

## GP Workforce survey 2018

This survey was designed for the GP Partnership Review by Wessex Local Medical Committees. The aim was to seek the views of all GPs working in England on the current challenges facing General Practice. Participants were also asked about the potential solutions to these problems.

GPs were invited to complete an online questionnaire which was open between 19<sup>th</sup> November to 25<sup>th</sup> December 2018. Invitations were sent via email to GPs on databases of Local Medical Committees, the General Practitioners Committee of the BMA and RCGP.

3182 responses were received. The key facts and discussion are presented below.

This unique piece of work has given grassroots GPs the opportunity to express their views. In turn this has formed part of the information gathering exercise for the GP Partnership Review and helped in the development of the key recommendations made to the Government and NHS.

### Key facts

3182 responses were received.

#### Status of respondents (GPs may have more than one role)

GP partners	71%
Salaried GPs	17%
Locum GPs	10%
Retainer GPs	1%

#### Gender of respondents

- There were an equal number of responses from male (n=1576) and female (n=1580) GPs
- There were more male than female GPs in the older age group
- There were more female than male GPs in the younger age group

More male GPs who completed the survey were partners (79%) compared to female GPs (63%). Female GPs were slightly more likely to be salaried GPs (24% compared to 11% for male GPs) and the % of GPs who were locums was about the same.

#### Age spread of respondents

There was a fairly normal distribution across the ages of the respondents.

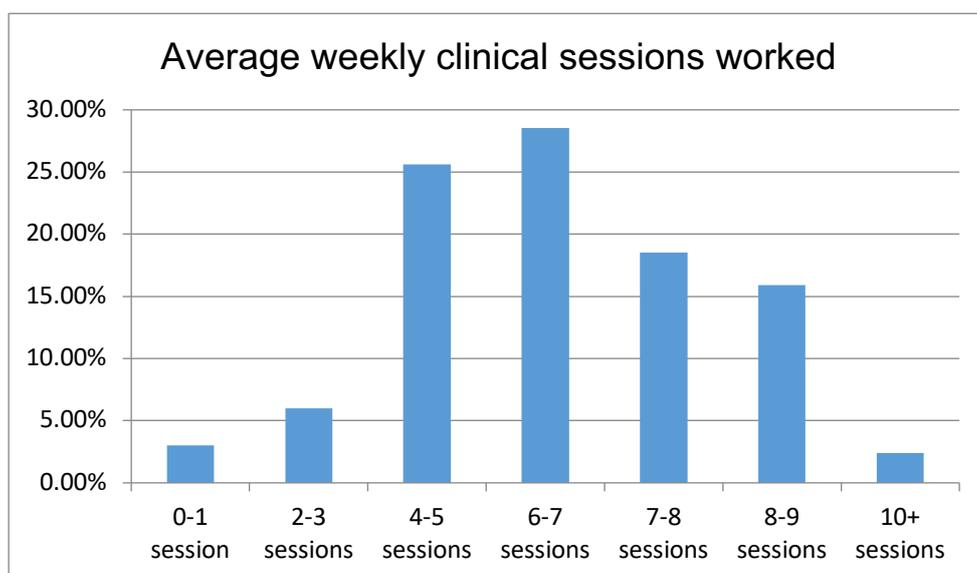
Age between 25 and 34 years	7%
Age between 35 and 44 years	28%
Age between 45 and 54 years	36%
Age between 55 and 64 years	26%
Age between over 65 years	2%

#### Stage in career of respondents

- 18% consider themselves early in their career
- 35% consider themselves in the middle of their career
- 47% consider themselves in the later stages of their career

## Sessions worked in a week by GPs

To understand more about current working patterns in Primary Care GPs were asked how many clinical and non-clinical sessions they work in an average week.



*It should be remembered that a session is described as ½ a day.*

*For a GP this would be a minimum of 5 ¼ hours (8am – 1.15pm and 1.15pm – 6.30pm) but many GPs will start before 8am and many will finish well after 6.30pm. Therefore with a full-time role being 37.5 hours this would equate to working 7 sessions per week.*

Female GPs were more likely to work less than full time. Just under 50% of female GPs worked 5 sessions or less compared to 21% of male GPs.

### Non-clinical sessions

Over 50% of GPs indicated that they were working 1 or more non-clinical sessions a week.

When comparing stage of career there is very little difference between the mid and later career GPs however more early career GPs report working no non-clinical sessions.

Number of non-clinical session a week	Early career	Mid-career	Late career
None	58%	45%	47%
1-2	32%	35%	36%
3+	10%	19%	16%

Areas of non-clinical work were varied and some GPs have more than one non clinical role.

Roles included Research, Education, Management, CCG work, Business, LMC, Research, Appraisal, Leadership, Medical Advisory, Mentoring, Quality Improvement work, Digital/Innovation roles, Federation and Community engagement roles.

## Future intentions

### The survey asked GPs what their career intentions are in the next 2 years:

- 4% intend to increase the number of sessions worked

This was predominantly in early career GPs.

Of the male GPs only 2% are intending to increase their sessions worked compared to 6% of female GPs.

- 48% intend to continue working the same number of sessions

54% of early career GPs are intending to continue working the same number of sessions, this increased to 58% in mid-career but fell to 36% in later career GPs.

Of the male GPs 43% are intending to continue working the same number of sessions compared to 52% of female GPs.

- 36% intend to reduce the number of sessions worked

39% of male GPs reported intending to reduce their sessions compared with 28% of female GPs.

This planned reduction in sessions work was consistent across the age groups. While this was expected in later career GPs it is a surprising find and worrying sign in the early career GPs groups.

### Notable trends identified

- 9% of all respondents intend to stop clinical practice in the next 2 years

There is a difference seen in different career stages.

3% of early career GPs intend to stop clinical practice, 5% of mid-career GPs and 15% of later career GPs.

The gender spread was similar.

- 10% were intending to retire early (*within the next 2 years*)

20% of late career GPs and 7% of mid-career GPs intend to retire early

- 11% of early career GPs intend to stop clinical practice, emigrate permanently or leave NHS work

### For those who were going to reduce their clinical commitment or stop clinical practice they were asked to provide a reason for this decision.

Workload was the most cited reason for GPs indicating they intended to stop clinical practice. This was closely followed by stress/burnout. This was consistent across all stages in the career.

Issues with workforce and recruitment and family commitments were also reasons to stop clinical practice across all generations of GP.

Pensions are given as a significant reason for stopping clinical practice in the later career GPs.

### For those who indicated they are intending to reduce their clinical commitment or stop clinical practice the following were the top ranked interventions that would assist in keeping them in clinical practice.

- Reduced number of patients seen in a day and/or extended appointment length
- Protected and funded time to manage complex patients
- Protected and funded time to mentor others
- Facilitate your development of a portfolio career

These findings were consistent across all career stages and there was no difference in terms of gender.

## **Sessional GPs (salaried and locums) were asked if they would consider being a partner in the future**

- 19% answered yes potentially
- 26% answered they would see what happens to general practice
- 53% answered they would not consider it
- 2% undecided

Female GPs were more likely to consider partnership (55%) compared to their male colleagues (46%).

## **Sessional GPs (salaried and locums) were asked to rank factors that would help for them consider being a partner in the future.**

- 37% reported flexible working time around family being the most important factor
- 30% reported reduced financial risk of the premises being the second most important factor

Female GPs were more likely than their male colleagues to look for a well led practice that offered more flexibility for the working week.

## **Sessional GPs (salaried and locums) were asked how much the last person standing term influenced their decision in terms of taking up a partnership.**

- 5% not aware and would not influence them
- 10% not aware but would make them less likely to become a partner
- 16% were aware of the issue but it did not influence their decision
- 68% were aware and would make them less willing to consider partnership

## **Would a portfolio career help GPs prolong their career in general practice?**

- 42% reported it probably would
- 21% said it definitely would
- 21% said it wouldn't
- 16% were not sure

Of the 3182 GPs who completed the survey 2034 left free text comments on how to retain GPs. The themes presented in these comments were the same that the Review heard during the consultation period. The predominant themes are presented below with comments received.

### **Workload**

*"The "all you can eat buffet" model of GP is unsustainable"*

*"The admin pressures and workload dumping on general practice is the biggest current concern and cause of burnout. I work a 12 hour day but spend half of that on the admin workload related to patients. Increasing culture of hospital transferring work to general practice/ requests for clinical notes under GDPR with no funding attached to account for time required to provide this/ multiple organisations referring everything they don't want to deal with to the GP to sort. Even a letter back to refuse inappropriate takes up more admin time! More funded back office support which could potentially be delivered at scale may help this. E.g. an external service where data requests can be processed and third party references removed without having to be done at a practice level."*

### **Workforce development**

*"There needs to be more flexibility for doctors in later career. Their skills need to be used for mentoring, education or seeing complex patients - wherever the GP's special interest is. I have worked full time for most of my life as a partner devoting 100% work life to the practice. There were little opportunities to be a portfolio GP then. Most of my peer group would welcome new imaginative opportunities for work relating to primary care."*

*“Really, we should have a great job - our work is interesting, varied, working with people and hopefully making people's lives better. So why isn't this the case? We need longer time with patients, at least 15 minutes per appointment. We need to be valued, not just by other staff but by patients. I like the idea of the 'GP consultant' role. More input into mental health - I don't need to see half the mental health patients that I do - they can be seen by someone a lot cheaper and with more time etc. Make the job more enjoyable and people will stay*

#### **Risk**

*“GP's are bashed from every side, no support from anyone, constant criticism, hours far too long, asking to do more complex tasks look after extremely complex patients with no improvement in staffing, time, facilities/community services. Out in GP land you are exposed and vulnerable, everyone happy to knock you, online insults etc, every trainee I've spoken too will not work in such a vulnerable and unprotected environment, I look forward to throwing in the towel as soon as I can.”*

*“I have already changed from being a GP partner for many years to being a locum GP. The financial aspects of partnership are not risks I need to take towards the end of my career.”*

#### **Status**

*“Morale is low. There needs to be a change in the culture of how doctors are treated, and respected. We are practising more and more defensive medicine in fear of being sued, or facing a complaint, some of which may be malicious. While it is right that patients should be in the centre of their care, sometimes the pendulum has swung too far and people with unreasonable requests or demands of the NHS take up far too much time and energy. It is due to this small number of unreasonable people that makes me want to leave clinical practice.”*

#### **Expectations**

*“Somehow challenging the public's unrealistic expectations”*

*“Morale is low because of expectations....patients, hospital colleagues, other community teams. Rather than all being on the same page/team, it all seems to be about shifting responsibility and eventually it lands on the GP's lap to sort....e.g. no appointments in dressing clinic, shortage of medication in chemist, appointment with cardiology 6 -9 month wait, elderly patient with dementia wandering the street because social services stretched, Refer for talking therapy and they get computerised CBT which does not resolve their ongoing problems...all end with see your GP. Firefighting these issues alongside trying to manage chronic complex medical problems (which is what we are trained and are meant to do) in 10 minute (impossible) just wears you down and leads to burn out. Oh and add in the infinite number of boxes that we need to tick in order to get the finances to pay for dealing with all of the above.”*

#### **Pension issues**

*“Sort out the pension issue. It is not financially viable for me to continue working. I do not want to retire. If I wasn't doing my extended MSK clinic I would have retired from general practice before now. I am only 55.”*

#### **Partnership model strengths**

*“Promote the GP Partnership model. Abandoning this is unwise for the NHS generally. GP Partners drive management of practices in a lean way with which no other model of care can compare.”*

## Discussion

This survey is important as the findings quantified and agreed with the views that the Review team have heard during the various meetings that have been held around England. The Review team received written comments but also heard verbal feedback from practices, Partners, Salaried GPs, Locum GPs, Practice Managers and Practice Nurses. The results also reflect the views of organisations who represented GPs that the Review engaged with.

A strength of the survey is the number of GPs who responded. 10% of all GPs in England participated and this can therefore be considered a reasonable sample of views. However with all surveys there are always limitations. Caution is advised when interpreting the results as the survey may have over-represented those with the strongest views or with time to complete the survey.

It does show a good overview of current practice. Over 2/3<sup>rd</sup> of the GPs are working more than 37.5 hours a week but an increasing number are reducing clinical sessions with non-clinical sessions. Many commented on the workload and the associated intensity of work caused by managing more complex patients and reducing clinical sessions is a way they are trying to cope.

When asked what their intentions were in the next 2 years, just over 50% said they would remain working the same number of sessions or increase them (48% stay the same and 4% increase them). What should be of great concern is 9% intend to stop clinical practice, 10% intend to retire early and 36% intend to reduce the number of clinical sessions worked. These findings should be a major concern for the NHS because if these views are reflected across the whole of the NHS and nothing changes in the next two years the NHS is going to face some significant problems.

To reverse these trends general practice needs to be made a better place to work and this means addressing the issues identified by the majority of GPs.

Workload is reported as the major issue, this has increased significantly over the last 5-10 years and has now reached a level for many whereby the working day has become too long, the intensity of work too great and GPs do not have sufficient time to manage complex patients appropriately. All of this leads to increased levels of stress and burnout and will in turn compound the workforce shortage. The free text responses in this survey confirmed this.

The workforce is no longer considered sufficient to manage patients in the community. There may be many reasons for this. One theme heard consistently in this piece of work is that this may relate to the loss of the wider primary care team with community nurses no longer working closely with practices. Additionally mental health management has become a much larger part of general practice's workload yet there is significantly less access to mental health services and a lack of support and practice level. The lack of social care has a direct impact on practice workload and finally as hospitals have seen an increase in workload more work has fallen to general practice as a result of poorer access to hospital based services.

Our own GP workforce in turn has changed over recent years. The need to look after children and also elderly relatives means that more GPs require, expect and hope for greater flexibility in their working lives to allow them to undertake these family responsibilities. Lack of flexibility in the working week was considered an issue by a significant number of GPs. This was more likely to be a view expressed by female GPs but not exclusively. This survey also demonstrates the known gender difference that currently exists between the generations of GPs. There are more females in early career roles. It has been reported repeatedly that the profession loses many female GPs in the mid 30s – perhaps the explanation for this is family commitments and the lack of flexibility that now exists in many practices. This is an area that practices or groups of practices could start to address in terms of increasing their capacity by offering some more family friendly roles and trying to retain more GPs who when circumstances change may have the potential to increase the number of sessions worked in general practice. This provides General Practice with a real incentive to innovate and retain valuable GPs. It is time to re-consider and flex the working day.

The issue of pensions and taxation cannot be ignored. The survey results show this clearly. The reality is that for many GPs in the later stages of their career they are likely to see a significant impact following the reduction in the lifetime and annual allowances. This has resulted in many GPs in the mid to late 40s facing significant tax bills and as a result becoming disillusioned with the NHS Pension scheme and either opting out of this or reducing the number of sessions worked.

In terms of taxation the loss of personal allowances has resulted in GPs being advised to reduce the sessions they work. Depending on their personal level of income by working fewer sessions they could lose only a small amount of net income or in some cases their net income will increase. This therefore may act as a disincentive to later career GPs to remain in the working population or work as many sessions as they would like. Many later career GPs commented that they did want to work more but these rules make it less financially efficient. This therefore compounds the workforce shortage and is allowing the profession to lose this expertise.

The survey is clear to revitalise the partnership model the current workload in general practice needs to be addressed. GPs need to regain control of their working day and to achieve this they need to reduce the number of patient contacts and to have more time to manage complex patients. To achieve this the GP workforce needs to be increased and a greater percentage of it needs to be in substantive roles such as GP Partners or Salaried GPs. The non GP workforce needs to be expanded but these roles must be supporting GPs and be able to 'take work' off GPs to free up some of their time and reduce the number of patient contacts. Also there needs to be a focus on delivering care within a community and a re-establishment of the primary care team, co-located with general practice but also working as part of the same team having the same case-load using a common health record.

In all this survey has provided input from real GPs into the workforce issues. More GPs will become partners if there is a positive future for general practice which is clear and addresses the issues discussed above. Flexibility, greater opportunities and a reduction in the significant risks of being a partner are definite starting suggestions to allow the workforce to grow.

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