NIHR | Collaboration for Leadership in Applied Health Research and Care Greater Manchester

Greater Manchester Primary Care Workforce Project (GMWF)

Report for Work Package 2D: Recruitment and Retention of GPs in Greater Manchester
(Focus groups with current FP doctors & GP trainees)

Working in collaboration with:

The 10 Clinical Commissioning Groups across Greater Manchester

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1. Executive Summary

This report presents a study of the factors influencing the decisions of Foundation Programme (FP) trainee doctors and GP trainees to specialise in general practice and continue working in 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 general 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 of GPs), GMHSCP engaged NIHR CLAHRC GM to investigate the views of trainee doctors about specialising in general practice and continue working in Greater Manchester (GM).

1.2 Methods

The study was an in-depth qualitative exploration of trainee doctors' views on the factors influencing their decisions about specialising in general practice and continuing to work in GM. It was informed by a rapid scoping review of the literature on the recruitment and retention of GPs and involved thematic analysis of four semi-structured focus groups with 36 trainees (32 FP doctors and four GP trainees) from two areas in GM.

1.3 Findings

FP doctors' perceptions of being a GP were fairly negative, reflecting the belief that GPs experienced poor job satisfaction, a heavy workload, a lack of variety and low levels of intellectual stimulation.

In contrast, a small number of GP trainee participants reported choosing general practice for its variety and in the hope of a better work-life balance and greater flexibility compared to other specialties.

Importantly, full-time general practice was seen as unfeasible due to perceived detrimental effects on wellbeing and relationships outside of work.

All GP trainees intended to work part-time in portfolio careers combining their GP work with other components, such as working in a specialist clinic or educational setting.

Both FP doctors and GP trainees saw GM as an attractive region to live and work because it offered a mixed population with a balance of patients and attractive places to live that were easily commutable.

1.4 Discussion

General practice was perceived to involve a heavy, time-pressured workload and was regarded as a relatively low status medical specialty. The derogatory comments about GP work in medical schools reported in other studies were also echoed among doctors participating in this study during their training in GM.

Also reflecting the prior literature, participants saw general practice as offering the potential for a better work-life balance; however observations were that many GPs were over-stretched by excessive workloads and full-time general practice was not a sustainable career choice due to the potential for professional burn-out. GP trainees were planning to limit their commitment to GP work through portfolio working to accommodate their interest in other specialties/additional roles.

The importance of positive general practice placement experiences in attracting trainee doctors into the profession was emphasised, as negative experiences during placements could have the opposite effect. Working in practices with an on-going commitment to peer support could overcome the sometimes isolated nature of general practice working and offer shared learning communities to both trainees and staff.

There were mixed views of the current drive towards the introduction of a wider range of practitioners in practice teams to deliver patient care alongside GPs. Some roles were seen as valuable in taking away routine work from GPs to reduce their workload but others were seen as a potential threat, fragmenting the GP role by undertaking selected tasks while leaving GPs to deal with the most time-consuming and complex work.

In contrast to some other areas in England and particularly in the North West, GM was seen as a desirable place to live, train and work. The region offered participants attractive locations to live and was recognised as offering excellent undergraduate, FP and GP training. In addition, the socio-demographically varied GM population was considered to

contribute towards balance and professional stimulation through working with mixed populations.

1.5 Key messages

a) Negative perceptions of general practice and GPs continue to influence the career choices of students in medical school;
b) Negative views include perceptions that general practice is monotonous, unfeasible due to time pressures and intellectually unchallenging, with little opportunity for career advancement or personal development;
c) Work-life balance and flexibility continue to be among the most powerful factors motivating trainees to pursue general practice, along with a strong preference for portfolio working;
d) Direct experience of general practice through placements can counteract negative perceptions: however, poorly supported placements in challenging contexts can also reinforce such negative views;
e) Isolation in practices experienced during placements can also deter trainees from committing to general practice;
f) Mixed views were evinced on skill-mix changes in general practice, with perceptions that this may reduce GP workload or that it may intensify work-pressures on GPs by taking away simpler cases;
g) On balance, GM was seen as a relatively attractive place to work, with mixed populations offering a variety of patients.

2. Background

2.1 Recruitment of GPs: a national primary care workforce challenge

The number of GPs in England has declined in recent years and general practices are facing continuing challenges to recruit and retain doctors while providing care for an ageing population living with increasingly complex health needs [1]. Recent estimates demonstrate that England had 6% fewer full time equivalent (FTE) GPs in September 2018 than in 2015 (2,500 fewer than required, a number which could rise to 7,000 by 2024 according to current trends) while demand has risen[2].

The 2016 General Practice Forward View (GPFV) heralded a new national policy focus on addressing the increasing workforce pressures in general practice[3]. Key priorities were the recruitment and retention of GPs (and practice nurses), along with the recruitment and integration of other health professionals into the primary care workforce to redistribute the workload. However, the GPFV's goal of another 5,000 GPs by 2020 has not so far been delivered and the target looks unlikely to be reached[4].

The NHS in England has been struggling to fill GP training programme places for a number of years. Our prior NIHR CLAHRC GM literature review on GP recruitment and retention highlighted that the number of UK medical graduates choosing general practice were low and decreasing and that a range of factors influenced the decision to go into general practice or not[5]. Factors that discouraged young doctors from entering general practice included hearing negative reports of GP work while at medical school, as well as the framing of general practice as a lower status medical specialty with increased workload; a lack of career progression; poor pay; and an associated lack of respect. Factors that encouraged consideration of general practice as a specialty were fewer, but included having positive experiences of general practice clinical placements and the view that general practice might offer a better work-life balance and job satisfaction than other medical specialties. The review also identified a number of strategies to improve early orientation towards general practice, such as: improved funding for clinical placements; encouragement of respect between medical professionals; promotion of inspirational GP role models; and improving the public image of general practice through outreach work in schools and with the public. However, evaluation of these strategies has been lacking and it is not yet clear how far these initiatives are working. While the number of GP training places and the fill-rate have increased, with almost 500 more trainees entering the 3-year training programme in 2018 compared to 2015/16 (up from 2,769 to 3,250), the extent of their entry to substantive GP work on completion of training remains to be seen[2].

2.2 The Greater Manchester workforce strategy

In GM, a fifth of current GP trainees reportedly plan to move abroad in the next five years[6]. 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[7,8]. 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 the heart of services, requiring changes in how the future workforce is developed and sustained[6]. Key priorities for delivering an integrated health and care model in primary care involving a multi-skilled, multi-professional workforce are to[6]:

- 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'.

2.3 Study aim

To inform the development of their primary care workforce strategy (and in particular the recruitment of GPs), GMHSCP engaged NIHR CLAHRC GM to investigate the factors influencing the decisions of Foundation Programme (FP) trainee doctors and GP trainees to specialise in general practice and continue working in GM.

3. Methods

We conducted a qualitative study to understand the factors influencing the decisions of young doctors to specialise in general practice and work in GM. To gather a range of stakeholder views, GM-based participants were sampled purposively by professional role in the following groups:

1) FP doctors;
2) GP trainees.

Emails were sent to all General Practice Specialty Training Programme leads and all Foundation Programme training leads within GM, asking that they pass on study details to potential FP or GP trainee participants. In addition we sought to recruit GP trainees through contacts in HEE North West, RCGP North West and through the GP Lead of a GM area training hub. To minimise inconvenience, participants were invited to take part in

focus groups immediately after a scheduled group training session. (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).

A focus group interview schedule (Appendix 3) was developed from the rapid NIHR CLAHRC GM review of the literature on factors influencing the recruitment and retention of GPs[5]. Questions focused on two areas:

1) Factors influencing the decision-making process of FP doctors when selecting specialism;
2) Factors influencing the decision-making process of FP doctors and GP trainees when considering GM as a longer-term location in which to work.

A University of Manchester ethics committee gave ethical approval for the study. Focus groups were conducted between March and May 2019. With consent these were audio recorded, transcribed and anonymised before being exported to NVivo software[9] and analysed thematically using a combination of pre-determined and emergent codes[10]. The focus was on identifying overarching factors influencing decisions around choice of specialism and location.

4. Findings

4.1 Participants

Four focus groups were carried out in total (three with FP doctors and one with GP trainees). A total of 36 trainees took part (32 FP doctors and four GP trainees) with a fairly even gender split. Table 1 presents the final sample. GP trainee recruitment numbers remained low despite several attempts to recruit from a wide range of sources and take steps to mitigate difficulties (such as avoiding clashes with exam pressures and making recruitment attempts at different stages of training e.g. GPST2 and 3). Therefore, the sample is not evenly balanced and the views of GP trainees are under-represented.

Table 1. Final study sample (FP doctors and GP trainees)

Focus group type	Number of participants	Gender split of participants
FP doctors		
Focus group 1 GM Area 7	10	4 female; 6 male
Focus group 2 GM Area 7	10	6 female; 4 male
Focus group 4 GM Area 2	12	7 female; 5 male
Sub-total	*32*	*17 female; 15 male*
GP Trainees		
Focus group 3 GM Area 2	4	2 female; 2 male
Sub-total	*4*	*2 female; 2 male*
TOTAL	**36**	**19 female; 17 male**

4.2 FP and GP trainee perspectives on general practice

In general, FP doctors' perceptions of being a GP were rather negative, reflecting the belief that GPs experienced poor job satisfaction, a heavy workload and lack of variety. In contrast, the small number of GP trainee participants spoke about choosing general practice in the hope of a better work-life balance and greater flexibility compared to other specialties. Variety in the job was also a reason for choosing general practice, but generally via portfolio working where part-time GP work could be combined with other roles/components, such as working in a specialist clinic or educational setting. Full-time general practice was perceived as detrimental to wellbeing and relationships outside of work.

Key perspectives from participating FP doctors and GP trainees gathered are presented in more detail under three main themes:

1. Perceptions of GP working life (including workload; work-life balance and portfolio working; risk and defensive practice and working in GM);

2. Experiences of learning (including training; shared learning and skills development);

3. Perceptions of professional roles in general practice (including the professional status of the GPs' role and skill-mix changes).

4.2.1. Perceptions of GP working life

4.2.1.1 Workload

FP doctors held fairly negative perceptions of the workload in general practice. They reported increased stress levels due to the expectation of completing consultations within a ten minute appointment. Participants felt they would be unable to assess patients safely and effectively within this timeframe, a situation made more challenging by the delegation of some routine tasks to other healthcare professionals, leaving GPs to deal with more complex patients. This time pressure had the potential to increase working hours as GPs would have to catch up on other aspects of their work later in the day:

> *It's kind of an impossible job, and that's what most of the senior GPs say, especially with the targets set, like the NHS, the Government, ten-minute appointments, everything. It's impossible to do a whole clinic of ten-minute appointments. And I don't think I've ever seen one of the GPs finish even close to on time, just because they can't…and then you finish late. So really it's an impossible job to do it as expected. (FP4: Focus group 1, GM Area 7)*

Doctors reported that general practice was so stretched that GPs sometimes saw patients on days reserved for administration duties, meaning that they had to catch up with administrative work in their own time, compounding the long-hours culture:

> *I know GPs have admin days as well, and on so many of the days my senior GPs would actually have patients booked up …they don't actually have their time to do all of the catch up…all of the other work you have to do is not well fitted within the work hours I think. (FP8: Focus group 2, GM Area 7)*

4.2.1.2 Work-life balance and portfolio working

Despite negative views expressed about workload, some doctors felt that GPs had better potential for work-life balance than doctors working in other specialties. A better work-life balance was a recognised component of GP trainees' decision to choose general practice and was a factor that FPs found appealing. Avoidance of weekend working and night shifts was seen as a potential draw for some FPs and working part-time in general practice was seen as a preferable alternative to working in hospital medicine by GP trainees:

> *I think the work-life balance… would be the thing that would make me most not enjoy medicine in a hospital…the fact that you're doing on-calls and nights and weekends forever. And I think GPs have a much nicer lifestyle overall. So that*

would be the thing that would make me I think leave hospital medicine and go to GP. (FP1: Focus group 1, GM Area 7)

Just sheer exhaustion working in hospital medicine, and I can't be the doctor or person I want to be when I'm running at that level of stress and exhaustion, I just can't. And I had to choose a career where I would be a good doctor and happy where I was working, but also a good person and being a good partner and sister. (GP Trainee 4: Focus group 3, GM Area 2)

However, there was disagreement about how good the work-life balance of GPs was in practice as participants had observed GPs working long hours and felt that there was a large administrative burden:

Also I'm not sure how good the work-life balance actually is, because most GPs I know, they do end up staying late, they do a lot of paperwork. It's becoming more and more administrative as opposed to clinical. (FP5: Focus group 1, GM Area 7)

In order to improve their work-life balance and job satisfaction, GP trainee participants unanimously agreed that they did not intend to work as full-time GPs after completion of training. This was because they perceived that full-time working in general practice would have a detrimental effect on their well-being and could lead to burnout. These participants highlighted that many newly qualified GPs were no longer working in traditional full-time roles and many were shifting towards part-time portfolio working to buffer themselves from stress and burnout:

Interviewer 1: So are you thinking a portfolio career as well, but with mixing it with other things?
GP Trainee 1: A hundred percent, couldn't be a full-time GP. No way.
GP Trainee 3: Yeah. I don't know anyone that does full-time GP.
Interviewer 1: No, that's a thing in the past, is it not?
GP Trainee 3: Yeah. And I think the most someone that I know who does about eight sessions. (GP Trainee Focus group 3, GM Area 2)

GP trainee participants felt that limiting GP work to a part-time commitment was the only way to successfully combine work and home life as full-time working in general practice was regarded as not conducive to a normal life and potentially harmful to personal relationships and wellbeing:

You see others just getting burned out; I used to date a GP who did ten sessions a week as a [GP] partner and worked in out of hours at the weekend, and he was just brain-dead, like, completely, he just lived and breathed general practice; I don't know how he did it… he just didn't have a life...you just can't have a normal life with doing that much work as a GP. (GP Trainee 4: Focus group 3, GM Area 2)

In addition to working part-time in general practice, the opportunity for portfolio working had been a strong influence on GP trainees' choice of specialty, to maintain interest. While general practice could be seen to involve a degree of variety, all trainees were planning to develop a portfolio career and extend their GP roles as full-time general practice could be viewed as potentially monotonous:

> *I'm the kind of person that gets bored really easily, so I like to be surprised; so I quite like the mystery of when a patient comes in and then I'm trying to find out what they might be coming in about, or what's going on their social life, I'll be a bit nosy about the family. (GP Trainee 4: Focus group 3, GM Area 2)*

> *So I think… maybe doing a bit of sort of possibly sports medicine and doing another thing. I'll probably want to work full-time, but then do something that more interests me in the sort of one and a half days. So… yeah, definitely just not full-on GP day-in-day-out; because you would just die, I think. (GP Trainee 2: Focus Group 3, GM Area 2)*

> *I like the idea of a portfolio career… things like public health or education, or sports medicine; but I'm not too sure yet, but something to sort of mix it up a bit, something to keep it interesting and not always patient facing necessarily. (GP Trainee 3: Focus Group 3, GM Area 2)*

Among FPs there was some disagreement about the level of variety that would be part of the GP role. While some felt that variety of patients and spectrum of health problems seen by generalists would be stimulating, others felt that GPs repeatedly see the same problems:

> *FP 5: I just find it monotonous. It's the same every day. And you can't really change. Whereas in hospital at least there's other opportunities you could maybe get involved in.*
> *FP 6: I've got to disagree with the monotonous bit a little bit. Because you end up…some specialists become so specialist, don't they? The orthopaedic surgeon becomes 'hip man' and he does hip surgery every single day – the same operation on slightly different hips! Whereas at least if you're a GP you do get to see literally the entire spectrum of people's health, don't you?*
> *FP 5: Yeah, to an extent, but it's still that kind of same room, ten-minute appointments, a lot of the same patients coming in. For the majority of the cases it's the same kind of issues… from what you hear its similar stuff. Back pain, depression, it depends on the time of year as well I guess.*
> *FP 3: So much depression, it actually really gets you down.*
> *(FP Focus group 1, GM Area 7)*

Among FPs there was a perception (which chimed with the reported intentions of the GP trainees in the study) that very few new or recently qualified GPs worked in traditional full-time GP roles and that extended roles were a way to retain a diverse caseload:

> *A lot of the younger GPs are doing the splitting. So they're not doing five days a week GP. They're doing two days a week GP… so the practice I'm at, there's one that does two days a week at a hospice… I think they'll be the first people to admit that because if they were to do GP practice, bog standard surgeries all day they'd just go nuts. So I think that's where it's going. They're splitting their time, because otherwise… they couldn't stand it. (FP1: Focus group 1, GM Area 7)*

4.2.1.3 Risk and defensive practice

Among FPs, there was a perception that shorter appointment times in general practice had a detrimental effect on the quality of consultations, which could have negative implications for patient safety. Some participants reported that they would prefer to specialise in a specific area to increase their knowledge, skills and expertise as they believed this would be a safer way to practice. General practice was felt to be inherently associated with greater risk of clinical errors because GPs could not have specialist knowledge about all aspects of health:

> *I want to do surgery…when I was on GP, I found it a bit…lonely and also it's a lot of stress that I don't really enjoy…there's so much you have to do and I struggled with half hour appointments. I just think I would definitely make mistakes. And you have to know about everything. Whereas at least if I was doing surgery it's a long training, but at least I'd be a specialist in that bit…Whereas a GP, I feel even after 40 years I'd not know what to do with a patient. (FP2: Focus group 1, GM Area 7)*

FP participants reported feelings of powerlessness in general practice, being unable to have immediate access to hospital services and investigations and believing that these restrictions limited the help they could offer patients:

> *It's access to investigations as well, that was the thing I found hardest to adjust to in general practice. When you're in hospital, if you go and see someone that's short of breath you can immediately order a chest x-ray, a set of bloods. Any investigation you want, and it comes back within a couple of hours. (FP10: Focus group 1, GM Area 7)*

There was a reluctance to see acutely ill patients if they felt unable to offer treatment, and this was particularly challenging in the case of patients with psychiatric problems where there may be an extended wait for specialist services:

I don't know what I'm doing with this patient from here on. And I found that quite difficult in GP at the moment, having to try and justify reasons patients need to be seen [by a specialist]. Especially by psychiatric services as well. It can be like patients that are actively suicidal that they won't see, or people that have self-harmed that they won't see for 28 days, because they don't think the risk is high enough. But from our perspective we don't want to be the last people that see that patient, because it's obviously a psychiatric problem. (FP6: Focus group 1, GM Area 7)

Some participants felt that GPs practiced defensively as a consequence of the short consultation times that characterised general practice, with limited access to diagnostic tests and a perceived lack of integration/collaboration between primary and secondary care. There was a belief that some GPs made unnecessary referrals, for example referring patients so they would be reviewed by a hospital specialist. It was felt that such so-called 'false' referrals, while understandable, could lead to negative perceptions of general practice among other medical specialties:

When I did orthopaedics, the number of referrals that you would get from GPs which were just completely false… you understand that they don't know what to do with them in the community, but in order for them to get the patient to come to hospital they've got to blur the lines or… the referrals are quite often really, really poor. (FP5: Focus group 1, GM Area 7)

4.2.1.4 Working in GM

Both FP doctors and GP trainees saw GM as an attractive region to live and work because doctors had the opportunity to reside in more affluent areas, yet easily commute for a variety of work:

I think Manchester's a very good place to live and work as a doctor in that you can live in a nice area like Locality 1 and still work in a lower socioeconomic area, but be very close by and easy to commute to. (FP3: Focus group 1, GM Area 7)

GM was also seen as an attractive place to do GP training because training providers had a good reputation:

I chose the training here because I'd heard good things about Hospital 5, and I knew from working, doing my foundation, and my year out in Region 3, I knew that this was a good hospital, and it had a good reputation as a GP training programme, and it's really competitive. So I was like, this looks like a good option. (GP Trainee 4: Focus group 3, GM Area 2)

By contrast, some locations outside GM were avoided, being regarded as neither desirable places to live nor to access quality GP training. Training programmes in these areas were seen as less competitive than in GM and not able to attract the 'best' applicants, setting up a vicious cycle:

> *Consultants and staff grades don't want to live there [Area 14] unless they're specifically from that area; so therefore you're more likely to get people unfortunately who've maybe not done as well in the interview process or in the training process, or people who've struggled to get a job in a more competitive setting. Not always, because it might just be they're from that local area, they're from Area 14 and their family has always been there, and that's fine; but more often than not it tends to be unfortunately quite a lot of foreign staff or people that didn't get jobs elsewhere in the more, like in GM Area 2, in the more competitive places. Therefore, you go there, you have a poorer training experience, you might be less supported because they're under stress themselves, or they maybe are not as good at being trainers maybe. And that's bad, and it just goes on and on and on. (GP Trainee 4: Focus group 3, GM Area 2)*

Working in GM with a main focus on socially deprived populations was considered as a challenging option. Participants reported that dealing with high levels of drug and alcohol problems or having to regularly work with patients through interpreters could be emotionally draining. However, working in a wholly affluent area could often be as challenging, because the patients could be equally demanding in a different way:

> *Like where I'm at, at the moment is quite well-off and you just get people coming in saying they've Googled all their problems, they know what's wrong and they demand this, this and this. Rather than you actually using your brain and assessing them, and them trusting you. (FP3: Focus group 1, GM Area 7)*

Interestingly, both GP trainees and FP doctors expressed a preference to work in areas with a balanced variety of patients, as serving a mixed socioeconomic population was considered easier to handle and more clinically stimulating. Working in GM could give access to this kind of varied population with a range of health issues:

> *It depends what kind of medicine you want to do, because if you want to do GP in a well-off area then it's going to be, I don't know, maybe the medicine's going to be slightly more dull, and there'll be different challenges. Whereas if you want to see lots of pathology then GM Areas 7 and 6 is probably quite good… I think [GM] does have a good variety. It's got very poor areas, very rich areas. It's got everything. (FP5: Focus group 1, GM Area 7)*

I've worked in two parts in GM Area 6, but two very different parts of GM Area 6; I was on the estate, where you get the more sort of working-class people, and then you've got the other side of GM Area 6 where a lot of doctors come in… so it's probably being somewhere, in a middle area, in a middle area where it's not completely deprived – that's really hard – but somewhere just in the middle is probably what you want, or a mixture of the two. (GP Trainee 3: Focus group 3, GM Area 2)

4.2.2. Experiences of learning

4.2.2.1 Training

Some FPs reported that being exposed to a positive training experience in general practice during their training programme had encouraged them to consider it as a possible career, when they had not considered it previously:

I did it and really enjoyed how different it was to hospital. Having done three hospital jobs and the majority of medical school in hospital, it was like oh… I enjoyed the break from hospital… so I'm glad as well that we had to do it... because it wasn't on my list at all. So I was personally surprised. (FP3: Focus group 1, GM Area 7)

Other FP participants described their training experiences positively and reported that while they were not intending to opt for general practice, experiences of working in primary care had been beneficial:

I know that I don't want to do it [go into GP training] … but I think you don't realise until you work in general practice how completely different it is to working in a hospital. Like so, so different…I'm really glad that I've been able to do it just to see what happens. (FP2: Focus group 1, GM Area 7)

However, there was a view that where training experiences were poor, this could deter doctors from specialising in general practice. Both GP trainees and FP doctors had experienced working in practices with limited support and supervision while being expected to contribute to service provision. Trainees interpreted this as a signal that training was not taken seriously and could discourage them from applying for general practice as a specialty:

Making sure that the trainers actually care about the trainees that are going through there; it's just the amount of practices where they don't look after you is terrible, and you're just driving people out of choosing general practice. (GP Trainee1: Focus group 3, GM Area 2)

I think it's supposed to be that as F2 doctors we're not supposed to be there for service provision. But I don't think that's really true. And obviously it's fair enough because you need people to be seen...but you're also there obviously to try and encourage people to do GP…so the more service provision you're providing, the less that you feel like you're valued and that you're learning. (FP6: Focus group 1, GM Area 7)

One FP participant perceived that introducing mandatory GP rotation into training programmes (with the intention of increasing numbers of GPs by increasing exposure to general practice), could have the opposite effect if training experiences were negative. Instead, placements in poor training experiences would do little to increase recruitment but would promote an adverse view of general practice as a specialism to be avoided:

Everybody I've spoken to and everybody in my practice so far, I mean you're the practice, and you don't sell it, do you?... I don't know if it's just at GM Area 7, but I got the impression in the North West they were making all foundation doctors do GP in the hope of persuading some of them to do GP. If anything, it's had the opposite effect because for most people I talk to, they've not enjoyed their GP... (FP5: Focus group 1, GM Area 7)

4.2.2.2 Shared learning

General practice was viewed by FPs as potentially isolating in comparison to other specialties' where doctors worked in teams with support from shared learning. Participants felt that the support of their peers and colleagues was necessary for professional development and reported that the isolation experienced in general practice could have implications for learning, socialisation into the profession and job satisfaction. This isolation was perhaps exacerbated by a lack of communal spaces in some GP practices which meant that opportunities for interaction were limited:

So I'm on GP at the moment… it's very, very lonely. You're sat in your room on your own. All the GPs in my practice have staggered breaks, so they don't even spend that much time together in their break times. I like working in a big team and being a member of the team, which I don't think you really are in GP. (FP3: Focus group 1, GM Area 7)

However, while many FPs saw isolation and lack of peer support as inherent in general practice settings, this could be dependent on individual practice ethos and access to shared space. In this example, learning was enabled by providing opportunities for peer interaction through a commitment to taking breaks in a communal area:

I've worked in two… and the difference was massive… just the whole feel inside a GP surgery can completely change your experience of the profession. And like people said, you missed teamwork. But the one that I was in at home, there was two practice meetings a day; there was this feeling of like, if you had an issue with a patient, even as a GP partner, you would be discussing it over your breaks and things and I thought that was really, really good…the GP practice that we're in now… it's very nice but there's no communal area, there's nowhere people can meet to eat or to split up jobs during the day or anything. They just sit in their rooms and that's it…you want to have some feeling of belonging somewhere and doing something. (FP12: Focus group 4, GM Area 2)

A trainee GP also highlighted differences between practices in terms of collegiality and support and had been able to choose a practice with a team-oriented culture. This participant felt that smaller practices were more conducive to team working than larger practices where GPs could become isolated:

I've found I really like the practice I'm in, it's a small practice…it's like a family, very team orientated, everybody knows everybody and supports everybody; which I realise is really important to me. Rather than being part of this huge GP medical centre where I don't know anybody and what's going on. That's more important to me. (GP Trainee 1: Focus group 3, GM Area 2)

4.2.2.3 Skills development

In comparison to hospital specialties, FP doctors did not view general practice as a career that enabled the onward development of clinical skills. Given that FPs had been expected to contribute towards service provision on their placements often with limited support, there was a perception that they were already carrying out the full GP role. Connected to this was the belief that the GP role offered little by way of future skills enlargement (apart from being able to complete consultations in a shorter time frame), and difficulty grasping the nature and purpose of generalist skills:

I don't want to be a GP…there's nothing really to aspire to there…I'm a GP at the moment and it feels like the job that I'm doing is, well in terms of seeing patients pretty much the same as them. I just have more time…But I don't feel like that's, I don't think oh, in ten years, it will be great to be able to do this but just faster. (FP8: Focus group 4, GM Area 2)

I want to do surgery… I struggled with half hour appointments. I just think I would definitely make mistakes. And you have to know about everything. Whereas at least if I was doing surgery, it's a long training, but at least I'd be a specialist in that bit. And I'd afford to be able to only spend a bit, like a few…like ten minutes with someone, because at least it would be something I was

confident with. Whereas a GP, I feel even after 40 years I'd be not knowing what to do with a patient. So I didn't like that side of it. (FP2: Focus group 1, GM Area 7)

4.2.3. Perceptions of professional roles in general practice

4.2.3.1 Professional status of the GPs' role

Both FP and GP trainee participants reported that general practice was generally regarded as lacking the esteem and kudos of other medical specialties and was less valued by other doctors and society in general. Most teaching was reported to be delivered by hospital specialists who had a limited understanding of the GP role, with derogatory comments about general practice being commonly heard:

I think it's a very strong anti-GP sentiment which is pushed by hospital doctors a lot… (FP7: Focus group 1, GM Area 7)

GP Trainee 2: Some people say it's a bit of a cop out.
GP Trainee 1: Cop out. Yeah.
Interview 1: Why?
GP Trainee 2: Just because, I think, well, medical friends would think it's a cop out, because they're…in surgical training and their exams are more difficult, or longer route to it; and then your friends who aren't medics just think you give paracetamol and penicillin to everyone, and Google everything.
GP Trainee 3: It's not got the prestige of hospital.
GP Trainee 4: You're just a GP.
GP Trainee 1: Yeah, you're just a GP, you're wasted in GP; a lot of consultants would say you're wasted in GP. So even though you think, I'm a good doctor, it's not good enough…so don't you want good GPs? (GP Trainee Focus group 3, GM Area 2)

4.2.3.2 Skill-mix changes

While some participants could see that bringing in non-medical professionals to work alongside GPs in general practice teams could be beneficial to general practice, they also expressed negative views about skill-mix. There was a perception that because other professionals were now performing aspects of the GP role previously under the remit of GPs, skill-mix changes could lead to GPs under-utilising their wider skillsets. FPs felt that delegation of specific tasks through skill-mix employment had led to them being deskilled during their training or feeling that they were expected to deal with more complex cases than they were prepared for:

It also means that you just end up with the really awkward, difficult stuff. So you'll never really get a nice, oh, a diabetic patient, I can start them on the next one up. Or here's a COPD one, I'll start them on this inhaler. That's all getting done by someone else. So then you just get the really complex stuff that you don't… so there wasn't much satisfaction of oh, I know what to do with this problem and I can treat this patient. It was all like oh god, there's six things going on. I don't know what the right thing is. And I think because there are so many ANPs and things that are dealing with the more easy stuff, it means that we're just getting all the hard stuff. (FP2: Focus group 1, GM Area 7)

Other FPs were more positive about skill-mix and felt that diversifying the workforce was beneficial as non-GP professionals could share their knowledge with other staff including doctors:

I think it just diversifies the workplace…I think it's great…my practice had a mental health practitioner as well, a pharmacist and all sorts of stuff. And [it] came to a point when I have a mental health question, I'd go to that practitioner rather than my supervisor… (FP5: Focus group 2, GM Area 7)

The pharmacist role in general practice was well-recognised and viewed as valuable by both FP doctors and GP trainees primarily because doctors were able to offload tasks to pharmacists that GPs might find mundane:

It takes away some of the stuff that's seen as a bit boring and dull. Like a lot of the repeat prescription checking has been taken away from the GPs where I was, because we now have two in-house pharmacists. So immediately so much of that was medication reviews. They all get booked in where possible. So that was a big thing that the GPs really hated doing. And they now don't have to do it anymore. (FP3: Focus group 2, GM Area 7)

The role of physician associates on the other hand was less well understood by GP trainees and could be perceived as a potential threat to the GP role as well as less safe for patients:

I don't really know what the physician associates…I'm kind of not sure what they're supposed to do…I don't really understand their…what they're for. (GP Trainee 2: Focus group 3, GM Area 2)

I feel it's just the government trying to provide cheap doctors, as well as complaining about the junior-doctor contract, and about all of the pressures on us; so they're just providing a cheap option for us, which is poorer for patients, terrible for us, undermines us, and [is] just upsetting. (GP Trainee 4: Focus group 3, GM Area 2)

5. Discussion

5.1 Summary of findings

Our study sample comprised a smaller number of GP trainees than FP doctors, however findings demonstrate that the in-depth focus group method stimulated lively discussion and debate in both groups and enabled exploration of different points of view and the generation of rich data.

Findings from this study reflect and build on those of prior research which were outlined in our CLAHRC GM literature review[5] on GP recruitment and retention. For many participants, general practice was seen as a medical specialty associated with a heavy workload and time-pressured working that was regarded as being a relatively low status and unrespected medical specialty. The derogatory comments about GP work in medical schools found in the literature were also echoed among doctors participating in this study during their training in GM.

Also reflecting the prior literature, in this study, participants saw general practice as offering the potential for a better work-life balance; however, participants' observations revealed that many GPs were over-stretched by excessive workloads and trainees were planning to limit their commitment to GP work. The small number of GP trainees who took part indicated their intentions to work part-time in general practice and possibly combine general practice with portfolio working to accommodate their interest in other specialties or additional roles. There was a strong belief among trainees that full-time general practice was not a sustainable career choice due to the potential for professional burn-out. Participants here, like those in other studies, emphasised the importance of positive general practice placement experiences in attracting trainee doctors into the profession, while negative experiences during placements could have the opposite effect. They also suggested that working in practices with an on-going commitment to peer support could overcome the sometimes isolated nature of general practice working and offer communities of practice to both trainees and staff.

Reflecting CLAHRC GM prior work in general practice skill-mix change[11] there were mixed views of the current drive towards the introduction of a wider range of practitioners in practice teams to deliver patient care alongside GPs. Particular roles such as practice pharmacists were seen as valuable in taking away routine tasks from GPs (e.g. mundane paperwork) to reduce their workload; others such as mental health practitioners, were viewed as complementing the work of GPs by bringing a deeper level of specialist expertise into practice teams. New roles such as advanced practitioners or physician associates, however, were seen as a potential threat, fragmenting the GP role by undertaking selected tasks while leaving GPs to deal with the most time-consuming and complex work.

In contrast to some other areas in England and particularly in the North West, GM was seen as a desirable place to live, train and work. The region offered participants attractive locations to live and was recognised as offering excellent undergraduate, FP and GP training. In addition, the socio-demographically varied GM population was viewed as contributing balance and professional stimulation through working with mixed populations.

5.2 Conclusions

A shift in national policy to increase the number of GP training places and improve uptake aims to strengthen the GP workforce. However, there will be some delay before these GPs are qualified and a rising proportion of newly qualified GPs are choosing to work part-time[2]. In the meantime significant numbers of GPs leaving or retiring continues to put pressure on existing GPs[12].

It has been shown that a positive clinical placement experience is one of the factors that can influence doctors' choice of specialty[13]. This was certainly true of participants in 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. This could maximise the opportunity to introduce FPs and GP trainees in GM areas to optimal general practice training experiences and encourage consideration of general practice for specialty training. Further, by creating within-practice collegial learning environments practices could overcome perceptions of isolation and potentially improve the working lives of practitioners within general practice more broadly.

It is also known that the proportion of students who choose general practice careers varies substantially between medical schools – suggesting that undergraduate experiences may influence their career choice[14]. It is also clear that commonly reported negative comments about general practice[15] can adversely influence career choice and GM participants also reported hearing such comments. The lack of respect for the profession of GP is a concern highlighted in other research with young doctors[12]. RCGP college leaders suggest that there needs to be encouragement of respect between medical professionals to protect all professions from denigration[16].

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 evaluated[12].

It has been suggested previously that recruitment strategies should highlight the many different roles associated with general practice[17]. Indeed the recent national toolkit issued by NHSE and NHSI, which is focused primarily on GP retention, emphasises portfolio working as a positive aspect of the GP role[18]. GP trainees in this study confirmed their intentions to limit their working time in general practice to part-time or portfolio roles. It is

therefore important to create flexible employment opportunities to sustain recruitment and further, to understand and take account of these reduced GP workforce plans when estimating the GP training requirements necessary to build and maintain overall GP workforce capacity. Additionally, findings highlight a belief among young doctors that general practice is viewed as a specialty with minimal opportunities for skills development. GP job design could ensure that the GP workforce has opportunities to improve their skills and that this offering is communicated effectively to undergraduates and FP doctors.

Doctors on training programmes in GM viewed this region as a desirable place to live, train and work. One of the attractions was the opportunity to serve populations that are socioeconomically mixed. This blend was seen as sufficiently balanced and stimulating to maintain energy and interest. This could be an element to consider as part of a future GM training offer for potential GP trainees.

A focus on investigating why general practice *is* chosen by some junior doctors (rather than the usual focus on reasons for avoiding general practice) has been suggested as a way of better informing national strategies to recruit pro-actively[19]. Our study was unable to recruit sufficient GP trainees to ensure gathering a broad spectrum of viewpoints; consequently the reasons for choosing general practice in GM remain under-explored and this could be an area for further research.

Our study sample was evenly split in terms of gender, however it is known that higher proportions of female doctors are choosing general practice as it is seen as family-friendly and flexible[20,21]. Gender is therefore a factor that needs to be considered in recruitment, meaning that there may be a need to recruit even more doctors to meet the demand for flexible, part-time, salaried working.

5.3 Key messages

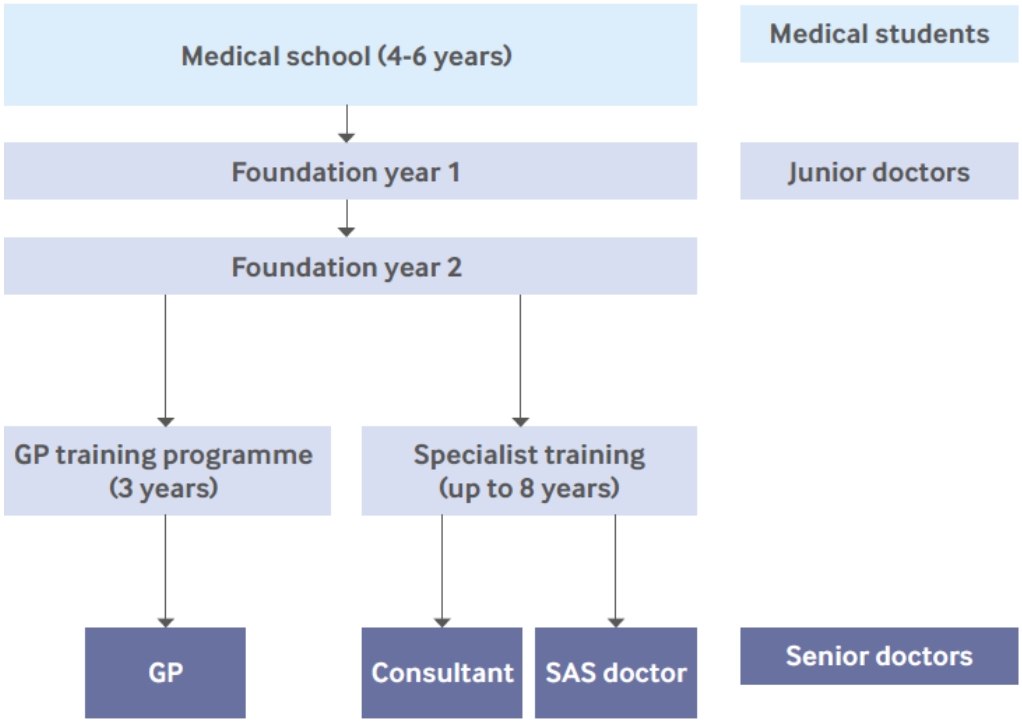
Key messages from this work:

1) Negative perceptions of general practice and GPs continue to influence the career choices of students in medical school;
2) Negative views include perceptions that general practice is monotonous, unfeasible due to time pressures, and intellectually unchallenging, with little opportunity for career advancement or personal development;
3) Work-life balance and flexibility continue to be among the most powerful factors motivating trainees to pursue general practice, with strong preference for portfolio working;
4) Direct experience of general practice through placements can counteract negative perceptions: however, poorly supported placements in challenging contexts can also reinforce such negative views;
5) Isolation in practices experienced during placements can also deter trainees from committing to general practice;

6) Mixed views were evinced on skill-mix changes in general practice, with perceptions that this may reduce GP workload or that it may intensify work-pressures on GPs by taking away simpler cases;
7) On balance, GM was seen as a relatively attractive place to work, with mixed populations offering a variety of patients.

6. Appendices

Appendix 1: Journey through medical training



(Diagram reproduced from[22] Figure 1 p.8)

Appendix 2: GP role definitions

Reproduced from [22, 23,24]

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.

Appendix 3: Recruitment and retention of GPs in Greater Manchester: interview schedules for FPs and GP trainees

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Introductory activity
Timed three minute task.
Draw and annotate your ideal future job
Where are you? What are you doing? Who are you working with? Where in the world are you? What does the building look like? How do your patients look/act?

GP Trainees

1. What where the main things that made you choose GP as your specialism?
2. What influenced how you think about GP?
3. How well did you think you could do the job of a GP and why?

Greater Manchester

4. Why did you choose to practice in GM?
5. Was there anything specific about GP in GM that influenced your choices?
6. Have you heard about any incentives and did these influence you?

Foundation Programme Doctors

1. Where does GP sit in your thoughts about choosing your specialism?
2. What influenced how you think about GP?
3. How well do you think you could do the job of a GP and why?

Greater Manchester

4. Where does GM sit in your thoughts about choosing your area?
5. Was there anything specific about GP in GM that would influence your choices?
6. Have you heard about any incentives and would these influence you?

If time, questions asked on the following two areas:

Deprivation

1. Does the socioeconomic profile of an area effect where you want to work?
2. Do you want to work in a community that feels familiar to you?

Skill-mix

1. Do you think GPs will be replaced by other sorts of practitioners?

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7. References

[1] House of Commons Committee of Public Accounts (2016) *Access to general practice in England. Twenty-eighth Report of Session 2015–16* https://publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/673/673.pdf

[2] Beech J, Bottery S, Charlesworth A, Evans H, Gershlick B, Hemmings N, Imison C, Kahtan P, McKenna H, Murray R & Palmer B (2019) *Closing the gap: Key areas for action on the health and care workforce* Health Foundation, Kings Fund & Nuffield Trust https://www.nuffieldtrust.org.uk/files/2019-03/heaj6708-workforce-full-report-web.pdf

[3] NHS England (2016) *General Practice Forward View* https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

[4] Palmer W (2019) *Is the number of GPs falling across the UK?* Nuffield Trust blog, 08 May https://www.nuffieldtrust.org.uk/news-item/is-the-number-of-gps-falling-across-the-uk

[5] Mitchell C, Nelson PA, Spooner S, McBride A and Hodgson D (2018) Recruitment, retention and returning to General Practice: A rapid scoping review to inform the Greater Manchester Workforce Strategy. NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC GM) https://www.clahrc-gm.nihr.ac.uk/media/Resources/OHC/Recruitment-retention-and-returning-to-General-Practice-A-rapid-scoping-review-to-inform-the-Greater-Manchester-Workforce-Strategy1.pdf

[6] Greater Manchester Health and Social Care Partnership (2019) *The Greater Manchester Primary Care Workforce Strategy 2019-2030*.

[7] Greater Manchester Health and Social Care Partnership (2015) *Taking charge of our health and social care in Manchester: The plan* https://wwwgreatermanchester-cagovuk/downloads/file/125/taking_charge_of_our_health_and_social_care_in_greater_manchester 2015

[8] Greater Manchester Health and Social Care Partnership (2016) *Commissioning for reform: The Greater Manchester commissioning strategy* http://wwwgmhscorguk/assets/GM-Partnership-Commissioning-Strategy-FINAL-webpdf

[9] QSR International Pty Ltd. NVivo Qualitative Data Analysis Software Version 11 2016.

[10] King, N (2012) Using templates in the thematic analysis of text. In *Essential Guide to Qualitative Methods in Organizational Research* (Eds. C Cassell & G Symon).

[11] Nelson PA, Bradley F, Martindale A-M, McBride A, Hodgson D (2019) Skill-mix change in general practice: A qualitative comparison of there 'new' non-medical roles in English primary care *British Journal of General Practice 2019; 69 (684): e489-e498*

[12] Spooner S, Pearson E, Gibson J, et al. (2017) How do workplaces, working practices and colleagues affect UK doctors' career decisions? A qualitative study of junior doctors' career decision making in the UK. *BMJ Open 7(10)*

[13] Svirko E, Goldacre MJ, Lambert T (2013) Career choices of the United Kingdom medical graduates of 2005, 2008 and 2009: Questionnaire surveys. *Medical Teacher 35(5):365-75*.

[14] Alberti H, Banner K, Collingwood H, et al. (2017) 'Just a GP': a mixed method study of undermining of general practice as a career choice in the UK. *BMJ Open 7(11):e018520.*

[15] Merrett A, Jones D, Sein K, et al. (2017) Attitudes of newly qualified doctors towards a career in general practice: a qualitative focus group study. *British Journal of General Practice 67(657):E253-E59*.

[16] Royal College of General Practitioners and Medical Schools Council (2017) *Destination GP*. https://www.rcgp.org.uk/policy/rcgp-policy-areas/destination-gp.aspx

[17] British Medical Association (2017) *Survey of GPs in England Full Report*. https://www.bma.org.uk/collective-voice/influence/key-negotiations/training-and-workforce/urgent-prescription-for-general-practice/key-issues-survey
[18] NHSE & NHSI (2019) *Making general practice a great place to work – a practical toolkit to improve the retention of GPs* https://www.england.nhs.uk/gp/gpfv/workforce/retaining-the-current-medical-workforce/making-general-practice-a-better-place-to-work/
[19] Spooner S. (2016) Unfashionable tales: narratives about what is (still) great in NHS general practice. *British Journal of General Practice 66(643):E136-E42*
[20] Elston M. (2009) *Women and medicine: the future*. London: Royal College of Physicians
[21] Crompton R, Lyonette C. (2011) Women's Career Success and Work-life Adaptations in the Accountancy and Medical Professions in Britain. *Gender Work and Organization 18(2):231-54.*
[22] British Medical Association (2017) *Doctors' titles explained* file://nask.man.ac.uk/home$/Downloads/PLG-doctors-titles-explained.pdf
[23] Royal College of General Practitioners (2018) *RCGP framework to support the governance of General Practitioners with Extended Roles* https://www.rcgp.org.uk/-/media/Files/CIRC/GPwSI/RCGP-framework-to-support-the-governance-of-GPwERs-2018.ashx?la=en
[24] British Medical Association (2018) *Focus on taking on new partners - guidance for GPs* https://www.bma.org.uk/advice/employment/gp-practices/gps-and-staff/focus-on-taking-on-new-partners