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WORKFORCE

Models of working in general practice: personal perspectives

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ABSTRACT

Four general practioners share perspectives on their career pathways, which span different models in both partnered and salaried GP work, and reflect on the challenges and benefits of each model.

KEYWORDS: Primary care, general practice, workforce, partnership, salaried, personal perspective

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Introduction

General practice differs from other areas of the NHS in that there are two distinct models of providing care to patients: the GP partnership model, in which the GP is an independent contractor, and the salaried model, where staff are salaried within an NHS organisation. Currently partnerships are the most common model for general practice, but there are indications that this could change over the coming decades. The debate over which model is most effective in providing optimum care to patients, value for money to the NHS and a satisfying career to the GP themselves is ongoing, and the only thing that is clear is that one size does not fit all.

Even within the dichotomy of partnered versus salaried, there is plenty of variation in available ways of working, with each model offering many advantages in terms of scope, flexibility, satisfaction and interest for the GP who may be deciding between them. Here, four GPs – a GP partner in a small rural practice, a GP partner in a more urban multi-site practice, a salaried GP who has been able to develop a portfolio career, and a salaried GP working in out-of-hours care – share perspectives on their own particular career pathways and reflect on the challenges and benefits of each model.

The partner in a 'traditional' practice

Rowena Christmas writes:

I count myself as fortunate to still be enjoying my work as a GP partner in a small rural practice after almost 24 years. Our practice enjoys excellent continuity of care, so when I talk to our trainees during post-surgery supervision, I find I already know a wealth of background detail about most of the patients we discuss. This makes being a GP more interesting, and I believe it makes me a better GP.

I have been managing partner for many years, and have endured two tense and sleep-defying periods when I was last person standing. This pressure made me constantly tot up the cost, in terms of both finances for my family and the care for our patients if I were unable to keep going. I worried about ensuring the jobs of our amazing team, and tried not to reflect on colleagues who had no choice but to hand their contracts back, and then had to find a way to pay redundancy to their multidisciplinary team, while still paying the mortgage on their now-empty surgery. I know from my work as an appraiser that situations like this have happened across Wales, with consequent devastating impact on dedicated, hard-working GPs.

These experiences have left me well placed to see both the advantages and the challenges associated with our independent contractor status. With this insight I remain committed to the belief that independence allows us the autonomy to innovate and the agility to respond rapidly to changing situations and offers a greater variation in our daily work that makes our role more satisfying. The management techniques and understanding of the health system that you gain as a partner, which I learned long after my GP training had ended, can help to optimise the resources available and plan best care for our patients. As the scope of practice of our multidisciplinary team has developed over recent years, a partner's ability to work as an expert generalist, a managerial navigator and care innovator leaves them well placed to lead and coordinate the team.[1]

Examples of innovation that have helped recruitment in my own practice include having a partner who is a single parent and who only works in term time, and being able to employ an experienced and highly able locum to see just 12 patients with no additional duties. He was paid less than a normal locum session, but the patients he saw were exceptionally well managed. Having the freedom to make informed decisions based on our knowledge of the needs of our own practice and local communities is rewarding.

Recently, I travelled to North Wales, a spectacularly beautiful area, where I received a warm welcome from GPs and their teams. However, Betsi Cadwaladr University Health Board has a troubled history and earlier this year was put back into special measures. The region has difficulty recruiting GPs, which exacerbates the workload and workforce issues experienced

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nationally in primary care. As a result, Betsi has a greater than average proportion of managed practices. I witnessed both models in action on a normal working day at the five practices I visited during my trip.

For an area working to cope with such significant challenges, my overriding impression of all the practices, both managed and independent, was how strongly committed they are to providing the best patient care. Our conversations focused on the ways they are working to improve chronic disease management, as well as achieving greater efficiency so that GPs spent less time doing tasks that brought no value to patients (in Wales we still don't have electronic prescribing, so up to 30 minutes of GP time is spent each day signing paper prescriptions) and creating appealing roles that encourage doctors to move to the area.

There were also, however, marked differences between the managed and independent practices. There was frustration expressed by the managed practices about how long they had to wait for any decision to be approved by the Health Board – sometimes a response would take many months. This could be related to employing new staff, making adaptations to their premises or even minor decisions such as changing how they run their diabetic clinics.

In contrast, several of the independent practices we visited were brimming with enthusiasm. They talked with pride about changes they had made to improve recruitment, to manage their access issues or to boost morale. Their teams were highly committed to teaching or to research and explained how these activities supported practice wellbeing and improved patient care.

Many GPs have enjoyable salaried roles where they feel valued and that their opinion matters. They see their practice respond rapidly to situational change. These doctors are often employed by independent contractors though; if we were to lose GP partners altogether, we would all become salaried doctors working in managed practices. The most recent RCGP Tracker survey suggest that this is the least favoured career option.[2]

At the UK Parliament Health and Social Care Committee's inquiry into the future of general practice, the then committee chair Jeremy Hunt said that the government was looking to abolish the GP Partnership model by 2030. Last year, *The Times* reported that Sajid Javid, then health secretary, was planning to 'nationalise GPs' to help reduce hospital admissions, by encouraging doctors to move to salaried employment by hospital trusts.[3,4] As we approach an expected 2024 general election, we have heard similar proposals from Labour's Shadow Health Secretary. There is no evidence to support managed practices having lower rates of hospital admissions. It seems logical that as recruitment to these practices is more challenging, continuity of care is often reduced, and so they are more likely to experience higher use of emergency services and increased referrals to secondary care, as demonstrated by Sandvic *et al* in their observational study in Norway.[5]

Mike Holmes, a GP partner in York and the Royal College of General Practitioners (RCGP)s' chair of trustees, told the committee that the partnership model remains viable when it is resourced properly. The problem is the progressive lack of workforce, with a reduction over the past 5 years from 52 full time equivalent (FTE) GPs 100,000 patients to just 45 now. This figure is even lower in deprived areas: for example, Hull has only 42 FTE GPs for every 100,000 patients.[6]

A GP partner will often feel a greater sense of responsibility for their patients. In feedback from a focus group, a GP partner described feeling 'personally invested' and talked about staying until the work is done or logging on again remotely at home rather than just clocking off at the end of the day. Positive components of the partnership role included the freedom to shape local services and the ability to influence the next generation of GPs. One partner said 'it can be thrilling or frightening, but ultimately it is a privilege. It is empowering.'[7] A move away from the GP partnership model risks losing the goodwill this sense of responsibility and privilege imbues and which supports many partners to go the extra mile, day after day, week after week. This offers extremely good value for money for the NHS. GP partners often go above and beyond, which may explain figures from BMA Wales showing that health board managed practices were 30% more expensive to run.[8]

Partnership generally remains an option that offers greater remuneration than a salaried option, although the differential is reducing year-on-year as GP salaries increase in an effort to recruit the best doctors, and the pressures of inflation and running the business negatively affects GP partner income. In 2020, NHS England introduced the New to Partnership Payment Scheme (N2PP). This offered a financial incentive of up to £20,000 to new GP partners, who in return agree to work a minimum of two clinical sessions per week for the next 5 years. They also offer a £3,000 grant to train in the non-clinical skills involved in running a business.[9]

This extra training is important, as a King's Fund report[7] described salaried GPs who were deterred from considering GP partnership by the business element and the responsibility this entails. They did not feel medical school had suitably prepared them for this.

The partnership model gives GPs autonomy to act in the best interests of their local community. GP Partners are well placed to coordinate and supervise the care given by their wider multidisciplinary teams and can give patients confidence that they are not being palmed off with an inferior substitute, as some believe, but are seeing the member of the team best placed to manage their presenting condition.[6]

The model works well when adequately funded, with sufficient clinicians to manage the workload and enough partners to hold the contract. Challenges from falling resources and an insufficient workforce could cause the model to fail, to the great detriment of the NHS. The profession is seeing an exodus of senior partners. There are currently 16,563 full time equivalent partners in England compared with almost 20,000 five years ago. In Wales, GP partnerships now stand at 386, compared to 420 in 2018.[8]

With enough support and financial resource, the independent contractor model offers cost-effective healthcare for population health and allows for innovation and agile delivery of care. Partners often remain in their practice for many years, forging good relationships with their patients and creating continuity of care, which evidence shows, reduces acute admissions and referrals to secondary care, reduces mistakes and improves patient and clinician satisfaction scores. The continuity enables the partners to create an identity for their practice and to hire, train and support staff that work well together, improving retention of all members of the multidisciplinary team. As independent practitioners, GP partners take full responsibility for the quality of care their practice offers and can truly advocate for their patients, enabling practices to flourish.

The partner in an at-scale practice with the opportunity to undertake leadership roles

Thomas Campbell-Patel writes:

Working as GP partner is rewarding, challenging, involving and fulfilling. I have found the role incredibly enjoyable, and can't imagine working as a GP in an alternative role. I have a balance of clinical work, leadership roles and area expertise that I don't believe would be achievable if I were a salaried GP or locum.

NHS workforce data suggest 61% of GPs work as partners, 36% work in salaried roles, and 3% work in long-term locum roles.[10] Though the proportion working as partners is falling, the fact that there are still nearly twice as many partners to salaried GPs may come as a surprise to some, considering how negatively partnership is portrayed.

The GP partnership has been a bedrock of the contractual model of delivering general practice for decades, and the majority of contracts continue to be served by partnerships rather than the alternatives. They deliver efficient care to local populations, and are invested for the long term in their staff and patients over many decades.

Throughout my GP training I had always been attracted to partnership as a medium-term ambition. Indeed I joined the practice that I now work for (where I have been since CCT, and initially joined on a salaried contract) with the clear intent of becoming a partner.

My partnership is unusual in that we operate at a large scale, and have developed companies around our core GP contracts, ensuring that we can supplement the inadequate funding that is given by the NHS to fund the delivery of high-quality general practice. These companies are linked to providing primary care, with one delivering community pharmacy services, one delivering NHS and non-NHS training (including our regional workforce and training hub contract), and one allowing us to manage contracts outside the general medical services (GMS) contract such as alternative provider medical services (APMS). We are now 29 partners, operating in three localities within the Humber and North Yorkshire Integrated Care Board, with 250 staff supporting 95,000 patients across 10 sites.

We are aware that our partnership must thrive over the long term, so have set up structures to manage the managerial workload that overwhelms some partnerships, allowing partners to develop portfolio job plans. Personally this has given me space to develop an interest in respiratory medicine (though not to the level of a formal GPwER), and significant leadership responsibility as director of clinical operations for the organisation. I also have a role as the digital transformation lead for our GP Federation, and am a trustee for RCGP. I doubt that I would have been able to take on these roles without the linkage to my partnership, or the support of my fellow partners to be released for the roles.

Other partners in my partnership have focused more on direct clinical delivery, whether that be more extensive special clinical interests, or delivering high quality, undifferentiated care to their local patients, while some taking on similar leadership roles that I hold. We value each other's differences, which together make us stronger.

Our roles as partners in an at-scale organisation allow us time and freedom to take on leadership roles outside the practice. We have partners who sit on digital boards at regional levels, lead GP federations, have training roles including training programme directors, and one who chairs our regional ICB primary carer workforce committee, as well as taking on leadership roles within national bodies such as the RCGP. Working in a partnership that recognises and values the ability to influence at a regional and national level means we can do this work within partnership time avoiding burnout and over-extending ourselves by needing to do this as well as full clinical commitments. Bringing our experience as partners makes us more likely to be able to take on such leadership roles, as we understand the clinical needs of patient care as well as the organisational structures and external risks that affect our ability to deliver high quality patient care.

There were many reasons for my desire to become a partner, but on reflection I think that the role of a GP partner best meets the motivating factors set out by Daniel Pink in his book *Drive*[11]: autonomy, mastery, and purpose.

The level of autonomy that comes with working as a partner can feel overwhelming at times, but this as incredibly positive as an opportunity. Our ability as partners to rapidly shape our own working environment, including how we deliver care, how we support managerial aspects of the practice and how we manage our workload, is unparalleled. We can notice that something could be done better, discuss with partners and managers, and make changes extremely quickly, sometimes within days. The ability to do this in other roles, whether that be as salaried or locum GPs, or in other medical roles in the NHS is hampered by the need for decisions to go through bureaucratic committees, and NHS processes that are rarely efficient or rapid.

The stability of a partnership role allows space to develop the second motivator of mastery. It is suggested that it takes 10,000 hours of work to truly master an area, and this can take 5–10 years working in general practice, depending on full or part time working. As a partner, embedded in a specific practice, with control over working pattern and workload, I have had the space to master the role of being a GP. Some may say that this is possible in a salaried role, but my view would be that the ability to adjust working pattern and develop a portfolio allows more flexibility to achieve this as a partner.

Finally, when it comes to purpose, partnership is unparalleled. As a partnership we have a clear collective purpose, and we live our vision statement: 'To lead the evolution of high quality, patient centred, at scale general practice; being innovative, collaborative, and trusted by patients and partners'. All our work, whether that is in the consulting room, designing processes and workforce models, or managing back-office functions has this in mind, with all working towards a unified purpose.

We are seeing newly qualified GPs taking on locum or salaried roles post CCT and fewer interested in partnership initially. I would suggest that working as a partner in a highly functional partnership allows better autonomy, mastery and purpose, and better long-term job fulfilment over a 30-year career as a GP. We also hear of partners retiring from their partnerships due to high workload, or even handing back their contracts as a whole partnership. Our experience has been that working at scale has allowed us to thrive as a partnership, and we continue to expand, with the appointment of seven new partners earlier this year.

It is clear that the long-term trajectory of the NHS is seeing a fall in the number of GPs wanting to work in partnership. However, we are strongly of the view that partnership-led organisations lead to higher quality care. While recognising that alternative models have been successful, they are not always expandable to

other areas. For example, the Wolverhampton Hospital model of vertical integration has yielded positive outcomes, using a salaried workforce model for their GPs. However, this appears to work as well as it does due to investment into general practice from the trust. Given the parlous state of many trust finances, it may not be possible to expand this model across other areas.

There is a political risk to the partnership model, with political leaders such as Wes Streeting questioning the value of partnership. However, many, including Mr Streeting, have adjusted their views as they develop a better understanding of workload that partners undertake, especially how efficiently they manage their delivery of patient care.[12] Further, recent analysis has shown that investment in primary care provides more value for money (returning £14 per £1 invested compared with £4 per pound invested for health spending overall).[13]

We would strongly advocate for increasing financial investment into general practice to allow partners to undertake more of their work within their expected working hours, and protect those partnerships where the non-clinical workload is excessive and requires long hours to be put in, rather than a corporate structure led by non-clinical managers without local flexibility to deliver are to patients based on their needs.

Ultimately, I feel that my ability to continue working for the next 30 years in general practice is secure, in no small part due to my role as a partner. I strongly advocate for an at-scale partnership model, and the role specifically to GPs looking for medium to long term future. Without partnerships, the model of general practice as it stands would be unaffordable, and would not allow delivery of high quality, undifferentiated care to local communicates, which is why many of us chose to work in general practice.

The salaried GP with a portfolio career

Anneka (Shan) He writes:

Like most 'First5' GPs (those in their first 5 years after qualifying), I started a salaried GP role in East Anglia in August 2020, where I was trained. My first GP job was in a busy, inner-city practice with over 14,000 registered patients. Luckily, I was automatically enrolled into a 2-year funded general practice fellowship programme for newly qualified GPs and was given structured CPD time for learning and supervision. During this fellowship, I successfully completed a diploma in sexual and reproductive health and a diploma in improving diabetes care (IDC) from Warwick University. However, it was not without difficulties: there were huge challenges in terms of clinical management and time management and I experienced burnout 6 months into the job. What really helped me build my confidence following the burnout was the acknowledgement from the GP partners that the workload was too high to be sustainable, and the number of bookable appointments were reduced and standardised for all GPs. What also helped was that, despite having a high level of workload, doctors and allied healthcare professionals such as paramedics always came for the coffee break. It was a good opportunity to ask questions or just having a chat: everyone was approachable and there was no sense of hierarchy between a salaried or a partnered GP. Apart from daily coffee, we also had 3-monthly clinical meetings where all GPs contributed to discussions around clinical and practice management, for example on how to improve continuity of care for vulnerable groups or on how to manage workload on duty sessions.

During my first GP role, I worked six sessions a week and provided a good level of continuity of care to my patients, which I believe is no different from that provided by a part-time partner. I also enjoyed the quality improvement work which I did as part of the IDC diploma, where I had the opportunity to carry out an audit that examined the referral pathways of patients with diabetic foot ulcers and the reasons for delayed referrals. This audit revealed some system inefficiencies and I was able to present the findings of this audit both within my practice and in the wider primary care network. All the GPs at the practice welcomed the presentation and felt this learning was important for staff morale and teamwork. Another great thing about this practice was that the partnered GPs were good at protecting the salaried GPs and took on the majority of the busy duty sessions themselves. I was on call in only one out of every nine sessions. I would have happily stayed in that role if not for the changes in my family circumstances which meant that I had to take a career break and spend several months in China.

As a salaried GP, I have the freedom to explore working in different practices and to see which one fitted me the best. After this mini career break, I joined a smaller inner-city GP practice in a relatively deprived area and I dropped to four sessions a week to accommodate my research work. I thought it would be a smooth transition as I already knew two friends who worked there as GP partners. However, it turned out to be a complete mistake: the workload was high, with weekly on-call sessions, and the system felt hierarchical between salaried and partnered GPs. I was the only salaried GP on the days that I worked and was excluded from most meetings as they were for partnered GPs only. While there were clinical meetings for all GPs, they tended to happen when I was not in. Furthermore, it was not easy for me to discuss cases with GP colleagues, as there was no official coffee break. On reflection, I didn't enjoy working there as a salaried GP, but I think I would have enjoyed it more if I had been a GP partner, as the partnership was close-knit and was well-supported by the wider administration team. When I left the practice after 6 months, I seriously doubted if I wanted to continue being a GP. However, I loved the academic part of my job and as it came in a package, I could not keep one and let go of the other.

To my surprise, I was offered a salaried GP job a week later in a relatively wealthy area in London, with a practice population of over 19,000, where I am currently working. I like how GPs work in pairs during busy on-call sessions and there is also a daily lunchtime meeting among clinicians. They truly work in a multidisciplinary team fashion where everyone is encouraged to speak to one another; this includes GPs, a social prescriber, pharmacists, physicians associates and others. There is a designated room at this practice for GPs to do their administrative work, which is really helpful as it facilitates clinical case discussions and teamwork among GPs.

I am now 3 months into my salaried role at this third practice and I work 2 days a week, with my time split between a local care home and the surgery. The care home was the bonus as it has an outstanding CQC rating and I now work closely with patients living with advanced dementia and their families, which has opened up new learning opportunities. The pace at the care home is slightly slower than that at the GP surgery, which has helped me with the transition. The main challenge with my current practice, however, is to learn how to work with their patient population. I have noticed that while many patients have private insurance and ask

for private referrals, some families really struggle with a range of social and financial issues which adversely affect their health. In other words, the health inequality is fairly evident even within a single GP practice. As a GP with an active interest in public health, I aim to reduce that gap. Even though the journey to find an ideal GP practice was a bit wobbly at times, I am happy with where I am now and I am grateful for the lessons learnt on the way.

Currently, I am thrilled to be an NIHR in-practice fellow based at The Healthcare Improvement Studies (THIS) Institute, which aims at improving quality and safety in healthcare. I am supervised by two wonderful supervisors, Professor Graham Martin from THIS Institute and Dr Juliet Usher-Smith from the Primary Care Unit. Our research project aims to improving the interface between primary and secondary care in relation to referrals. My research proposal was timed well with the current move towards integrated care systems (ICSs), which calls on NHS providers to look beyond their organisational priorities and collaborate with others[14] and my research area of interest has become quite topical recently with the discussion of advice and guidance for all referrals.[15]

While the academic role injects additional meaning into my career as a GP, my GP work informs what it is that we need to change to improve things on the frontline. The academic role has also offered me opportunities for teaching medical students at the University of Cambridge and has given me a lot more control over my day-to-day and holiday schedule. I never wanted to be a GP partner because I was never interested in the business side of things and the role seemed to be very time-consuming and carried a great deal of responsibility. As a First5 GP, I would like to focus on developing my clinical skills and have the freedom and space to explore wherever my interests take me. Consequently, I am shaping a portfolio career based on academia, which is made possible by the salaried role.

The out-of-hours GP

Sian Tucker writes:

I have been working as a GP in out of hours (OOHs) in Edinburgh for 16 years, initially as an ad hoc GP besides daytime practice, then as a salaried GP alongside working in the emergency department (ED), then as clinical director of the OOHs service for 11 years, before moving back to a salaried GP when I took a deputy medical director job.

For this article, I canvassed my colleagues working in OOHs across Scotland to garner views on the best and worst aspects of OOHs working. The unanimous view was that the worst aspect of working OOHs is the unsocial hours, although conversely, many felt that it was exciting, going to work when everyone else is going home and going home when others are heading out. Of course, this is more delightful in summer when it is light and you have access to amazing sunrises and sunsets, the golden glow making home visits and lengthy drives much more enjoyable.

The smaller numbers of staff working OOHs leads to a tribe-like mentality. You have those within your direct OOHs team but also the wider community staff, including district nurses, mental health and social care teams. There are close relationships with your ED colleagues, with patients transferring both ways, those who would benefit from a more primary care approach being redirected to the primary care OOHs multidisciplinary teams (MDT) and obviously those who are more unwell being transferred to the ED. As we are an urgent care service and due to the absence of 'normal' pathways, it is often easier to speak directly to our secondary care specialist colleagues, avoiding the usual bureaucracy and getting advice in real time. It feels more like old school general practice.

The services in Scotland provide professional-to-professional advice lines for those working in the community, which includes ambulance teams, the police and often social care teams as well as health colleagues. This means the job is diverse, seeing patients face to face, travelling out on home visits and manning the phone lines to offer advice to fellow professionals or patients. There is a recognition that different members of the multidisciplinary team, and indeed individuals within the team, have differing levels of skills in different areas and there is more space to discuss cases, ensuring you make the most use of the collective knowledge and experience available. It is a fabulous training environment and teaching registrars, nurses and trainee paramedics provides a good platform for collaboration and interagency working. The patients you see often provide rare and unusual presentations.

One well-delineated aspect of shift working is you do not take work home: there is minimal administration, no referral letters to be written or results to be chased. OOHs feels like a more medical job, with a diverse patient group presenting with mainly urgent problems, avoiding the complexity of polysymptomatic problems, although often having to integrate multiple services to enable patients to remain at home as they wish. It feels like the purest type of general practice: the luxury of having one patient, one problem, usually with the ability to support, reassure or improve symptoms. There is, however, a loss of the continuity of care that is present in daytime practice and there is not the same ability to 'wait and see', hence the understandable lower threshold for treatment and the higher use of antibiotics. There can be an inability to follow through with patients that is frustrating, not knowing if you made the right decision. It can feel riskier, you can feel vulnerable when faced with medical emergencies, although this can be negated if you are co-located with an ED or working closely with the team, which helps you to feel less alone. It is important to connect with colleagues to cultivate a strong team-based ethic and ensure you are supported and that you can learn from mistakes and successes, both yours and those of your colleagues, which is why clinical leadership is so important in this space.

Overall OOHs can be a joyful job, challenging on the little grey cells in a dynamic environment where innovation and change are encouraged, where you are pushed to think outside the box to come up with novel solutions for patients who are incredibly thankful for your time and care. I love it! ■

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