**PAPER FROM NHS ENGLAND**

**Improving retention of older doctors**

**Overview**

1. This proposal is intended to contribute to a range of measures that will help reduce the number of GPs who leave the profession early, and contribute to the Government’s target to increase the number of doctors working in general practice by 5,000. This scheme will establish an opportunity for GPs to increase flexibility, variety and choice in their medical role.
2. This scheme will enable health systems to recruit experienced GPs, who are at risk of leaving the workforce, into a resource pool that work across a health systems area. These GPs would be recruited by a lead employer. The benefits of the GP pools would be to increase clinical capacity across the local footprint; and would be attractive to GPs as it would offer financial support for professional expenses and CPD and a portfolio of roles as part of a more flexible way of working.

**Background**

1. Research commissioned (Ipsos MORI, PRUComm[[1]](#footnote-1)) shows that a complex combination of factors lead to poor job satisfaction among GPs and push them towards leaving the profession, especially later in their career. The five key factors include:
2. workload
3. remuneration (and the impact of pension changes)
4. perceived lack of recognition (from patients, Government and indeed within the medical profession)
5. increasing bureaucracy and indemnity costs
6. lack of peer support.
7. We have a number of concrete actions in the General Practice Forward View designed to tackle most of these issues (save personal remuneration and pensions). This includes things like the £30m GP provider development programme, which supports practices make ten high impact changes to manage their workload better, and improve patient and staff satisfaction whilst doing so. We can provide further detail on this if necessary.
8. But we know that we have a particular challenge with older doctors (see below), and so also believe we need a more targeted approach – but one that is compliant with age discrimination legislation.

**Percentage leavers comparison (all) based on age group – 2004 and 2014**

Source: HSCIC General and Personal Medical Services, England 2004-2014, as at 30 September.

1. The table above shows that the number of GPs leaving the profession has risen sharply over the last 10 years for those aged 50 and over. The number of GPs between 55 and 59 who left the profession increased considerably from 243 in 2004 to 697 in 2014. This is nearly a trebling in the proportion of doctors leaving at this age.
2. The appetite for portfolio careers among GPs of retirement age is high, with many retiring to work on a locum basis and combining their time with other jobs such as teaching[[2]](#footnote-2).
3. We also know that anecdotal evidence suggests that many newly trained GPs, rather than committing to a salaried post within a single practice, choose instead to locum. This gives them greater flexibility and control of their working life and enables them to experience a range of work (in hours / out of hours) across a range of practices and health providers.

**Principles of the scheme**

1. NHS England led a workshop to develop ideas about how to retain experienced GPs, to increase clinical capacity and enable GPs to undertake portfolio of roles as part of a more flexible way of working. The workshop was attended by Chair and Chair elect of the RCGP (Maureen Baker and Helen Stokes-Lampard), senior members of the BMA and colleagues from Health Education England.
2. The workshop developed the idea of a scheme which could be called something like “GP Career Plus Scheme” or “Flexible Career Scheme”.

**The model scheme**

1. GPs who would otherwise leave are recruited into a permanent pool hosted by a lead employer (federation or other provider). It will be important to make it more attractive than leaving altogether, but less attractive than remaining a partner in practice – otherwise we are at risk of diverting clinical capacity from one part of the system to another, rather than increasing the quantum of clinical capacity in the system. These GPs would be salaried and paid by the lead employer who would then charge practices and other organisations for work done. The GPs’ salaries would be comparable to a practice based salaried post. The pool will cover a large population (potentially up to 1.5m) with a single organisation acting as a lead employer on behalf of others.
2. The GPs would be able to access CPD and other professional development and would receive a contribution to costs including indemnity and GMC registration. Support would also be provided for appraisal and revalidation. In the first instance, we are proposing that NHS England funds this although in the long-run this would need to come from core allocations. Administration and salary costs would be paid by the lead employer, and recouped through a charging system to practices and other organisations.
3. The GPs within the pool would be able to continue to contribute to the local health system as part of a local team. They would be matched and deployed to practices on various assignments depending on their skills, their requirements and the needs of the practice / population.
4. Work carried out by these GPs could be recharged by the lead employer. While the lead employer carries employment liabilities, much of the clinical activity would be recouped from practices and other organisations which requested help.

Assignments

1. The GPs within the pool could provide a range of services across the local system, which may include:
2. Clinical capacity for practices to cover: vacancies; annual leave; parental leave; and sick cover.
3. Specific types of work e.g. long term conditions, access hub sessions, home visits.
4. Leadership roles: clinical training, individual mentoring and coaching, innovation and change leadership, support for practices in crisis or in under-doctored areas.

*Example 1: GPs might be recruited into the pool if they have extensive experience of long terms conditions such as diabetes, heart failure or chronic respiratory disease. This enhanced service could be accommodated with extended appointment times where agreed. The lead employer may initiate these services in partnership with the GP within areas which have high numbers of complex patients. This would provide a flexible workforce which could respond to the needs of patients across multiple practice sites while offering a supportive and adapted employment option for these experienced GPs.*

*Example 2: A GP wishes to undertake specialised clinical sessions with patients with long term conditions and also undertake teaching / mentoring across the health system supporting less experienced GPs. The lead employer agrees to employ this GP on the condition that they undertake four standard clinical sessions a week to complement the other five sessions.*

**Implementation**

1. There is more work to refine the costs and implementation model, but our current thinking is:
	1. We would kickstart the programme by contributing to the costs of these GPs – potentially around £12-20K per GP. For £1 million investment in 17/18 we could secure around an extra 50-85 GPs, focused at, say, the five areas of greatest need. This is affordable from within our current nationally held budgets for workforce.
	2. We would assess the extent to which this was a sufficiently attractive offer to increase overall clinical capacity in the system, and did not destabilise local practices.
	3. In light of that, we would look to promote it in parts of the country with the highest ratios of 55-59 year old doctors; and potentially offer further support. In the long-run the model would need to be able to be sufficiently beneficial to be funded by local systems – recognising that it could be cheaper than reliance on locums or squeezing capacity in general practice to such an extent that people turn to the acute sector instead.
1. Worsley and Cook (2015) Research on the recruitment, retention and return of GPs in England. Ipsos MORI. Peckham, Marchand and Peckham (2015) General practitioner recruitment and retention: An evidence synthesis. PRUComm. [↑](#footnote-ref-1)
2. Worsley and Cook (2015) Research on the recruitment, retention and return of GPs in England. Ipsos MORI [↑](#footnote-ref-2)