainee doctors were described as wanting to be and stay in GM, recruitment to training programmes, and by extension the future likelihood of qualified GPs staying in a given GM area, was asserted to be geographically dependent. Preferences were commonly seen to rest on key factors such as: proximity to the city of Manchester and its more affluent suburbs; level of deprivation (with deprived areas more likely to lose their GPs post-training); proximity to areas in which new doctors wanted to live (commutability); proximity to family and friends;

and familiarity with an area (i.e. doctors more likely to choose to work in an area they have trained in):

Some areas are more easily recruited to than others and there are obvious reasons for that in terms of deprivation, career aspiration, remoteness of the area. (Regional GP Lead 4, Interview 7)

Where they've had their previous experiences, I think is an influence... so [area of GM] foundation doctors come back as GPSTs [specialty registrar in general practice] ... because they know it, because they've had an experience. There are also other sorts of geographical drivers, as in where your family live, if your family are close by, especially if you're planning on having a family of your own. (Regional GP Lead 3, Interview 5)

These factors were well-known in areas (including non-GM areas) that were less popular and were struggling to recruit, meaning that these areas had to make greater efforts to adapt by pursuing different ways of working or recruitment strategies:

So, in some... areas... like Area 28, Area 43, Area 44 etc. they've been struggling with workforce for many, many years and have failed to attract new blood into practices for a long, long time. So, they've been perhaps more at the forefront of change because they've had to, whereas in... some of the very affluent areas, they've never had problem recruiting GPs so they're a little bit less keen [to adapt]. (National Policy lead 4, Interview 38)

We've got radio adverts running... we now have a YouTube channel, so things that we film can go on there that will link to the website. We have a Facebook page that they've started yesterday, so we'll be putting advertisements on there, and we have Twitter ... they will be promoting the area... just a few nice things about the boroughs and what we're doing. (GP Provider Lead, GM Area 3, Interview 11)

A significant issue was the difficulty in converting trainee posts into full-time or substantive posts rather than locum positions. This meant that regardless of the increase in recruitment in GM and the region's perceived popularity, this was not enough to fill gaps completely, because GPs usually did not want to work full-time after qualifying. Both in GM and outside the region, a perceived combination of heavy workload and stress in general practice was understood to encourage newly qualified GPs to work fewer sessions and into portfolio careers. Some took a positive view, suggesting that such approaches were good for preventing professional burnout; others suggested that shortages would persist because recruitment on this basis was not currently matching the gaps in general practice. This was confounded by the fact that the benefit of recently reported increases was not yet being seen:

We actually recruit roughly the same number of GPs as we always did and it's going up as the population goes up. But the real problem is nothing to do with recruitment, it's the fact that they don't work full time ... and we've also compounded that by making portfolio GPs so exciting [that our GPs]... go part-time... and when I say part-time, I don't mean they're not in primary care, they are just not doing face-to-face general practice. (Regional GP Lead 4, Interview 7)

The new generation are already telling us that they're looking at different ways of working. They're probably looking at doing two to four sessions a week in general practice but they want other interests, both in secondary care and acute, and they want to work differently, so they wish to make use of modern technology and things like that. So, it's how we look at all of the tools we've now got in the box and how we cover our workforce areas with a multiple workforce going forward. (Policy Lead, Non-GM Region 5, Interview 3)

The ability to expand recruitment in GM further was seen to be limited by a combination of estates issues (a lack of space in GP premises) and a low level of willingness/capacity to take on more trainees and the clinical supervision that inevitably follows. Some felt that this issue needed to be more clearly articulated and addressed:

We don't have an estates strategy, so the thing that limits me taking training into my practice isn't people to do the training, it's not the will, it's actually having room space available. Because if I take a trainee in, I want them to start doing stuff independently, so I need a room where I can put them, you know, but I just don't have the room. So estates, increasingly is becoming a bit of a blocker to people taking people on. (GP Provider Lead, Interview 25, GM Area 10)

We are limited in expanding that because of supervision burden and premises. There is a definite willingness to train and supervise people, definitely, it's a core value of a GP but we are running out of space. So that needs to be articulated in the Region 3 plan to say, well, there is a will but we need to find a way. (Regional GP Lead 2, Interview 4)

Relatedly, the perception that fewer new doctors were said to be taking on partnerships, and were instead prioritising work-life balance, played into this too:

Less people actually want the responsibility of being a partner in a practice. Lots of people want more flexible working patterns. (Regional Policy Lead, Interview 2)

However, some areas were actively attempting to increase their placement capacity for medical students and others saw the advent of PCNs as a way of overcoming the limitations of estates and supervision burden:

...with the setting up of the networks that's one of the things we're already looking at, so rather than have to take the student for the whole four days, we could have them two days and you start working together. I think that's where networks in terms of education can take on a role. (GP Provider Lead, GM Area 4, Interview 19)

Having a reputation for providing quality GP training was seen by some as a particular draw for trainees and could be a stronger pull factor in attracting recruits than, for example, offering higher levels of remuneration:

...historically, GM Area 10 has weathered the recruitment challenges better than other areas. So we've always been pretty good at recruiting... [we are] underfunded financially compared to other areas in GM, so you would think that we'd struggle to recruit because we can't offer the salaries that some other areas can. I think the key is that GM Area 10's got a really strong history of GP training for medical students. And actually, I think that's probably the most powerful base from which to support recruitment. So if you do training well, if you look after your trainees, they'll want to stay. (GP Provider Lead, GM Area 10, Interview 25)

Despite the reported increase in recruitment, general practice was still described as less popular than other specialties, meaning recruitment remained challenging. This unpopularity was attributed first to negative perceptions of general practice among medical students and Foundation Programme (FP) doctors (e.g. beliefs that compared to hospital specialties, general practice lacks career progression/support structures; the wellbeing of GPs is undervalued; and general practice is not as intellectually stimulating as other branches of medicine). These perceptions were believed to derive from pejorative views of general practice encountered in interactions with medical educators. Secondly, negative media representations of general practice were also believed to be having a negative impact on applications:

I think the thing that affects whether people come into general practice the most is probably what's happening in national politics and in the press. And if we're going through a GP-bashing phase, which we have done for probably the last three to five years, people avoid it. (Regional GP Lead 4, Interviewee 7)

According to participants, the flexibility and work-life balance offered by general practice, with options for part-time and portfolio and careers, had been traditionally viewed as particularly appealing to women, recruits who may be more likely to have caring responsibilities. However, this motivation was seen to be losing its gender divide with flexibility and work-life balance becoming equally important to male GPs.

The trend for greater part-time working (compounded by portfolio working), was therefore viewed as a generational rather than a gender difference:

...if you look at younger and more recently qualified GPs, they tend to be working three days in five as a matter of course. There is a kind of gender pattern there, so you've got more women entering the workforce, but they are [generally] more likely to work part-time – actually, there isn't a huge gender difference in preferences for part-time working, but still essentially you get one GP leaving the workforce through retirement or whatever and they're being replaced by one new head of GP but they're working three days a week. (National Policy Lead 2, Interview 28)

4.2.2. Recruitment from abroad

The international recruitment drive to tackle the GP workforce shortfall was described as having performed poorly against expectations. This was attributed to factors such as Brexit, language barriers and disparities between medical curricula in different countries. There was also recognition that the GP shortage was actually an international problem, making it even harder to recruit to the UK. Further, as well as having failed to achieve its targets, the International GP Recruitment (IGPR) programme was seen by one national participant as an expensive failure:

I'm most suspicious about international recruitment, and that really has been a sad tale – enormous amount of money and effort has gone into international recruitment challenge...two years down the line we've recruited 38... if your choice is working in [socially deprived area of UK]... for 12 or 14 hour days, or working an eight hour shift in Australia and then at five o'clock going down to the beach and having a beer and a barbecue, then what would you do if you're a youngster? Probably not the [first] option I suspect... so I think the large amount of money...that's currently being put into international recruitment, at some stage or other NHS England probably need to say, this isn't going to work, and to back off from it and put that money into other areas, and part of that is about funding schemes to retain the workforce so that we stop the leakage at one end. (National GP Lead 1, Interview 8)

Funding under the IGPR programme was seen to encompass both the recruitment of international GPs and the provision of support to them once in the UK. Regionally there were reports of plans to use these ring-fenced funds to train clinical supervisors to support not just international doctors, but also new roles professionals and make some wider improvement to learning environments:

Primarily, training of clinical supervisors because they have to have qualified clinical supervisors and we don't have the number if the predicted number [of international recruits] comes... so we have to deliver the clinical supervisor, we have to then approve the learning environments, because they have to

be approved learning practices. And then they need an education course delivering. And, of course, support of the supervisors. So in fact, the education component for the international doctors... we're putting on supervisor courses but we're going to make it a generic supervisor course... we will use the international recruitment money to train up qualified clinical supervisors of the future primary care... workforce. (Regional GP Lead 1, Interview 1)

4.2.3. Measures to improve recruitment

As mentioned, although there are still issues in the recruitment of doctors to general practice, numbers are increasing each year. Participants felt that a range of regional and national strategies had influenced this increase to varying degrees.

For example, both nationally and regionally a lot of 'image' work had been done to tackle negative perceptions of general practice found in both the media and other areas of medicine. National teams were described as spearheading social media and communication campaigns that were promoting general practice as a good career and dealing with negative perceptions. In particular, the emphasis here was reported to have been on demonstrating new models of working, which underlined the flexibility, work-life balance and wider career options that appeared to be attractive to trainee doctors.

Key to this 'image' work was the promotion of the flexibility that a career in general practice could offer. Different areas across the region (and nationally) were seeking to offer flexible portfolio careers and job variety. GP federations were described as doing significant 'backroom' work to make it easier to recruit newly qualified GPs, offering flexibility in the posts available and enabling portfolio working for those who did not wish to be partners or work full-time. Areas with the ability to offer a range of working options/contracts and variation in the type of work/patient population served, were described as better able to recruit and retain their doctors:

Where I work as a GP... we ran a scheme in which we recruited new GPs straight off VTS [vocational training scheme] into half-time or 60% clinical posts and the rest of it was either quality improvement or research-type posts, and that proved attractive. Again, it fits in with a model that we know exists amongst the younger generation of wanting a career portfolio, wanting not to be tied down. (National GP Lead 1, Interview 8)

[GP trainees] wanted a variety of experience... they wanted to build a portfolio, they didn't want to start day one in GP looking at 18 appointments and do the same 20 years later. And I think that's a very healthy trend... they don't want the pressures of partnership... so the reason training practices retain quite a lot of the trainees in GM Area 1, even if they are from GM Area 6 or [outside GM] or anywhere, is because a lot of these happen in training practices almost organically. (GP CCG Lead, GM Area 1, Interview 20)

Work was also going on in foundation courses to promote general practice to counteract the image of general practice as a lower status medical specialty. A key scheme across the North West that was viewed positively by some was the mandatory rotation of all FP doctors through general practice via 4-month long placements. A positive experience during general practice placements was believed to be very influential in opening FPs' minds to general practice as a career choice:

... some [FPs] are set against [general practice] from the start, they say, I want to be a brain surgeon, I don't want to mess about doing this namby-pamby, tree-hugging, cardigan-wearing general practice nonsense, I want to do real medicine... most of them nowadays keep an open mind and... we do see people who were thinking, I'm not interested in this, but once they've seen it are converts and then will like it. And we do know... if you're exposed to that specialty then you're more likely to go for it. (Regional Medical Training Lead, Interview 9)

Though seen as successful, improvements were still required to the planning of rotations to maximise positive student exposure to general practice. The timing of the GP rotation, for example, was seen as problematic, as some FPs did not have a GP rotation until after the application period for general practice. More exposure to general practice as an undergraduate was also seen to be necessary by some, with longer placements in 3rd and 4th year, over and above the one-day placements currently provided.

Increasing the exposure of trainee doctors to general practice was one issue, but crucial to the success of such initiatives, was the availability of good training practices. This was seen as hit-and-miss in many areas. In places where this could be achieved, retention rates were reported to be better, but certain areas were struggling to increase the number of GP practices that would take medical students.

It was suggested that GM could perhaps learn from recruitment initiatives in other areas. For example, one non-GM area that was reportedly struggling with recruiting into medical schools was described as focusing on exposing students to general practice at a much earlier stage in their education, before medicine had even been considered as a career. This was being done in the belief that pupils from less affluent areas, who would not traditionally have been considering medicine, might be more likely to stay in an area after training than those from elsewhere. This area had been successful in a bid to support this activity and was engaged in visiting schools and encouraging local pupils:

Recruiting, I think it's 50 per cent, I can't remember, from schools that don't traditionally send to medical school, so in [non-GM area]... they very much focused in their bid – and that's how they got it – in focusing on local recruitment in their region, retaining doctors, et cetera, in their region. (Regional GP Lead 1, Interview 1)

Incentives that relied solely on offering higher GP salaries as a draw were seen to not work and had failed previously. For example, GM Area 5 had previously run a scheme aiming to recruit and retain doctors to general practice by offering higher levels of remuneration. Reportedly, however, this had not worked because newly qualified GPs were seen to be looking primarily for work-life balance. The 'Parachute Scheme' to bring GPs into socially deprived areas was viewed as unsustainable, because GPs would commute from elsewhere into the area to obtain the money temporarily and then move at the end of the scheme.

The recent Fellowship Scheme for newly qualified GPs announced in the NHS Long term Plan, was seen as a novel mechanism to retain newer staff at a key juncture just after qualification, by ensuring peer support, mentoring and opportunities for role extension:

...when we look at the loss points through your career journey, we often lose GPs in that first couple of years, thinking did I choose the right... should I have gone to the hospital with my friend who works in A&E who deals with people whose legs have fallen off or shall I stay here in a room on my own looking after coughs and colds? That is an extreme example, but that is a time that we lose people, they feel isolated. So the intention of [Fellowship Scheme] is to build that peer support network, get some mentorship built in, clinical supervision, some leadership training, have some opportunity to look at things other than your common presentations, maybe look at a specialism and such like. (National Policy Lead 3, Interview 35)

4.3. Plugging the gaps

The loss of GPs who are already in the workforce was seen to be a crisis both nationally and regionally, despite a range of schemes aimed at encouraging them to stay:

...the bad news is about retention of the current workforce... so that's partly because they haven't really found ways of stopping the leakage of the workforce in people over the age of 55 and there's a combination of factors again about do-ability in the job and pensions and tax and a whole range of other things which are just making people who should be at the height of their powers as a GP, in terms of experience, just walking away from general practice. So that is a big crisis. (National GP Lead 1, Interview 8)

In GM, there was a perception among some that the funding of retention activities tended to be allocated in a fragmented way in pockets, rather than more uniformly across the region. This reportedly meant that money was distributed in a rather piecemeal fashion and due to time pressures, was not used strategically but quickly spent without adequate planning. In addition, some described a sense of disconnect

with regional bodies, with current approaches being experienced as ‘top down’ and ‘done to’ rather than as efforts to co-produce solutions in conjunction with practices^{iv}.

4.3.1. Retention of GPs below retirement age

It was perceived that nationally, GPs below retirement age were leaving the profession in greater numbers and GM was no exception. A range of national and regional schemes were cited as aiming to halt or slow down this trend and keep GPs in practice. Main reasons for GPs leaving early were burnout, feeling undervalued, the difficulty of staying in the profession after a career break, lack of work-life balance and the pension ceiling:

... GPs don't particularly, I think, want to quit. They're not looking to get out, but they often feel ... it's the only option that's left to them... they've got pensions that are complete ... there are push and pull factors combined and we actually need to address these core issues ...because... we are heading into major problems, because whilst training schemes are currently full, which is good news, they are not going to kick through for a few years, and in the meantime, we are going to lose vast numbers of GPs in their mid-50s who are just getting out of the system... people feel undervalued... (National GP Lead 2, Interview 6)

GPs within and outside GM were described as often frustrated and dissatisfied with the system and many areas had schemes aimed at keeping them in the workforce. These were focused either on widening GP skills (such as clinical supervision skills) or schemes enabling doctors to work differently, often by making their careers more portfolio based:

...we started to promote the idea of doing the PRiME [Professionals in Medical Education] training, having medical students, being a mentor, because they've got a wealth of experience, and if they could mentor some of our First Five GPs and keep them involved in that way... looking at other roles that they can do that may be not be directly face-to-face patients with unrealistic expectations, but still keeps them in the workforce and then takes the people who want to see patients into seeing patients. So that's the GP Career Plus work that we'd started to develop, and then we've done a bit more with it from the GM retention bid. (GP Provider Lead, GM Area 3, Interview 11)

...we have worked very hard to change nationally the... Retainer Scheme, from what it was which was really to deal with people that have possibly physical or mental disabilities that precluded them from working full-time in general practice... [and] young mothers with children... we extended that [to those] with caring needs, effectively, and... to allow people to go part-time,

^{iv} GMHSCP report that, beginning in 2019, these concerns are being addressed by via a consultative approach to supporting and evaluating regional and local initiatives

supported educationally for up to five years, for up to four sessions, salaried as a step down in their retirement. And it's worked very well ...two and a half years ago I think we changed the scheme and we had about ten to twelve retention doctors in the North West and we now have, I think at the last count we had, it's between 65 and 70. We are keeping GPs on and they love it, they really do love it. They keep their hand in, they stay on the performers list, and we encourage them to teach and pass on their knowledge. (Regional GP Lead 4, Interview 7)

More generally, the introduction of a range of new roles professionals was viewed by some as an initiative to help reduce GP workload and encourage GPs to continue in practice. However, others highlighted that time and effort needed to be spent on training and supervising new roles professionals, which could be a further drain on capacity:

...there are certainly some practices in GM Area 1 that are actively using nurses and have seen a real benefit of nurses. I know that there's a pharmacy scheme in GM Area 9... and quite a lot of those practices have taken on the pharmacist that was with them, because they can really see the benefit, not only financially, but workload wise, of keeping them. (Regional GP Lead 3, Interview 5)

I think there is a limit to how much... there is like a sponge holding so much water and training practices that are all enthusiastic about, 'well yeah, let's go and train an ACP [Advanced Clinical Practitioner]'... it has a knock on [effect]... [whether] there is capacity, even amongst the enthusiasts, even if they have got the space and things like that. (GP CCG Lead, GM Area 4, Interview 24)

4.3.2. Retention for GPs nearing retirement age

GPs that were nearing retirement age were also leaving or cutting down their hours, for the same reasons reported among newer colleagues, but with the pension cap seen as more pressing at this career stage:

I think people have decided they don't necessarily want to work until they're 65, or whatever. I think they've filled their pension pot, I think they've got enough to live on, and I think they make the financial decision. I think there are some people who have just had enough. Whether they're burnt out, or whether they are just trying to move before that. And I think a lot of people are cutting back, rather than leaving, so they reduce and then they go... I can see the autonomy with which we always worked, is not quite there anymore. (Regional GP Lead 3, Interview 5)

Because our pensions are capped... we get to the point in our senior clinical lives where there is actually no benefit in working whatsoever. (Regional GP Lead 4, Interview 7)

GM Area 3 reported that they were particularly struggling with retaining GPs and had held information events to help GPs find ways to navigate the pension cap and the financial restrictions it was seen as placing on them.

GPs were described, in many places, as gradually retiring rather than leaving the profession completely. The provision of flexibility in the role, training and new forms of work to keep up interest was frequently seen as helping with retention:

There is a scheme where they're trying to improve skills, so in clinical supervision of other people and things. To give people another string to their bow, to maybe keep them interested in staying in general practice. So, I know that's happening, and I know there's a pot of money available to try and support that. I know that there is the GP Retainer Scheme, across the board, for people who maybe need a little bit more support, who don't want to work so many hours, to try and keep them in general practice, if they would ordinarily have left. So, that's what the GP Retainer Scheme does. (Regional GP Lead 5, Interview 5)

Technology was also said to be being used to retain or reclaim the skills of doctors who were either near to retirement or who had already retired. GM Area 3 was reportedly looking into providing online/skype consultations to enable retired GPs to work from home and avoid the challenges of working in a busy surgery. The use of a single clinical computer system across a geographical area was seen to support this type of online working, as GPs could work across several practices.

The lack of succession planning within GP partnerships as GPs neared retirement age or sought to cut down their working time was seen as a growing problem, particularly in areas which struggled most to recruit and retain doctors:

...they haven't really planned for retirement or succession. And unfortunately we've had several times when a well-respected practice or a practitioner, either they fall ill or are of such an age and they suddenly go, and then the practice implodes into an issue, which takes a huge amount of time for the quality team, for the CCG... and sometimes it has as domino effect on the other practices. (GP CCG Lead, GM Area 1, Interview 20)

Efforts were therefore seen as needed not merely to keep GPs in the profession, but also to help prepare practices for their retirement or withdrawal from work due to unforeseen circumstances.

4.3.3. GPs returning to work

GPs who had taken a career break also needed help to return. Women aged 35-45 years were seen as a key cohort to target here as they were the group most likely to have taken time out. Those who had taken a break longer than two years, however, were required to take the Refresher Scheme and this was seen as a potential barrier to their return. An area outside GM reported embryonic plans to use technology to keep such individuals involved in practice and prevent a complete two year break:

...they've got to then do the Refresher Scheme to come back in and a lot of them are saying that that's a challenge and... to some extent, that makes them have to think twice about whether or not they want to put themselves through... so again, modern technology, we know now that GP surgeries are being asked to deliver extended access, so, you know, let's use modern technology, let's see if we can ask some of the female cohort to use that technology and to still do online consultations, maybe out-of-hours, maybe at weekends, but that keeps them involved, it keeps them up to speed, and it gets us over the hurdle around them having to do the Refresher Scheme to then get back in... (Policy Lead, Non-GM Region 5, Interview 3)

Another approach was the Returner Scheme, seen as mainly applying to GPs who had gone abroad or to another job rather than wholly retiring. This scheme was being promoted across the North West and was reportedly bearing fruit due to key changes that made entry to the scheme performance-based. This meant that GPs who had been working in some other countries as a GP were now eligible for entry:

...so there's lots of promotion of [the Returner] scheme. The numbers have gone up... about two years ago... we had about eight in the North West...we had about 30 last year... so that's a really positive thing about attracting people back. And I think that's 'cause the scheme has changed a little, and so your navigation through the scheme depends on performance. So, if you've been working as a GP in Australia, it's actually quite easy to come back, because you've already been doing the job, it's just somewhere else, whereas other people who've been out of GP for quite a long time, it takes a little bit longer, but it's there to support you. (Regional GP Lead 3, Interview 5)

Though some of these schemes were said to have increased the number of returning GPs, it was felt that better promotion would still be needed in order for an awareness of the schemes to reach all doctors thinking of leaving and those who had already left.

5. Discussion

5.1. Summary

Findings from this study reflect and build on those of prior research which were outlined in our CLAHRC GM literature review on GP recruitment and retention¹¹.

5.1.1. Recruitment of GPs

Broadly, a shift in national policy to increase the number of GP training places and improve uptake aims to strengthen the GP workforce. However, it is recognised that there will be some delay before these GPs are qualified and a rising proportion of newly qualified GPs are choosing part-time working². Although recruitment of undergraduates into Foundation Programmes (FP) and FP doctors into GP training was reportedly rising, the study highlights concerns that this may not result in a corresponding rise in qualified GPs entering general practice. GM training programmes were perceived to fill at rates above the national level. Factors affecting the choice of work location in GM for newly qualified GPs were cited as centrality (relative to the city of Manchester's more affluent suburbs), commutability, proximity to friends and family, and familiarity with the area in which they had trained. However, newly qualified GPs were said to be less likely to choose to work in areas of high deprivation. Areas that were less popular were being forced to make extra efforts to adapt, by pursuing different ways of working or recruitment strategies.

Despite the increase in recruitment and the region's perceived popularity, GPs were prioritising work-life balance and usually did not want to work full-time after qualifying due to perceptions of general practice as stressful, with a heavy workload. Increases in part-time and portfolio working were seen to protect against professional burnout, but the corollary was that workforce gaps could not be completely filled without FTE GPs (or larger numbers of non-FT GPs). Although the flexibility and work-life balance offered by general practice had traditionally been viewed as particularly appealing to women, this was reportedly becoming equally important to male GPs, so that the trend for greater part-time working was becoming a generational rather than a gender issue.

General practice remained a less popular choice among FPs than other specialties due to beliefs (picked up during education and training and from media reports) that it involved a lack of career progression, low levels of intellectual stimulation and that GPs were undervalued. In terms of training, some areas were actively attempting to increase their placement capacity for medical students, viewing PCNs as a potential way of overcoming the limitations of estates and supervision burden (factors which traditionally deterred many practices from taking more students).

International recruitment was perceived not to be performing as well as hoped. However, regional plans reportedly included making wider improvements to learning environments under support from the IGPR programme.

A range of regional and national strategies had been employed to increase recruitment and were thought by some to be having a positive effect. A key strategy was 'image' work to address negative perceptions of general practice and emphasise new models of working which underlined the flexibility, work-life balance and wider career options that appeared to be attractive to trainee doctors. Work was taking place among FPs to address the image of general practice as a lower status specialty too. It was hoped that mandatory rotation of FPs through general practice longer placements would encourage consideration of general practice as a career choice. However, it was noted that this could only have a positive effect if trainees had positive placement experiences.

A scheme to 'parachute' GPs into socially deprived areas had only been a temporary solution as GPs moved when funding ran out. It was suggested that GM could learn from recruitment initiatives in other areas such as encouraging school pupils from socio-economically deprived areas to consider medical training as they may be more likely to stay in an area after training than those from elsewhere.

It was hoped that the Fellowship Scheme for newly qualified GPs announced in the recent NHS Long term Plan would be a way of keeping GPs in the system at a time when they could often be lost.

5.1.2. Retention of GPs

While recruitment numbers are rising, the significant number of GPs leaving or retiring continues to increase general practice workforce pressures¹⁹. The loss of existing GPs (both of retirement age and younger), despite a range of measures to retain them, was seen as a crisis both nationally and regionally. Some perceived this to be exacerbated by fragmented allocation of funding for schemes and a sense of disconnection from policy-makers and funders^v. The main reasons for GPs leaving early or reducing their working time were: burnout from heavy workload and a lack of work-life balance; feeling undervalued; encountering barriers to returning after career breaks; and the pension ceiling. A lack of succession planning within GP partnerships was highlighted as a growing problem in GM.

Retention efforts were focused either on widening GP skills (e.g. in clinical supervision) or enabling GPs to work differently, often by extending roles/working part-time. The introduction of a range of new roles professionals was viewed by some as helping to reduce GP workload and encourage them to stay; although this increased the time needed for training and supervision which could be a further strain. Some areas were attempting to support GPs to navigate the pension cap;

^v GMHSCP report that, beginning in 2019, these concerns are being addressed by via a consultative approach to supporting and evaluating regional and local initiatives

others were considering online/Skype consultations to enable retired GPs to continue working from home. Online working was also seen as a potential way of keeping GPs who were on career breaks involved in work, avoiding the need for refresher training (a known barrier to returning to practice). Another scheme was reportedly helping GPs who had been working in other countries and then returned to the UK, to re-enter GP work. While some of these schemes were said to have increased the number of returning GPs, better promotion was needed to reach doctors thinking of leaving and those who had already left.

5.2. Conclusions

5.2.1. Recruitment of GPs

Positive clinical placement experience in general practice is one of the factors that can influence doctors' choice of specialty²⁰. This was certainly a view reinforced by the findings of this study and emphasises the importance of support for GM general practices to understand and demonstrate commitment to become a positive and attractive training environment.

It is known that undergraduate experiences in medical school influence career choice²¹, and that negative views of general practice can discourage consideration of this specialty²². The reports of a lack of respect for general practice during education and training that have been found in other research¹⁹ were also heard in this study. GP leaders have called for respect between medical professionals to combat this²³. Links between GP training programmes and local medical schools could be fostered to encourage the formation of positive perceptions of general practice, both at medical school and in training environments. GP involvement in undergraduate medical student selection and clinical teaching to counteract negative attitudes is one strategy that has been suggested to address this, but this approach has not been evaluated¹⁹.

A key challenge is designing a GP role that doctors wish to do. To this end it has been suggested that recruitment strategies need to highlight the many different roles associated with general practice²⁴. There was certainly a view in this study that GPs of the future intend to work only part-time or in portfolio roles in general practice. Creating flexible employment opportunities to sustain recruitment will therefore be important; however, planning must take into account these part-time working plans in any estimation of GP workforce capacity/requirements. Other challenges for job design are that, although many GPs report wishing to work as partners within GP organisations, GP partner vacancies remain high²⁴. Additionally, findings suggest that trainee doctors may perceive limited opportunities for intellectual stimulation/skills development if they choose general practice. Future GP job design could ensure that the GP workforce has opportunities to, for example, do research or teaching and otherwise improve their skills; these offerings also need to be communicated effectively to undergraduates and FP doctors.

It was perceived that trainees in GM viewed this region as a desirable place to live, train and work but that this was geographically dependent. One of the inhibiting factors was seen to be intensive working in areas of high socio-economic deprivation. Ensuring that trainees and working doctors have the opportunity to serve mixed populations could be a component to consider including in future GM training offers for potential GP trainees.

While flexibility and part-time working were seen to be elements of general practice that were valued by both male and female trainees/working GPs, higher proportions of female doctors choose this specialty^{25,26}. Gender needs to be factored into recruitment plans, because more doctors will probably need to be recruited to meet the demand for flexible, part-time, salaried working.

The recruitment of international GPs was viewed in this study as having failed to live up to its promise. Indeed, of the 2,000 hoped-for international GPs between 2017 and 2020, only 85 were obtained in the first year, and the long lead-in time has been a downside²⁷. Although the number of applications are said to be increasing²⁸ it is clear that this recruitment drive alone will not adequately fill current gaps.

5.2.2. Retention of GP's

The reasons for GPs retiring, leaving the profession early or failing to return after a career break that were found in this study reflect those identified in previous literature, including dissatisfaction with organisational churn, increasing workload, negative portrayal in the media, lack of support and feeling undervalued^{29,30}. A GM-focused extract of the Ninth GP WorkLife Survey¹² showed that a third intend to leave the medical profession and/or direct patient care in the next 5 years. While a slightly higher percentage of GM GPs reported satisfaction with their working hours compared to the national sample and were 7% more likely to agree their work was flexible, 61% of GM GPs reported high/considerable pressure due to worry about patient litigation, which was almost 8% more than the national sample. Just over three-quarters of GM GPs agreed/strongly agreed that their work provided variety (4.49% less than the overall sample).

Funding and schemes to address retention and return to work across the working lifespan are in place³¹ (such as enabling existing GPs to develop portfolio careers or sub-specialisations³²) but have yet to be evaluated. The recent national toolkit issued by NHSE and NHSI, which is focused primarily on GP retention, is one scheme that emphasises portfolio working as a positive aspect of the GP role³³, although time is needed to assess its effectiveness.

The Retainer Scheme (originally aimed at preserving the skills of doctors by supporting them to reduce clinical commitment due to caring responsibilities or health reasons) and the 'Induction and Refresher' scheme (aiming to reintroduce GPs to practice following career breaks and as an entry for EU doctors) are two schemes that have been evaluated³⁴, with indications that subsequent GP working

years can result in good value for money. Uptake of the Retainer scheme, however, has been slow³⁵, suggesting a need for increased promotion of these types of initiatives among doctors.

There are indications in the literature that more consistently applied support/incentives may be needed for those returning to work after having children (particularly, but not limited to, female GPs)^{36,37,38}, and this was echoed in the current study too.

Additionally, this study highlights a number of other concerns in relation to retention. There were general concerns about finding no guaranteed way of retaining the existing GP workforce to date and a sense of disconnection from policy-makers and funders in relation to retention scheme planning and resource allocation^{vi}. There were also concerns that introducing non-GP new roles professionals to help with GP workload may not be time-saving in the long-run. More specifically, an urgent need for succession planning across GM for GPs retiring or leaving was highlighted.

The study highlights a number of other solutions being pursued by different areas e.g. supporting GPs with personal finances or online/skype working; however, these were being trialled in particular areas of GM in isolated pockets of activity^{vii}.

The NHS workforce implementation plan is expected later in 2019; meanwhile, the LTP is seeking to build on the GPFV by increasing the number of GPs through the two-year Fellowship Scheme for new GPs (offering a secure employment contract with a portfolio role tailored to individual/local needs)⁵. The plan also includes commitments to afford doctors adequate time for supervision, enable them to broaden the scope of their practice during and after training (with an emphasis on developing the generalist skills needed to meet the needs of an ageing population, alongside acquiring specialist knowledge and skills). Again, time is needed to assess whether these measures have any effect on the retention of exiting GPs in the general practice workforce.

5.3. Key messages

Key messages from this study.

5.3.1. Recruitment of GPs

- 1) Recruitment into GP training places has increased but may not translate into a corresponding increase in qualified GPs entering general practice to fill gaps completely.

^{vi} GMHSCP report that, beginning in 2019, these concerns are being addressed by via a consultative approach to supporting and evaluating regional and local initiatives

^{vii} Ditto above

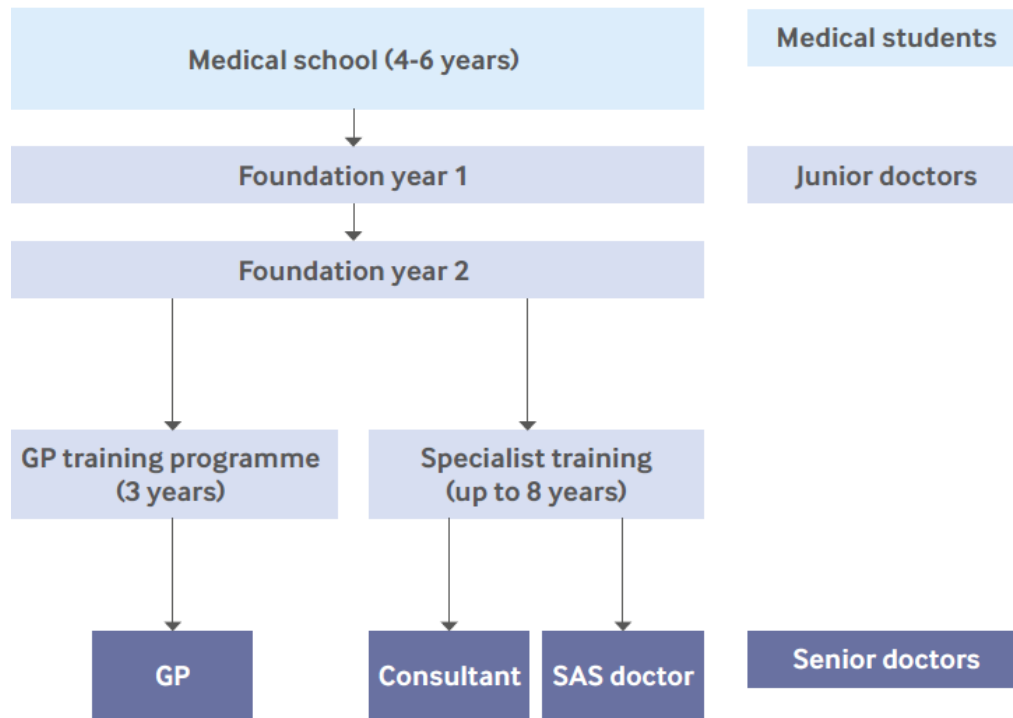
- 2) General practice was perceived as a less attractive medical specialty involving a negative work-life balance, a lack of intellectual stimulation and career progression, and the potential for professional burnout. Work to tackle negative perceptions of general practice needs to continue with an emphasis on promoting the job as flexible, with a range of working options/contracts and opportunities for research, teaching and other skills improvement.
- 3) Positive clinical placement experience can encourage undergraduate and trainees to choose general practice but negative experiences can be a deterrent; general practices need support to become positive and attractive training environments.
- 4) GPs of the future (both female and male) intend to work largely part-time or in portfolio roles; flexible employment opportunities to sustain recruitment are needed, but planning must take part-time working intentions into account.
- 5) GM was viewed as a desirable place to live, train and work but this was geographically dependent. Intensive working in areas of high socio-economic deprivation was viewed negatively and the opportunity to serve mixed populations might be factored in to future GM training offers.

5.3.2. Retention of GPs

- 1) Factors that are influencing GPs to retire, leave the profession early or fail to return include: a lack of work-life balance; professional burnout; the pension ceiling; obstacles to returning after a career break; and feeling undervalued.
- 2) Schemes to address retention and return to work across the working lifespan have focused on widening skills or enabling GPs to work differently, but have yet to be evaluated.
- 3) While some schemes were perceived to be having positive effects, uptake could be slow, suggesting a need for increased promotion of these types of initiatives among doctors.
- 4) The lack of a systematic approach to GP succession planning was seen to be a growing problem in GM
- 5) There was a reported sense of disconnect between regional policy-makers/funders and GM areas in relation to the planning and resource allocation of retention schemes; isolated pockets of activity suggested the need for a more consistent regional approach to GP recruitment and retention.

6. Appendices

Appendix 1: Journey through medical training



(Diagram reproduced from³⁹ Figure 1 p.8)

Appendix 2: GP role definitions

Reproduced from^{39,40,41}

GP partners: GP partners are self-employed independent contractors who supply general medical services to a registered patient group. They are responsible for the employment of clinical and administrative staff, and for provision of suitable premises. The workload undertaken by GP partners varies widely and depends on many factors including their individual level of commitment (i.e. partnership share), organisational working practices, patient demand etc. GP partners normally share the profits and losses of a practice. A legal agreement governs how GP partnerships operate and make decisions; partnership is therefore usually regarded as a longer-term commitment.

Salaried GPs: Salaried GPs are fully trained GPs who work as contracted employees in GP practices. Their work can be described in a job plan which describes the extent of their clinical and administrative duties and for which they receive a salary. Their involvement in the organisation of the practice/s where they work varies from one practice to another. Working as a salaried GP may be a temporary or longer-term appointment.

Locum: A locum doctor is a fully qualified doctor who is temporarily covering a position, for example, if a doctor is on sick leave. In general practice, locum GPs are fully qualified in general practice and are registered with, and regulated by, the GMC.

GPwER: GPs with Extended Roles (GPwERs) undertake roles that are beyond the scope of GP training and require additional training. The term GPwER includes those previously referred to as GPs with Special Interests (GPwSIs) and activities such as teaching, training, research, occupational medical examinations, medico-legal reports and cosmetic procedures.

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