RECRUITMENT AND RETENTION OF 'DEEP END' GP PRACTITONERS

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Recruitment and Retention of 'Deep End' General Practitioners

1.0 Abstract

Background:

UK NHS GP Practices serving relatively more deprived communities have the dual challenge of a relative increase in service demand whilst operating with a reduced workforce, a recipe fuelling widening health inequalities. 'Deep End' practices consist of GP surgeries providing healthcare services to the 15% most deprived populations as per the UK Index of Multiple Deprivation (IMD) rank. The literature search strategy exposed a paucity of research as related to the study objective. Retention of pre-existing working age GPs accompanied by additional recruitment is critical in ensuring adequate workforce supply to meet future NHS service demands. Theories of employee motivation and engagement are explored.

Research Objective: To identify key factors that influence the recruitment and retention of GPs working within 'Deep End' Practices from the perspective of GP surgery partners.

Research Question: What perceptions do 'Deep End' GP Surgery Partners have on the factors that influence the recruitment and retention of GPs?

Methodology: This research study is situated within a qualitative framework with interpretivism as the epistemological basis and constructivism as the research paradigm. As perceptions were explored, a phenomenological approach was adopted. The participants were selected utilising a purposive sampling technique as partners specifically within 'Deep End' practices were required. Luton within England, UK was selected as the geographical location given the relative high concentration of 'Deep End' practices and closeness to the researcher. 8 semi-structured interviews were conducted virtually via synchronous video consulting facilities utilising Zoom© software as the data collection tool to assist efficient collaborative dialogue in the context of the ongoing Covid 19 pandemic. Ethical

approval was gained from the University of Wales, Trinity Saint David. Thematic analysis was utilised as a strategy for data analysis.

Data Analysis: Overall 5 themes were identified: **GP Partner identity/role** (including value of GPs as 'specialists' in primary care, role as the 'named' GP, adverse media coverage and future viability of the partnership model), **patient factors** particularly relevant to 'Deep End' practices (including wider determinants of health, language barriers and co-morbidities at a younger age), **work environment** (including job satisfaction, workload, safety, premises and the GP market), **continuous professional development/career progression** (including portfolio careers and training practices) and finally **resources/remuneration** (including the Carr-Hill formula, wider workforce and the NHS Pension scheme).

Recommendations: 20 recommendations linked to Maslow's hierarchy of needs theory (physiological, safety, belonging, esteem and self-actualisation) albeit with cessation of the pre-potency principle are proposed for stakeholder action to ensure meaningful 'levelling up' is realised for all communities with regards to the provision of NHS primary care health services within the UK.

Recruitment and Retention of 'Deep End' General Practitioners

2.0 Introduction

This chapter outlines the study objective and related question with the rationale provided. It provides related contextual information in terms of the contractual basis of GP surgeries, the role of GP surgery partners and their supply and the definition of 'Deep End practices'. This study relates to the UK National Health Service (NHS) and specifically NHS England. It is anticipated that the findings will relate to the whole of the UK NHS given the uniformity of the role of GPs throughout the UK but an appraisal of the individual variations of contracted services or polices within each devolved UK nation is beyond the scope of this report. The related literature review will further explore the pre-existing research base and outline relevant theories of employee motivation and engagement.

Research Objective: To identify key factors that influence the recruitment and retention of GPs working within Deep End Practices from the perspective of GP surgery partners.

Research Question: What perceptions do 'Deep End' GP Surgery Partners have on the factors that influence the recruitment and retention of GPs?

Primary care within the UK National Health Service (NHS) continues to experience unprecedented challenges in relation to the recruitment and retention of General Practitioners (GPs) with a sustained fall in the number of qualified GPs arising for the first time since the 1960s (Nuffield Trust, 2019). The 1978 Alma-Ata declaration enshrined the function of primary care in the provision of community-

based person-centred holistic care at all stages of life (WHO, 2022). Furthermore global efficient primary health care services proactively seeking to address the socio-economic determinants of health were considered essential in the eradication of health inequalities leading to more equitable societies. GPs providing primary care services contribute to a reduction in morbidity and mortality particularly amongst vulnerable groups (Starfield, Shi and Mackinko, 2005). Conversely, an increase in secondary care provision without adequate primary care support structures has not shown to lead to enhanced population health outcomes. Personalised care planning whereby the patient takes shared responsibility for their holistic physical, social, and psychological care needs is a fundamental element of primary care (NHS, 2019a). GPs have a unique role within primary care in being accountable for the coordination of care of named registered lists of patients in the community (BMA, 2020a). The provision of GPs is fundamental to the delivery of personalised individual care alongside the improvement of population health outcomes and the reduction of health inequalities. Thus investigating the factors influencing the recruitment and retention of GPs is of vital importance to the field of human resource management particularly theories of employee motivation and engagement and public sector healthcare provision within the UK.

Nussbaum et al (2021) states areas that are relatively more socioeconomically deprived experience disproportionate GP shortages. The analysis adopted involved calculation of the slope index of inequality (SII), a measure of the of the difference in full time equivalent (FTE) direct patient facing staff per 10,000 patients between dissimilar areas based on deprivation levels determined by utilisation of the index of multiple deprivation (IMD). The IMD ranks neighbourhoods according to relative deprivation determined by several factors including levels of income, working age employment, risk of premature death due to suboptimal physical and mental health, localised crime, access to adequate housing and the quality of the local environment (GOV.UK, 2019). Deep End Practices consist of GP surgeries providing healthcare services to the 15% most deprived populations

as per the IMD rank (Watt, 2012). On average, life expectancy is reduced by 7-9 years and healthy life expectancy by 19 years in the most deprived populations as compared to the least (Office of National Statistics, 2017). Overall no studies exist which define the factors that influence the recruitment and retention of GPs working in Deep End practices within the UK. This report seeks to address this gap in the academic literature, with resulting outcomes intended to influence GP workforce recommendations particularly for 'Deep End' practices, a workforce instrumental in improving health outcomes and health inequalities.

General practice surgeries are small to medium-sized enterprises (SMEs) commissioned to provide NHS services via a state funded contract (King's Fund, 2020). The organisational structure of GP surgeries as independent organisations dedicated to providing holistic care to local populations free at the point of service regardless of patient income has been enshrined since the inception of the NHS in 1948 (DFID, 1999). At the origin of the NHS, the independent GP contractor status was largely a pragmatic resolution as given the paucity of state owned health infrastructure GPs usually provided services from their own homes which were not subject to nationalisation. Moreover prohibition exists on the sale of GP surgeries including goodwill and the advertisement of services for business purposes (Irvine, 2021). Additionally patients are not subject to an eligibility assessment based on their needs in order to access equitable healthcare when they register at a NHS GP practice. The overwhelming majority of GP practices function under a partnership model with the partners operating as self-employed contractors with unlimited liability status (Watson, 2019). GP surgery partners are personally responsible for all organisational liabilities including costs related to staff, premises and some forms of indemnity. Thus GP partners are the prime subjects of this study given their unique role in providing primary healthcare services within the UK.

King's Fund (2020) outlines the following three GP surgery NHS contract types with the related rates of uptake: General Medical Services (GMS) at 70%, Personal Medical Services (PMS) at 26% and Alternative Provider Medical Services (APMS) at 2%. The GMS contract is the standard contract negotiated annually between NHS commissioners and the British Medical Association (BMA), the trade union representing GPs. The PMS contract which is being phased out, is determined locally via direct liaison with local commissioners and GP surgeries. The APMS arrangement allows the NHS to provide contracts to non-GP surgery organisations such as private companies and social enterprises. Funding for APMS practices is higher based on income received per registered patient than GMS/PMS practices (Bhatti and Majeed, 2016). The APMS avenue has attracted much controversy as it has been deemed a vehicle allowing the sale of NHS services for corporate gain with maximisation of profits rather than provision of equitable healthcare as the main organisational strategic objective (Iacobucci, 2021). Although the NHS constitution precludes the sale of GP surgeries, change in ownership of APMS organisations has been allowed to proceed due to the acquisition of parent private companies. Critics of the APMS structure cite such changes in ownership as an exploitative loophole allowing corporate companies to avoid the usual NHS procurement rules that traditional GP partnerships under GMS/PMS contracts must abide by.

King's Fund (2020) highlights the services GP practice surgeries are contracted to provide (see the table below).

Table 1: NHS contracted GP services.

Service	Features
Essential	Mandatory provision between 08:00 and 18:30 Monday to Friday. They include assessment and management of acute and chronic physical and mental health conditions including terminal illness, health promotion and referral to other specialist services including emergencies.
Additional	Optional extra specific clinical services that the practice have a preferential right to provide such as minor operations.

Out-of-hours	Provision of primary care health services outside of mandatory hours (08:00-18:30). GP surgeries can opt out of these services leaving NHS England the responsibility to commission alternative providers to cater for the needs of the local population.
Direct Enhanced Services (DES)	In 2019, plans were introduced to allow the formulation of Primary Care Networks (PCNs), groups of GP practices working collaboratively to provide localised services to at least 30-50 thousand patients to optimise local health outcomes by seeking to utilise economies of scale (NHS, 2022a). Although membership of the PCN DES is currently optional, in reality significant financial disincentive ensues in the absence of membership. Over 99% of GP surgeries are members of a PCN. Additionally via the PCN DES additional roles reimbursement scheme (ARRS), GP surgeries have access to resources to employ a range of allied health professionals.
Locally enhanced/commissioned services (LES)	These are bespoke locally commissioned services based on the unique needs of the local healthcare environment such as the development of a homelessness service.

General practice surgeries generate approximately 50% of their income via a mechanism known as the global sum which caters for the provision of essential, additional and out-of-hours services (King's Fund, 2020). The global sum is calculated using the Carr-Hill formula based on a capitated funding principle utilising a weighted patient list (Rhys, Beerstecher and Morgan, 2010). The objective of the Carr-Hill formula introduced in 2004 was to allocate resources equitably based on practice workload with measures for age, sex, deprivation, rurality, labour costs, list turnover and care home residents encompassing the calculation. Inevitably some GP practices incurred a loss of income on implementation of Carr-Hill which was compensated by additional payments known as provision of the correcting factor until 2021 (BMA, 2020b). Arguably the correction factor largely negated the underlying principle for the adoption of Carr-Hill as a mechanism for resource redistribution. Nevertheless criticisms of the Carr-Hill formula include the implementation of a national/local modification application factor negating the assessment of direct comparison of resources at a UK wide level, linking the time spent accessing the electronic health record stratified by patient demographics as a precursor of related workload rather than the measurement of actual clinical activity and continual use of standard mortality and long standing illness rates for patients under 65 years of age based on data from 1998-2000 as the indicator for deprivation.

Gopfert et al (2021) further highlights the limitations of the use of pre-existing consultation lengths as a valid indicator of healthcare needs arising from deprivation and/or multi-morbidity as consultation lengths are not necessarily increased in practices serving the most deprived populations. In reality, it has been postulated that patients receive what is offered during a consultation whereby a clinician seeks to maximise efficient use of their resources in often under-doctored areas. Practices operating within more deprived populations are allocated approximately 7% less funding per need weighted registered patient as compared to those serving the least deprived (Fisher et al, 2020). In essence, GPs navigate distribution of the limited clinician time amongst a surplus of patients with complex needs to ensure each patient at a minimum receives some access to care rather than none to initiate the primary steps in their ongoing care journey and exclude any immediate emergencies. Rather than consultation length times, frequency of consulting has been identified as a potentially valid determinate of healthcare needs. Patients aged 50 in the most deprived areas consult at the same frequency as those aged 70 in the least deprived areas (Boomla, Hull and Robson, 2014). Currently frequency of individual consultation rates are not operationalised within the funding formula and thus this absence is considered to play a role in exacerbating health inequalities.

Quality and outcomes framework (QOF) payments introduced in 2004 comprise approximately 10% of GP practice income (King's Fund, 2020). These payments are performance related whereby income is currently contingent on the achievement of several clinical indicators including chronic disease management, health promotion, vaccination uptake, cervical screening, safe prescribing and optimisation of service access designed to ensure equity of service outcome amongst primary care nationally (NHS England and NHS Improvement, 2022a). Approximately 95% of practices partake in QOF as involvement is optional. Systematic review evidence contends that although QOF led to benefits in terms of consistent capture of clinical data, development of disease registers and perhaps

modest slowing of related emergency admissions, increased consultations for those with severe mental illness and improvements in diabetes care, overall no impact on mortality rates has ensued (Forbes et al, 2017). This systematic review was plagued with paucity of adequate outcome data with identified findings confounded by the impact of other variables such as the wider socio-economic determinants of health. Additional drawbacks of QOF include a lack of correlation with factors considered fundamental to optimising health disparities such as the provision of holistic, personalised and integrated care in a coordinated manner (Close et al, 2018). It can be concluded that although QOF provided a template to streamline consistent recording of data enabling reliable comparison of certain outcomes this may have been at the expense of clinicians focussing solely on the individual needs of their patients. Clinical guidelines enshrined within QOF predicated on managing single disease presentations are not consistent with the reality of patients presenting with multiple long term conditions requiring an individualised approach to providing care.

GP surgeries are reimbursed for the costs associated with residing in premises providing NHS services (BMA, 2018). Based on whether the partnership has complete ownership, a mortgage in situ or leases the premises, the NHS reimburses the associated costs by providing the related rent at current market values or borrowing costs. GP practices can also claim for certain costs known as primary care (PCO) administered payments related to locum cover in specified circumstances such as maternity, paternity or adoption leave and annual appraisal costs (King's Fund, 2020). A GP practice may decide to pursue formal accreditation as a GP training practice becoming responsible for the specialist training of the future GP workforce. The GP practice will receive funding for hosting the junior doctors in training in the form of trainer grants, payments for regular reviews known as educational supervisor reports (ESRs) for each trainee, allowances for continuous professional development (CPD) and external payment of the salary of each junior doctor (Health Education England, 2022a). Accredited GP trainers within training practices provide the educational supervision for each trainee. The associated expense

of GPs training to become educators is subject to reimbursement from Health Education England (HEE). The host training practice is responsible for financing the resources required to clinically supervise each trainee. Overall GP training practices have the potential benefit of maximising the utilisation of the medical skills of junior doctors with their salaries fully reimbursed. Additionally GP practices, may decide to receive funding by hosting undergraduate medical students subject to direct contractual liaison with local medical schools.

3.0 Literature Review

This chapter outlines the adopted literature search strategy to elucidate the pre-existing body of academic knowledge and thus highlight the space in which the aforementioned study is located as an original contribution. The current GP workforce operating within specific NHS service demands particularly as relevant to 'Deep End' practices will be evaluated. Furthermore this chapter will appraise the UK national GP retention and recruitment programmes and employee engagement/motivational theories.

3.1 Literature Search strategy

Aromataris and Riitano (2014) highlight the vital importance of the literature review as being a prerequisite in establishing the necessity of the proposed research project. In essence, a robust analysis of the relevant body of knowledge allows a determination of the uniqueness of the proposed study objective and its potential significance in seeking to contribute further insights into a particular field. Thomas and Tee (2021) cite generativity as the core principle of a research project, namely that the eventual study output should seek to evoke rejuvenation of the pre-existing historic context of the study subject or introduce novel perspectives for further consideration. This study pursues the perceptions of 'Deep End' GP partners on the factors that influence the recruitment and retention of

GPs. The literature search strategy exposed a paucity of research in the specific aforementioned criterion, with no studies identified seeking the views of 'Deep End' GP partners.

Aromataris and Riitano (2014) propose a serial strategy in identifying relevant research items with focus on the following in order of importance: systematic reviews, peer reviewed journal articles, policy papers, books and then conference papers and grey material. Using this strategy, The University of Wales, Trinity Saint David, online library and learning resources search tool was utilised to detect applicable materials. Additionally Google Scholar was utilised for any additional resources not identified from the original search mechanism. The advanced literature search was conducted using the Boolean search mode (see table below).

Table 2: Literature search criterion.

Search category	Search items
Multiple mesh terms	Fields General Practitioners (GPs, Primary Care doctors, Family doctors), AND Recruitment (Retention, Employment, Staffing, Workforce, Partnership) AND Deep End (Index of Multiple Deprivation, Deprived, Inequalities).
Peer review	Peer reviewed resources worldwide published in the last 20 years.
Language	Items restricted to English
Process	All available results/abstracts were reviewed for relevance and thereafter critical analyses conducted on the entirety of the selected items. Furthermore, reference lists within peer reviewed articles were scrutinised for potential relevance. The grey literature was explored to ascertain any additional pertinent resources.

3.2 The GP workforce and service demands

In 2015, the UK government announced a target of an additional 5,000 GPs by 2020 to address the historic deficit in the supply of primary care staff at a time when exceptional demand in services existed given an aging population with multiple morbidities (Gov.UK, 2015). This recruitment target was not achieved but rather aggravated with a corresponding projected reduction of 1,863 FTE GPs

(Buchan et al, 2019). Moreover, further analysis reveals a lack of consistency in establishing what constitutes a GP for the purposes of government recruitment targets with those in training (GP registrars and foundation doctors) also contributing to the overall total calculated FTE GPs. Subsequently the UK government has re-pledged the requirement to address the staff shortages within primary care, setting a recruitment target of 6,000 extra doctors and 26,000 extra allied health professionals by 2024 (Conservatives, 2019). As stated within the introduction chapter, PCNs are the vehicles by which NHS funding is allocated to allow the employment of allied health professionals such as pharmacists, physiotherapists, dietitians, health coachers and social prescribers.

Retention of pre-existing working age GPs accompanied by additional recruitment is critical in ensuring adequate workforce supply to meet future NHS service demands. Walker et al (2020) state those GPs aged over 55 years of age are most likely to leave the profession through early retirement. Unprecedented work pressure and a lack of job satisfaction are cited as the main contributory factors to early retirement. The data for this analysis was collected prior to the Covid 19 pandemic. The Covid 19 pandemic continues to place unparalleled challenges on the NHS and primary care as the health service deals with a severe backlog in care contributed by Covid 19 related morbidity and mortality, emergence of long Covid as a chronic condition, staff sickness, public health isolation guidelines, initial reduced system-wide service provision, prioritisation of the Covid 19 vaccination programme and provision of emergency care, postponement of patient presentations and possible delayed diagnoses leading to acute emergency attendances (Institute for Government, 2022). The Care Quality Commission (2021), the UK health and social care regulator has acknowledged the detrimental impact of the pandemic on staff stress, morale, and mental health. A plan to confront a GP workforce deficit must seek to address challenges posed by staff retention as well as additional recruitment, particularly in those areas historically disproportionately affected by shortages.

Covid 19 further exacerbated these underlying inequalities with pandemic related mortality rates for those under 65 years of age almost four times higher in the most deprived 10% of localities in England (Suleman et al, 2021). Pre-existing health conditions, unemployment and unstructured work contracts, disproportionate essential work employment involving direct people facing roles not protected by the furlough scheme, crowded housing and reduced rates of vaccination coverage are cited explanations for the excess mortality within relatively poorer communities. Norman, Wildman and Sowden (2021) state primary care staff working in Deep End practices during Covid 19 have found patients struggling with accessing health and community services due to lack of health literacy and digital poverty as technological applications are increasingly adopted. Consequently GP Practices serving relatively more deprived communities have the dual challenge of a relative increase in service demand whilst operating with a reduced workforce, a recipe fuelling widening health inequalities. Hart (1971) termed this inequity the inverse care law, with the misdistribution of resources further exacerbated within healthcare structures unduly exposed to market forces. Upon certification, GPs have the liberty to seek employment not only anywhere within the UK, but indeed the wider world. Although UK primary care is fundamentally state commissioned, the recruitment of professionally qualified staff is subject to open market forces.

Several studies have been conducted reviewing the challenges posed by the recruitment and retention of GPs within the UK. Marchand and Peckham (2017) conducted a systematic review which concluded recruitment is optimised by early and sustained exposure to pre and post graduate GP placements whereby individualised education learning plans are developed. Furthermore portfolio careers and positive job satisfaction are key determinants in retaining staff. A lack of evidence exists to showcase the benefits of extrinsic factors such as income incentives to remain in clinical practice. An earlier systematic review corroborates these findings but highlights flaws in the methodology of trials assessing the impact of strategies generally (Verma et al, 2016). Similar challenges exist specifically

within rural settings with the additional pressures on maintaining a support network for professional and personal roles (Holloway, Bain-Donohue and Moore, 2020). Campbell et al (2019) cite threats to professional identity and perceived devaluation of the GP role, inability to provide services within a safe working environment and a lack of defined career opportunities as critical issues negatively contributing to retaining GPs. This research involved interviewing GPs within one region in the UK (South West of England). The study did not focus on identifying Deep End practices and nor exclusively draws inferences with specific regard to deprivation. Overall no studies exist which define the factors that influence the recruitment and retention of GPs working in 'Deep End' practices within the UK.

3.3 National GP Retention and Recruitment Schemes

The National GP Retention Scheme consists of additional central NHS provision of financial and educational support catered to retain GPs who may otherwise exit from providing front line NHS clinical care (NHS, 2019b). The eligibility criteria for the scheme involves specifically targeting GPs who are at risk of leaving clinical practice due to personal reasons such as caring responsibilities or ill health, or approaching retirement or desire for enhanced work flexibility to fulfil additional roles, in circumstances whereby their pre-existing work schedule is ineffective and additional education supervision is recommended to aid the maintenance of professional networks. Although a paucity of analysis assessing the effectiveness of the programme exists a number of case studies reveal its positive impact. Case studies have demonstrated the active utilisation of the scheme maintaining GPs in the workforce during times of illness, additional family caring responsibilities and in the accommodation of other crucial healthcare related roles within a supportive environment (NHS, 2022a). The GP International Induction and Return to Practice Programmes (2021) allow qualified GPs practicing abroad or GPs returning to clinical practice after a significant break of at least 2 years to enter the UK NHS workforce (Health Education England, 2022b). The quality assurance of these programmes is maintained by evaluation of individual qualifications and subsequent additional

summative assessment, UK workplace placements overseen by trained educational supervisors and the maintenance of a placement e-portfolio evidencing competence in essential capabilities via workplace based assessments and reflective practice. The programmes are supported via a centrally funded bursary of up to £3,500 per month during the placement, financial assistance towards child/social care and access to a dedicated manager aiding in the navigation of the system for each applicant.

Shah, Nayar and Grzesiak (2021) demonstrate the relative success of the GP International Induction and Return to Practice Programmes (previously entitled Induction & Refresher [I&R] scheme) with approximately 82% of GPs enrolled within the programmes continuing to provide NHS services. Furthermore the scheme was overwhelmingly viewed as equally positive for both UK (45% of applicants) and overseas graduates (92% of which qualified from a medical school within Europe) with acculturation to the NHS system, educational supervision and the opportunity to gain clinical experience cited as particular strengths. Limitations of the analysis include a lack of appraisal of the effectiveness of the programme at the UK level given only a specific region (London) was the focus of the study, lack of detail on the exact working profile of individuals as a collective such as the average number of clinical sessions worked and a lack of correlation linking recruitment to the deprivation of an area. Rimmer (2017) in contrast states the I&R scheme nationally has been of limited success, although statistical analysis is not provided. Additionally, the transition period with regards the UK leaving the European Union (EU) has concluded. Consequently, GP practices must formally apply to hold Tier 2 sponsorship licenses as part of the process to host international GPs whom are not UK residents (GOV.UK, 20220). This application process is somewhat eased with medical practitioners currently on the shortage occupation list (SOL) negating the need for practices to apply the resident market labour test (Wessex LMC, 2022). Nevertheless, the process does place additional bureaucratic and cost burdens on GP practices and the wider NHS with possible implications on the future ability

to recruit GPs internationally particularly from within the EU, a subject requiring further evaluation in the near future.

3.4 Employee Engagement

The recent UK labour market outlook report reinforces enduring recruitment challenges especially within the public sector with vacancy rates being highest within healthcare (54%), education (49%) and the voluntary (49%) sectors despite an unrivalled appetite in the marketing of related job roles (CIPD, 2022). Additionally the forecast highlights investment in staff development, pay rises albeit with the public sector more restricted due to financial restrictions, and adoption of flexible working conditions being increasingly utilised in mitigation to address staff shortages. The cited 3% median pay increment (within the public sector 1-2%) significantly dwarfs the current rate of inflation (ONS, 2022). The ensuing real terms reduction in disposable income and living standards could potentially become detrimental to employee wellbeing and thus work performance and organisational productivity. Nevertheless, investment in workforce continual professional development and upskilling leads to optimisation of personal (Bapna et al, 2013) and institutional outcomes (Georgiadis and Pitelis, 2016). Overall an affirmative approach to staff development and adoption of an organisational learning culture enhances the engagement of employees (Eldor and Harpaz, 2016). Employee engagement has materialised as the dominant prognosticator of NHS impacts (West and Dawson, 2012). This engagement leads to the co-creation of novel elucidations particularly during uncertain and challenging periods.

Macleod and Clarke (2009) found a lack of consensus in defining employee engagement with over 50 related terms in operation leading to a lack of scientific rigour in modelling its impact. Additionally a lack of uniformity in defined outcome measures and weak methodological approaches have hindered

a standardised approach to the implementation of best practice guidelines to enhance organisational employee engagement. Nevertheless a range of leading definitions considered to aid practical applicability have emerged. Robinson, Perryman and Hayday (2004) contend employee engagement consists of the adoption of an institutional structure facilitating the presence of a reciprocal two-way communication system between management and the wider workforce in formulating innovations to achieve strategic objectives. Therein the employees and employers genuinely cooperate to co-create, co-implement and co-own the strategic outcomes to justify the organisational mission statement. CIPD (2021) cite utilisation of an overall institutional engagement framework encompassing work engagement, organisational commitment (employees' psychological buy in/pledge to their workplace), organisational identification (how employee's view their workplace organisation) and work motivation. The subcategory of work engagement consisting of vigour (energy, resilience), dedication (passion, pride) and absorption (immersed in one's work) improves individual task and organisational performance (Schaufeli and Bakker, 2004).

3.5 Theories of Motivation

Maslow (1948) postulated that individuals are motivated to achieve objectives based on a hierarchy of needs whereby consciousness is predominantly monopolised initially on a series of deficiency needs before focus is shifted towards growth necessities. This hierarchy initially consisted of 5 levels (4 deficiency and 1 growth) with motivation being sequentially driven in an incremental nature, with person required to largely meet the factors within one level before progressing onto the next (see Figure 1 below).

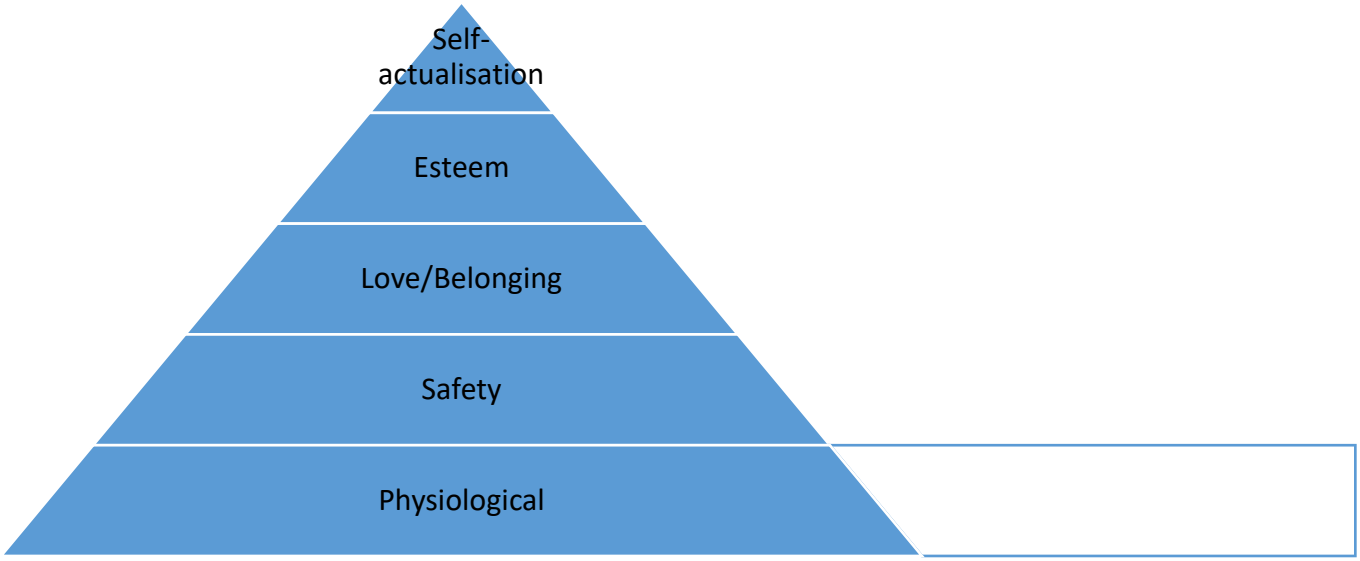

Figure 1: Outline of Maslow's hierarchy of needs.

The deficiency needs whereby motivation is considered to decrease as the requirements at each level are fulfilled consist of physiological, safety, love/belonging and esteem. The growth need whereby motivation is suggested to increase as it is accomplished consists of self-actualisation. Physiological needs contain biological necessities for survival such as nutrition, water, oxygen, warmth, clothing, sexual satisfaction and adequate sleep. Safety seeks to ensure stability in the status quo comprising of physical safety (shelter, avoidance of war/natural disasters/family violence/abuse and reasonable adjustments at home/work), financial security (job security, savings, pension, life and home insurance), and optimisation of physical and psychological health. The love/belonging subcategory involves a desire to enhance interpersonal relationships with family, friends, work colleagues and the wider community whilst gaining membership within formal groups such as religious groups. Esteem is subdivided into 2 categories with a yearning to enhance self-esteem (dignity, mastery, independence) and external respect (status, prestige). Self-actualisation involves an individual seeking to achieve their full potential at various stages of life with mastery of elements unleashing further inherent motivation to succeed in other avenues (developing talents, partner acquisition).

Maslow (1970a) expanded this five stage model to include growth elements of cognitive (requirement for intellectual curiosity, innovation, and creativity) and aesthetic needs (personal presentation, immersion in natural surroundings and appeasing imagery) below self-actualisation. Later an eighth category sitting at the pinnacle of the model termed transcendence which relates to providing oneself at the service of the community at large via acts of altruism and spirituality (Maslow, 1970b). A significant criticism of the use of Maslow's hierarchy includes the lack of diverse representation amongst the study subjects upon which particularly the theoretical basis of the apex of self-actualisation is predicated upon (Mittelman, 1991). The study subjects entailed only 1% of the college population and consisted with few exceptions of highly educated western white males. This western ethnocentric focus has led some to question the external validity of the hierarchy in those collectivist cultures placing primacy on the fulfilment of interpersonal relationships and responsibilities to the wider community over maximisation of personal material gain as prevalent in individualistic societies (Hofstede, 1984). Furthermore the lack of compatibility of the model with those whom consider their spiritual beliefs as a central tenet of their existence and source of motivation in the achievement of all aspects of life has been postulated (Bouzenita and Boulanouar, 2016). Overall Maslow's hierarchy of needs provides a pragmatic framework for motivational analysis by allowing consideration of interrelated items that may be contributing towards an individual's life circumstances despite the challenge of justifying the exact ordering of the subcategories obeying the pre-potency principle.

Herzberg's motivation-hygiene theory contends discrete characteristics either enhancing work satisfaction and motivation (motivation factors) or minimising dissatisfaction (hygiene factors) in a dichotomous manner exist (Hertzberg, Mausner and Synderman, 1959). It is postulated that an optimisation of motivational factors is not directly proportional to the lessening of dissatisfaction but rather each subcategory operates along an independent scale. Motivational factors consist of intrinsic work related features such as the nature of the challenge, level of autonomy and

responsibility, involvement in strategic decision making and recognition of achievements. Hygiene factors consist of extrinsic features allowing the maintenance of the status quo such as work conditions, salary, job security, annual leave, company policies, level of supervision and relationships with colleagues. Herzberg's theory states four discrete possible outcomes can arise (see Table 2).

Table 3: Hertzberg's theory possible outcomes

Category	Outcome
Low motivation, high hygiene.	Few complaints but lack of employee engagement. The job is viewed as a pay-check.
High motivation, low hygiene.	Employees are engaged but numerous complaints about work conditions exist.
High motivation, high hygiene.	Optimal situation. Employees are engaged in maximising efforts to achieve organisational objectives with few complaints about work conditions.
Low motivation, low hygiene.	The least desirable situation. Employees are least satisfied with the nature of the work and also find the work conditions very dissatisfying.

Herzberg claimed that factors leading to work dissatisfaction (hygiene factors) should initially be addressed in order to subsequently create the climate for the augmentation of organisational practices to improve work satisfaction (motivational factors) and subsequent employee engagement. Shujahat et al (2018) state positive work satisfaction leads to valuable knowledge sharing and subsequent innovative solutions to unique problems. A significant criticism of Herzberg's theory includes the premise that the motivational and hygiene factors occupy distinct unrelated scales, with research for several decades indicating the contrary viewpoint, such as the vital importance of the maintenance of positive working relationships being central to the enhancement of work satisfaction (Hines, 1973). Nevertheless Herzberg's theory provides an additional tool to allow an analysis of the several interrelated factors contributing to the overall work environment and job motivation. Herzberg's motivation-hygiene theory and Maslow's theory of hierarchy of needs both provide a framework predicated on the supposition of a 'standard' or 'average' person limiting their applicability for individual behaviour variability. Vroom (1964) provides an expectancy theory determining that

motivation is based upon an assessment an individual formulates on whether their task effort will lead to the desired performance (expectancy), whether the performance leads to a measurable individual outcome (instrumentality) and whether the outcome is valued by the individual based on their current predicament (valence). Overall the individual motivational force (MF) = expectancy X instrumentality X valence. A long standing criticism of this model includes its relative simplicity in trying to elucidate a complex interplay of several factors influencing motivation (Lawler and Suttle, 1973). Overall the aforementioned motivational theories provide a complementary toolkit that allow ascertainment of several interrelated factors contributing to a motivational value system when applied to individual behaviour.

3.6 Conclusion

This study pursues the perceptions of 'Deep End' GP surgery partners on the factors that influence the recruitment and retention of GPs. The literature search strategy exposed a paucity of research in the specific aforementioned criterion, with no studies identified seeking the views of 'Deep End' GP partners. It is envisaged that the findings of this study will inform recommendations influencing related GP recruitment and retention decisions. Retention of pre-existing working age GPs accompanied by additional recruitment is critical in ensuring adequate workforce supply to meet future NHS service demands. GP Practices serving relatively more deprived communities have the dual challenge of a relative increase in service demand whilst operating with a reduced workforce, a recipe fuelling widening health inequalities. The National GP Retention Scheme and the GP International Induction and Return to Practice Programmes are cited examples of national policy decisions contributing positively to enhancing the GP workforce. Employee engagement has materialised as the dominant prognosticator of NHS impacts (West and Dawson, 2012). Engagement leads to the co-creation of novel elucidations particularly during uncertain and challenging periods. Overall Maslow's hierarchy of needs provides a pragmatic framework for motivational analysis by

allowing consideration of interrelated items that may be contributing towards an individual's life circumstances despite the challenge of justifying the exact ordering of the subcategories obeying the pre-potency principle. Herzberg's theory provides an additional tool to allow an analysis of the several interrelated factors contributing to the overall work environment and job motivation. Vroom (1964) provides an expectancy theory determining that motivation is based upon an assessment an individual formulates on whether their task effort will lead to the desired performance and outcome.

4.0 Methodology

4.1 Qualitative Research

This research study is situated within a qualitative framework. Characteristics of qualitative research include exploring participant viewpoints on an emerging topic within a particular field usually within the participants' usual setting utilising an inductive process whereby data analysis seeks to formulate general themes from specifics (Malterud, 2001). A qualitative process supports an inquisitive approach to individual mean making by grappling with multifaceted data with the objective of understanding complex phenomena. In contrast, a quantitative methodology seeks to test the veracity of specific predetermined hypotheses utilising instruments to measure the correlation between distinct variables leading to numerical outcomes subject to analysis to determine statistical significance. Overall the selected research methodology is determined by an appraisal of the proposed study objective and thus the related question, the target audience and the personal views of the principle research investigators (Cresswell and Cresswell, 2018).

The objective of this study was to seek the perceptions of 'Deep End' GP Surgery Partners on the factors that influence the recruitment and retention of GPs. As outlined previously, the literature

review revealed no prior research specifically on the defined research question and thus no pre-conceived conclusions were foreseen. As the perceptions of participants to elucidate viewpoints on a multidimensional subject via an inductive process were to be discovered rather than the testing of pre-defined hypotheses leading to a determination of statistical significance of defined variables a qualitative approach was imperative. Furthermore, the requirement for the unvarnished thoughts, feelings and judgements of participants were necessary for data analysis, negating the utilisation of an objective measurement instrument designed to collect numerical data. The research envisaged stakeholders included all those with a vested interest in optimising the recruitment and retention of GPs particularly in 'Deep End' areas: patients, GP surgery partners, and the wider primary care workforce, GP training programmes, Health Education England (HEE), the wider NHS and ultimately the UK government. In summary a qualitative approach was employed as the purpose was for detailed textured narratives relating to the perceptions of the participants in a specific setting to be discovered rather than the construction of arithmetical facts to examine pre-defined hypotheses.

4.2 Paradigm

Several methodologies, theoretical frameworks and research methods exist within the overarching umbrella denoted qualitative research. A research paradigm consists of a prevailing belief system determined by a set of values underpinning the conceptualisation of the fundamental nature of phenomena as its theoretical approach (Gray, 2018). A number of definitions often contradictory with regards to defining several distinct theoretical frameworks exist, leading to confusion in distilling concrete notions and thus methodological inconsistencies in their application within research. Kivunja and Kuyini (2017) highlight the paradigms of positivism/postpositivism, constructivism, transformative and pragmatism as the four distinct subcategories meriting further evaluation. Rehman and Alharthi (2016) emphasise the delineated paradigm of a study is predicated on notions of ontology and epistemology with ontology consisting of the belief in the actual nature of reality and epistemology with the nature of knowledge and its acquisition.

Kivunja and Kuyini (2017) indicate that historically the ontological basis when conducting scientific research has been grounded in realism, a belief that a singular true reality exists to elucidate a particular occurrence. Consequently the epistemology related to realism is that of objectivism, in essence the existence of only one true valid possible observance to explain the phenomenon of interest. In contrast, the ontology of constructivism advocates the existence of manifold actualities of a particular item leading to various iterations of the creation of knowledge as the subject grapples to make sense of their unique context whilst rejecting the notion that a singular validated truth can be revealed. The coinciding epistemology related to the ontological viewpoint of constructivism is termed interpretivism, namely that several possible realities of a single manifestation of interest exist. Quantitative research is predicated on realism and objectivism whereby the focus is to delineate defined outcomes based on the principle of testing the veracity of pre-defined hypotheses using a validated instrument designed to objectively measure numerical values. Conversely, qualitative research wherein this study is situated to explore perceptions of GP surgery partners, builds on the notions of constructivism and interpretivism with emphasis placed upon the co-creation of outputs designed to explain complex phenomena.

Kivunja and Kuyini (2017) as cited earlier, compare the respective research paradigms. Postpositivism is usually the purview within quantitative studies as its central tenant consists of seeking the most plausible truth to a distinct query. This a slight departure from the positivism stance in knowledge being absolute with only one true reality present, with postpositivism advocates instead proposing that certain causes probably lead to specific outcomes subject to controlling for confounding variables. Postpositivism adopts a deterministic position acknowledging that a given notion of reality is subject to further qualification with advances in scientific instruments allowing ever more sophisticated

measuring methods. Nevertheless postpositivism restates the reductionist approach with a focus on defining the objective reality using validated instruments able to provide statistical measurement.

Constructivism supports a practice whereby knowledge is co-created by participants reflecting on their contextual experiences leading to multiple possible valid realities providing insights into the phenomenon in question and rejects the reductionist postpositivism method developed to test the validity of pre-defined hypotheses. Consequently constructivism is mainly adopted as the most prevalent paradigm within qualitative studies. Furthermore the particular insights of the researcher are encompassed as part of the iterative process required in mean making. The unique contribution of each participant is equally valid and utilised for further analysis. The emphasis is on maximising the potential of each and every contribution provided by individual participants by formulating a communal web of ideas to illuminate the complexity of a particular manifestation and thus subsequent iterations in an inductive process. The contributions of participants are constructed via a facilitated shared contextual social environment rather than merely being makeshift offerings. In essence the views of participants are the vital resource within the study and thus the selected methodological instrument must be designed to facilitate the maximisation of participant contribution.

The transformative paradigm is premised on the view that at the onset the central objective of the proposed research must seek to address a particular social challenge in the interests of enabling subsequent restorative justice particularly for marginalised communities such as those with disabilities, ethnic minorities, refugees and traveller groups. Study participants should include members from communities whom are the subject of the proposed research. As a political agenda is contained within the transformative paradigm, the research field should seek to address unique social predicaments such as income inequality, structural discrimination, homelessness or female

empowerment. The involvement of the research participants at all stages in the study design is critical to its validity and therefore collaboration is required when establishing the specific objectives, methodology, analysis, conclusions and recommendations. The transformative paradigm is distinctive in that it is not inhibited by the reductionist nature evident within a postpositivism approach whilst also serving a particular agenda limiting the possible field of study as compared to a study underpinned by constructivism.

Pragmatism contends that the study design should not be restricted by any predetermined commitment to a specific belief in ontology or epistemology but rather argues that the specific design should be dictated by the study objectives. Pragmatism involves the development of trial objectives subject to the usual literature search on the topic of interest and then subsequently adopting the most desirable methodological approach utilising both qualitative and quantitative methods to achieve the accomplishment of the objectives. The aim is to embrace achievement of the objectives and thus reality in a pluralistic manner whilst maximising the benefits inherent within adopting a mixed methods methodological process. Pragmatism seeks to address any concerns related to restriction in the methodology and/or analysis of study due to an overtly partisan philosophical approach to research.

This research study is situated within a qualitative methodology as the objective consists of seeking to gain the perceptions of 'Deep End' GP Surgery partners on the factors that influence the recruitment and retention of GPs rather than on numerical data for further statistical analysis. The relevant paradigm consists of constructivism as a focus on the co-creation of multiple possible realities of GP surgery partners with regards to their perceptions on the aforementioned objective within their unique contexts are desired to elucidate constructive narratives of a complex subject. The view that one probable certainty subsists to elucidate the perceptions of GP surgery partners in this setting is

rejected. Postpositivism would be unsuitable for this study as no predefined hypothesis amenable to statistical measurement via a validated tool with subsequent relevant analysis is intended. Conversely a constructivist methodology accommodating the personal nature of the investigation facilitating an inductive process to delineate multiple possible realities of the phenomenon not subject to predefinition is necessary. A transformative approach is not applicable as the primary focus of the study does not include defining a specifically oppressed group of society necessitating recuperative justice. Pragmatism lacks applicability as no quantitative methods are required as participant perceptions are being explored.

4.3 Research Design

The research study is situated within a phenomenology design. Neubauer, Witkop and Varpio (2019) define phenomenology as a study concerned with the lived experience of participants within a specific context such as an event, theory or manifestation. Within the research study, the perceptions of 'Deep End' GP Surgery partners on the factors that influence the recruitment and retention of GPs are envisaged. The cited advantage of a phenomenological approach consists of the establishment of an iterative inductive process allowing constant reflection on the data collected and the subsequent generation of themes facilitating revelation of opulent insights of the lived experience of participants within unique contexts. Neubauer, Witkop and Varpio (2019) state that a lack of potential generalisability of the findings to a wider context beyond the mentioned context of the study participants is often claimed about phenomenological studies.

4.4 Research Methods

4.4.1 Participants

The participants included within the research study were GP surgery partners within 'Deep End' practices. In terms of FTE, the NHS England GP workforce consists of 16,862 partners, 9810 salaried

GPs, 706 locums and 250 retainers as of May 2022 (BMA, 2022a). Additionally approximately 4% of GP surgery partners are not GPs but rather have other clinical (e.g. nurses) or purely managerial backgrounds (MDDUS, 2014). The participants potentially included all clinical and non-clinical GP surgery partners within 'Deep End' surgeries given their delegated responsibility for workforce staffing as custodians of independent NHS organisations. The participants were selected utilising a purposive sampling technique as partners specifically within 'Deep End' practices were required. Luton within England, UK was selected as the geographical location given the relative high concentration of 'Deep End' practices with 11/17 'Deep End' practices within the whole of Luton, Bedfordshire and Milton Keynes located within Luton (University of Cambridge, 2020). Additionally, I (as the researcher) am a GP partner within a 'Deep End' GP surgery within Luton, facilitating access to the targeted potential recruits. Campbell et al (2020) state the benefits of purposive sampling within qualitative research whereby explicit participant selection is linked to the objectives whereby in-depth views of parties of interest are sought include optimisation of methodological rigour and validity of the overall results.

In contrast, random probability sampling is usually the behest within quantitative studies pursuing valid statistical outcomes with external validity to a wider population. Purposive sampling complements an interpretivism epistemology and constructivism paradigm whereby the perceptions of GP partners within a specific context are desired rather than the implementation of deductively gleaned numerically significant outcomes designed for wider applicability. As stated earlier, several potential vested stakeholders with regards recruitment and retention of GPs exist including patients, GP surgery partners, and the wider primary care workforce, GP training programmes, HEE, the wider NHS and ultimately the UK government. Within this study, the specific views of GP surgery partners within 'Deep End' practices were explored as the criteria for the purposive sampling method. All eligible GP surgery partners within 'Deep End' practices within Luton were approached to partake in the study. All eligible participants were emailed the participant information sheet (Appendix A) and

the consent form (Appendix B). The potential participants were identified based on local knowledge (I am also a GP partner within a 'Deep End' practice within Luton) of GP partners within Luton and liaison with the practice managers of each eligible GP surgery. All eligible participants possessed a work related NHS email with individual addresses readily available via the NHS workforce email search facility inherent within NHSmail©.

Overall 8 participants from 4/10 eligible 'Deep End' GP practices were successfully recruited for the study, which was consistent with the 6-8 participants suggested at the project proposal stage. All eligible participants who consented to partake in the research project were recruited. The initial proposed recruitment target was established for both pragmatic and data saturation purposes. Pragmatism consisted of assessing the potential availability of GP surgery partners particularly given the pre-existing operational workload challenges as revealed within the literature search, timescale to complete the research and advice provided by the project supervisor. Additionally 3-10 interviews are considered the norm when conducting a study underpinned by a phenomenological theoretical basis (Creswell and Creswell, 2018). Conversely, recruitment of participants predetermined by an abstract number of interviews can lead to the lack of exploration of themes as data saturation may not have been reached. Fusch and Ness (2015) highlight data saturation is achieved when further participant inclusion does not yield any further insights and thus no further thematic codes are feasible. It appeared data saturation had been achieved after the 6th interview with no further themes being generated but rather a consolidation of perceptions gleaned from earlier interviews.

4.4.2 Research Instrument: Semi- Structured Interviews

Semi-structured interviews conducted virtually via synchronous video consulting facilities utilising Zoom© software was used as the data collection tool. The purpose of the study was to gain the

perceptions of 'Deep End' GP surgery partners in relation to the factors that influence the recruitment and retention of GPs. McIntosh and Morse (2015) state that semi-structured interviews allow for the efficient exploration of participant viewpoints within a constructivism paradigm whereby the interviewer and interviewee work in partnership to co-create data within a thematic framework. An exclusively structured interview agenda would have been constricting leading to participants' perceptions being potentially restricted. Conversely an unscheduled discussion approach whilst provides the freedom for unrestricted participant insights the associated risk includes the inefficient use of limited time to focus on areas of key study objective interests. Furthermore semi-structured interviews allow the questioner to guide the discussion topics to areas of study interest whilst allowing flexibility to explore participant thoughts whilst operating within an environment that allows explanation of questions and space to innovate by framing follow up queries.

Although the interviews consisted of a face to face format they were conducted via a video consultation facility principally to enhance recruitment and avoid unnecessary physical contact given social distancing guidelines particularly within healthcare settings during the ongoing Covid 19 pandemic. In person and synchronous live face to face interviews allow enhanced facilitation of conversations as benefits of both verbal and non-verbal communication can be exploited allowing the nuances of phonology to be utilised. Thiyagarajan et al (2020) contend that although video consultations provide invaluable access and ability to communicate remotely, they do not entirely replace the benefits of in person face to face interactions with the use of video software potentially hampered by technical problems, relative reduction in the use of non-verbal communication (e.g. in order to maintain eye contact individuals need to focus on the camera rather than the screen lead to possible missed non-verbal cues) and delays in audio/visual transmission. Nevertheless notwithstanding the restraints of video software facilitated discussions, it was concluded the use of synchronous virtual video face to face interviews was imperative to ensure the viability of the research

project. In person face to face interviews would have introduced disproportionate risk with reasonable requests for cancellations/postponements and virtual facilitation of interviews given the potential ongoing Covid 19 impact.

A disadvantage of employing interviews includes being more resource intensive given the time required in their mutual arrangement with participants, in conducting interviews and their subsequent transcription. Additionally, inherent associated costs with possessing required hardware and software to conduct and record interviews, the lack of interviewee anonymity and participant time required are additional limitations when utilising interviews as a research tool. Alternative tools of data assortment were judged to be unsuitable. Audio/telephone interviews are restrictive as the advantages of non-verbal communication are denied. Surveys are restraining when seeking to elucidate the perceptions of participants as outputs are confined to textual entries. Similarly observational methods would have been pointless as perceptions are not readily agreeable to sole observational detection. Focus groups allow dynamic participant interaction with the potential for an exchange of views of individuals connected to a specific context allowing for an opulent source of information. Conversely often individual detailed perceptions are stifled due to a relative lack of time afforded to each individual. Additionally significant challenges would have existed in setting up in person focus groups during the ongoing Covid 19 pandemic. Furthermore it would have been challenging to implement video application facilitated focus groups in terms of the associated set-up, actual process and subsequent transcription.

All conducted interviews were conducted virtually via synchronous video consulting facilities utilising Zoom© software at a time convenient to participants and lasted approximately 30-45 minutes. A convenient interview time was scheduled via email communication after an initial expression of interest with participants returning a completed consent form. The interviews were audio recorded

using Zoom © software and self-transcribed. An interview schedule predicated on a semi-structured interview design was utilised with the participants asked the relevant questions as per the schedule order (see Appendix C). The interview questions were trialled with pilot interviews conducted on volunteers with their feedback enacted prior to using the finalised version on actual participants. In response to participant responses, further follow up questions were asked to further explore their thoughts. Flexibility in following the interview schedule was afforded based on participant cues to enhance participant contribution (see Appendix D for an example of an interview transcript).

McIntosh and Morse (2015) highlight that the reliability of research enacted by the use of semi-structured interviews as the research instrument is dependent upon the ability of the schedule to measure the stated trial objective. In essence the reliability of this research project was reliant on the interview process guided by the interview schedule to determine the perceptions of 'Deep End' GP partners on the factors that influence the recruitment and retention of GPs. Moreover the reliability was enhanced as a reflective journal was formulated after each interview with a focus on the conduct of the interview process particularly whether any undue bias by careless encouragement of any specific viewpoint transpired. The reflective exercise also provided an opportunity to appraise the advancement of any emerging themes requiring any supplementary exploration and whether data saturation had been reached. The participants were provided the prospect to evaluate the transcription of their interview for correctness. Overall the participants included 6 GPs and 2 non-GP (managers) partners with equal male/female representation.

4.4.3 Ethical considerations

Ethical approval was gained from the University of Wales, Trinity Saint David ethics committee approval process. Prior to participant enrolment into the study, each participant provided written

informed consent after reviewing the participant information sheet prepared using guidance from the ethics committee of the University of Wales, Trinity Saint David. Participants were informed that their involvement in the trial was entirely voluntary and they could decide to withdraw their involvement at any time without needing to provide a reason. Throughout the study, participants were encouraged to ask questions about the research and their involvement. Details of access to a third party who was independent from the research was provided for any further queries. Preserving participant data confidentiality is inviolable in maintaining an ethical methodology when conducting research (World Medical Association, 2017).

Confidentiality was conserved by instilling numerous practices. The interviews were audio recorded using Zoom© software as a local copy onto the laptop and instantaneously anonymised, assigned a unique number and saved in a password protected file. Additionally only I had access to the password protected laptop containing the saved recordings. No interviews were recorded utilising the Zoom© cloud option. Furthermore an excel file linking the participant to the anonymous interview recordings was password protected and only accessible to myself. Recordings were self-transcribed with corresponding created word documents stored electronically under password protection with no associated paper copies. Reporting of results will ensure anonymity with no identifiable data presented. Although no distress from partaking in the research was envisaged participants were informed that they could end the interview at any juncture if they felt uncomfortable. The interviews were conducted at a time and virtual location convenient to the interviewees. I can confirm thus far no participant has highlighted any distress caused at any stage due to partaking in the research process. In the event of any distress caused, the plan consisted of offering to terminate the interview with further signposting to suitable counselling services.

4.5 Thematic Analysis

Thematic analysis was utilised as a strategy for data analysis for this research study. Kleinheksel et al (2020) highlight the inductive data driven nature of a qualitative research enquiry, as opposed to the deductive theory driven approach of a quantitative methodology. A lack of analytical rigour with discordance in agreed objective guidelines is often cited as a criticism of qualitative data analysis particularly by those influenced by a predominantly positivist paradigm inherent within quantitative research. Gray (2018) contends the existence of equally rigorous investigative methods albeit an adoption of a differing focus within a qualitative constructivist paradigm, whereby an exploratory approach is vital to enhance appraisal of the richness of the data. Braun and Clarke (2006) as one of the pioneers of thematic analysis delineate its presence as a structure consisting of reviewing the subsets of data to identify patterns or themes to elucidate detailed underlying meanings. The thematic analytical framework consists of constant reflective emersion of the data retrieved to determine codes (rudimentary sections of data of interest), examining for relevant themes (unit of analysis allowing a consistent meaning from a number of codes), consolidation of possible themes during a process of constant reflective practice, identification and definition of finalised themes and finally reporting of the outcomes with supporting data.

Clarke and Braun (2017) cite the necessity to ensure the thematic analysis process is strategically operationalised to illuminate detailed considerations and to avoid a superficial reflection of the related dataset. Kleinheksel et al (2020) opine the usefulness of content analysis as an alternative method of data exploration which involves determination of specific pre-existing criteria for relevant data collection and development of codes resulting in a relative increased deductive methodology as compared to thematic analysis. Given the requirement for perceptions of 'Deep End' GP surgery partners on the factors that influence the recruitment and retention of GPs were to be pursued within a phenomenological constructivism qualitative study, an analytical framework that prioritised the

enhancement of an inductive approach was desired. Hence the decision to adopt thematic analysis as the framework of data analysis was implemented.

4.6 Validity/Reliability

A number of processes were implemented to ensure the validity of the study was enhanced. Participants were offered the opportunity to review the transcripts for accuracy. A range and contrasting views were explored and highlighted (within the data analysis section). Direct participant quotations were utilised to support conclusions arising from thematic analysis. The interview schedule was piloted with peers and feedback sought. I (as the principle researcher) also fulfil the eligibility criteria for the study and therefore able to understand the context of the participants when exploring perceptions. Study limitations include a lack of triangulation of data with semi-structured interviews the sole research instrument and the lack of an external auditor of the data. It was deemed that semi-structured interviews on their own would allow achievement of the study objectives. The use of an external auditor was deemed resource intensive especially within the time constraints of the study. A clear description of the methodology encompassing a description of the trial participants, data collection and analysis methods optimises the reliability of the study. Furthermore the transcripts were all self-transcribed and re-checked with the original recordings for accuracy. Themes within the analysis have been described (within the data analysis section). The reliability could be improved by utilising an additional researcher to obtain agreement on the generation of codes.

4.7 Conclusion

This research study is situated within a qualitative framework with interpretivism as the epistemological basis and constructivism as the research paradigm. This approach supports an inductive approach to individual mean making by grappling with multifaceted data with the objective

of understanding complex phenomena. The objective of this study is to seek the perceptions of 'Deep End' GP Surgery Partners on the factors that influence the recruitment and retention of GPs. As the perceptions are to be explored a phenomenological approach was adopted. The participants were selected utilising a purposive sampling technique as partners specifically within 'Deep End' practices were required. Luton within England, UK was selected as the geographical location given the relative high concentration of 'Deep End' practices and closeness to the researcher. Semi-structured interviews conducted virtually via synchronous video consulting facilities utilising Zoom© software were used as the data collection tool to assist efficient collaborative dialogue in the context of the ongoing Covid 19 pandemic. Ethical approval was gained from the University of Wales, Trinity Saint David ethics committee approval process. Thematic analysis was utilised as a strategy for data analysis for this research study. Overall it is reasonable to conclude that the validity and reliability of the study was robust.

5.0 Data Analysis

Within this section the outcome of the thematic analysis showcasing several overall themes and their subthemes are presented supported by a selection of the relevant data in the format of quotations from the semi-structured interviews with regards the perceptions of 'Deep End' GP surgery partners on the factors that influence the recruitment and retention of GPs. The overall themes and their subthemes are highlighted within the table below. The selected quotations are demarcated anonymously to uphold the confidentiality of participants.

Table 4: Outline of the overall themes with underlying subthemes.

GP Partner identity/role: Includes the perception of participants with regards the factors influencing the distinctiveness of the GP Partner role within the structure of GP partnerships.	Patient factors: Includes the perceptions of participants with regards pertinent patient dynamics particularly relevant to 'Deep End' practices.	Work environment: Includes the perception of participants in relation to the factors contributing to the work environment within GP surgeries.	CPD/Career progression: Includes the perceptions of participants in regards to the opportunities for professional development/ career progression of GPs throughout their working life.	Resources/ Remuneration: Includes the perceptions of participants in relation to factors influencing the provision of resources to fulfil the demands of operating within 'Deep End' GP surgeries.
- Value of GPs - Specialist in primary care - 'Named' GP - Media coverage - Viability of the partnership model	- Wider determinants of health e.g. poverty/isolation/ housing - Healthcare access – language barriers, health/digital literacy - Co-morbidities in younger age groups - Patient engagement in the healthcare plan	- Job satisfaction - Workload - Safety – personal and professional - Premises/facilities - Professional isolation - Workforce market – national and global	- Portfolio careers - Training practices and recruitment - Mid/Late career opportunities - Value of 'seniority'	- Incentives/Income - Staff supply/MDT - Carr-Hill formula - Pension/Tax

5.1 GP Partner identity/role.

5.1.1 Value of GPs

A sense of the GP as a trusted professional responsible for the co-ordination of personalised individual care for several generations of a family was cited as a crucial factor leading to a sense of enhanced self-esteem and a positive validation of the role. It was acknowledged this afforded bond encompassed a privileged positon in society allowing an unrivalled opportunity in optimising individual and potentially societal health outcomes. Additionally it was contended that within primary

care, one the foremost skillsets of a GP included the ability to manage uncertainty and the associated risks when managing patients presenting at a relative early and undifferentiated stage of their illness.

"You know it's a privileged job I think in terms of patients who come to you. They are giving to you the most valuable thing they have which is their health and their wellbeing. They're asking you its broken can you fix it". Participant 1.

"And also just the ability to manage risk surpasses any other group in the workforce really". Participant 2.

It was felt that despite patients being originally signposted to other services to address the wider determinants of health, the patient would seek to re-consult with their GP if the particular problem had not been resolved to their satisfaction. Several GP Partners felt their role as leaders in co-ordinating individual patient care had somewhat diminished over time from principally involved in delegating tasks for completion to other professionals, to increasingly receiving instruction to execute actions requiring no additional GP forethought.

5.1.2 Specialist in primary care

Participants felt GPs should officially be considered specialists within primary healthcare on par with the status afforded to secondary care consultants to enhance the prestige of the profession particularly amongst medical students. Furthermore this specialist recognition would assist in a recalibration of the notion of providing personalised care within the current workforce constraints with care being delivered in teams with GPs leading teams of junior doctors and allied health professionals akin to the secondary care format.

"But overall I think that one of the things we have to do if they don't do it officially is take our self as a primary care consultant because it's like that mind-set that the GP cannot see each and every patient

but the GP is keen to see the patient. And then you have a team which works under your name and I think that model will work". Participant 8.

5.1.3 'Named' GP

The concept of the 'named' GP responsible for the coordination of a registered patient list was considered fundamental to the effectiveness of the provision of personalised care. Consequently the excessive reliance on external GP locums for service provision was considered to lead to quality of care and organisational outcomes to be compromised. Moreover the external locum generated workload leads to additional tasks for the 'named' GP/partnership. The requirement for 'named' GPs to publish their annual income was seen as an inconsistent request as compared to other comparable healthcare staff and thus viewed as a deliberate attempt to solely target GPs by the UK government leading to a sense of devaluation.

"One or two of the partners will be paid as a locum but you know they're not going to just do blood tests and bring them back. They will do the complete patient related tasks so that reduces the knock on effect on appointments later on". Participant 6.

Additionally the notion of the 'named' GP was extended to feature a role as a formal mentor to newly employed staff and healthcare professionals in training.

5.1.4 Media coverage

GP surgery partners were unanimous in their condemnation of the overwhelming negative portrayal of GPs and general practice within the media. They felt this negative messaging was ideological, biased, unconstructive and devoid of the factual context harming recruitment of future generation of GPs vital for the preservation of the NHS.

"I mean if you're a GP at the moment the battering that you're getting in the press. But if you're a young doctor coming through the scheme why would you chose to be a GP because it doesn't seem to be the most popular choice of medicine at the moment". Participant 3.

5.1.5 Viability of the partnership model

Despite the challenges of operating within the 'Deep End', participants were enthusiastic about the partnership model and its flexibility in shaping services to meet the needs of local patient populations, each with distinctive demographics and healthcare needs. An expression of the unique mission, vision and culture of a partnership was emphasised as fundamental to the recruitment and retention of GPs and staff. Nevertheless concern about the future viability of the partnership model particularly for smaller practices whereby the UK government mandate contractual adjustments ensuring maximisation of economies of scale and enhanced flexible patient access for larger sets of populations was highlighted. Moreover GP partners expressed a possible transformational change whereby GP partnerships become extinct and instead the NHS directly employs the primary care workforce with one standardised approach to service provision. Conversely some participants postulated the possibility to explore alternative organisational formats such as shareholder ownership within limited companies.

"If a practice can describe its culture. You know its values. What matters to the team? Then being able to describe that and have a sense of optimism despite all the challenges that working in a deep end practice might bring. If they can describe a sense of moving forward and positivity. That will attract people". Participant 1

"So the independent contractor's status will go. We will be employed". Participant 3.

Participants perceived that uncertainty in the partnership model and the contractual status of general practice in the medium to long term acts as a disincentive when trying to recruit partners who value a level of certainty when committing to a long term project.

5.2 Patient factors

5.2.1 Wider determinants of health

Participants stressed the additional challenges of working in 'Deep End' practices with patients presenting with multiple problems on multiple occasions resulting in complex case management being the daily norm. The case management inescapably involves focussing on the wider determinants of health. It was contended that patients living in relatively deprived environments are more prone to experiencing social isolation as often daily survival becomes their principle modus operandi with limited resources to invest in the development and maintenance of meaningful relationships.

"Principally we're working with people with whom the wider determinants of health. The basics of living as in having enough money to be able to buy enough food". Participant 1

"There's a lot of lot of people who are frequent attenders. You know there are a lot of people in such a mess. Not because of their fault but because of their life around them and social circumstances they live in". Participant 8.

Additionally participants highlighted utilisation of the ample opportunity to improve individual and public health outcomes within 'Deep End' practices as part of the recruitment strategy in attracting applicants enthused by potentially partaking in shaping services leading to transformational change for the most vulnerable members of our society.

5.2.2 Healthcare access

Participants cited a lack of patient assets such as phones/ability to travel and health/digital illiteracy leading to difficulties in navigating appropriate services. Language barriers were deemed as affecting the optimal utilisation of services, the actual clinical consultation and health outcomes regardless of the presence of interpretation services leading to prolonged consultations negatively affecting pre-

existing workloads. Participants expressed positive affirmation from grappling with the complications posed by such patient populations.

"Don't have enough money to even put enough credit on their phone to sit on it long enough for the phone to be answered. And if they think then the educational attainment and literacy and health literacy". Participant 1

"So I think as I said time and time that the languages which doctor speaks has a lot of influence because a lot of people who don't speak any local dialect are in large prefer not to stay in this sort of area where you get 50 per cent consultations that are non-English language". Participant 8.

5.2.3 Co-morbidities in younger age groups

Participants highlighted the care of relatively younger patients with multiple healthcare concerns within an increasingly complex socio-economic context. This complexity provides a challenge to the wider healthcare team as often these patients require initial assessment and complex case management by a GP. This limits the implementation of a workforce policy contingent on recruiting allied health professionals to replace the skillset of GPs to compensate for shortage of GPs nationally. Participants felt Covid 19 illuminated and exacerbated pre-existing health inequalities, the impact of which will last for the foreseeable future.

"Obviously we have more patients who have more multiple health issues. And having the similar ten minutes for those patients sometimes does not fit right". Participant 4.

"…only the COVID pandemic really made that gap so wide when we see the amount of our patients with a lot of multi-morbidity dying. Compared to other areas and then you start realising that actually you know this is real. This is actually making people's lives short…" Participant 8.

5.2.4 Patient engagement in the healthcare plan

Participants felt that within relatively more deprived populations it is more difficult for patients to engage with their healthcare plan particularly in respect to optimising healthy lifestyle behaviours due to competing interests to accomplish self-preservation in the near future. A lack of appreciation of the disproportionate challenges faced by 'Deep End' practices in meeting universal targets was cited as unequitable practice exacerbating pre-existing health inequalities.

"And planning that clinical journey because these guys live such chaotic lives that for them to turn up to a GP appointment is sometimes a minor miracle. Trying to get them to focus on eight different things at once to try and solve everything at the same time is impossible. So it takes much longer term planning and that's not always recognised by the commissioner". Participant 5.

5.3 Work environment

5.3.1 Job satisfaction

Participants cited the maintenance of job satisfaction as vital in retaining clinicians albeit whilst acknowledging the challenges of working in 'Deep End' practices. Key components of optimising job satisfaction included providing opportunities for continuous professional development, instilling a learning environment which fuels intellectual stimulation, recognisable individual positive patient outcomes, manageable workload, focus on optimising staff wellbeing and external recognition of practice innovation in the specific context of operating with the most vulnerable in society.

"They chose deep end practices because they want to make a difference. But actually recognition that you are doing a great job in difficult circumstances. And you can see the outcomes for your population are improving. That's motivating". Participant 1.

"Staff wellbeing is really important and that gets picked up by juniors or doctors who come in so that makes them feel uneasy. The workload is one of the biggest things". Participant 6.

It was argued that instead of conceptualising a working environment as being difficult due to the prevalence of non-English speaking patients, the positive desirable skillset of a clinician able to conduct consultations in several languages should be accredited. Participants expressed opportunities to experiment in service innovation and enjoin flexibility in policy implementation within safe spaces facilitating change particularly ensuing from learning events as crucial in augmenting workforce engagement.

5.3.2 Workload

Participants expressed exceptional levels of current workload fuelled by unprecedented levels of patient demand affecting their work life balance. Effective administration and managerial processes releasing clinicians to focus on clinical decision making was considered imperative. Operational processes ensuring fairness within workload at the allocation of tasks level was deemed essential. It was contended that GP surgeries are perceived as providing open access not only for healthcare advice but various additional societal issues that could be addressed via alternative methods e.g. issuing of fit notes. It was felt additional allocated administration time within the working day was required to manage the multiple service use of 'Deep End' patients.

"But you can contact your GP because we're the only people who have open access. And we are meant to be the gate keepers of the NHS. That is our role. But we're not meant to be the gate keepers of all these rest of society's issues". Participant 3

"I think when you are stressed at work it does affect you coming back to your normal life so you know I myself went through a period of logging in many times from home trying to catch up with admin. Even on my off days. And I still probably do". Participant 4

"…so typically the BMA would always suggest that a clinical session is about 75% patient face time 25% admin time. For deep end practices I would probably suggest that ratio needs to change quite significantly probably closer to 50:50". Participant 5.

5.3.3 Safety

The risk to personal safety in terms of general wellbeing, impact on family life, stress/mental health and time to partake in healthy lifestyle activities due to work demands and exposure to potentially volatile behaviour from certain patients was underlined. It was felt that the risk to personal litigation and ultimately maintenance of a professional license to practice was amplified when operating within a complex case management environment particularly prevalent within 'Deep End' practices. Additionally all partnerships function under an unlimited liability business structure.

"I think some people have concerns for their own wellbeing. So there's clearly the pressure of the job has an effect on their health on their stress levels. And on their ability to cope. And even on their physical abilities. With the number of potentially violent people who we have to manage as well". Participant 2

5.3.4 Premises/facilities

Participants eluded to the often poor quality and limited quantity of clinical rooms as restraining their capacity to recruit staff and apply to become a training practice. Additionally a lack of facilities for personnel to informally meet and exchange ideas was lacking. The general location in terms of parking, quality of available buildings and external improvement were considered unfavourable particularly to 'Deep End' practices given their operational existence correlates to areas of socio-economic deprivation.

"It's not just having the clinical premise function. You need places you need buildings where people can meet. You need buildings that have got sufficient parking". Participant 2

"You're going to be coming into town centre probably quite poor premises. So when they drive into our surgery they'll come through horrible metal gates. They'll be litter all over the floor. There will be needles on the floor. They might be a homeless person sleeping where they're about to park". Participant 5

"Because my practice is not training. I want to become a training practice but I just do not have capacity in terms of physical space". Participant 7.

5.3.5 Professional isolation

Participants felt instilling opportunities within the work plan for GPs to benefit from peer support and operational/strategic decision making was crucial in preventing professional isolation and enhancing engagement cited as contributing factors to role retention. Several participants eluded to the benefits of allocating recruited GPs a formal mentor with opportunities to conduct regular meetings as part of scheduled work related activity.

"I think it goes back again to the support that GPs are feeling within the practice. I think if they're working in silos and working on their own behind a closed door without an organisational support behind them they're more likely to go. They need to have a voice of how things are run". Participant 3

Additionally it was considered prudent to organise meetings on a rolling schedule taking into account the working week of GPs especially as the majority may be working on a part time basis.

5.3.6 Workforce market

Several participants outlined their difficulty in recruiting and retaining GPs predominantly GP Partners over several years with implications for the provision of personalised care with some indicating contemplation of voluntary contract termination and cessation of operational activities in the recent past. An approach strategically charting workforce planning to the culture, vision and mission of an organisation whilst relying on the development of trainees and word of mouth when advertising

vacancies has yielded positive outcomes. It was acknowledged that partnerships were operating within an environment whereby an intense market for GPs exists, namely GPs opting to work as locums or abroad to manage their workload and optimise their quality of life. It was felt that the UK has become a less attractive option internationally when attempting to recruit GPs qualified abroad. It was stated that a mandatory annual amount of hours worked as a 'named' GP should be introduced in order to maintain a GMC license. A locum hourly income rate was considered unfeasible.

"So we had to when we were very short of GP numbers we had to go back to a centralised list system. So we had to move away from personalised care. So we look for people by mapping it to our visions and values and what our practice is". Participant 3

"So we had issues I mean still we have got issues getting any salaried. We have got a job advert no one has applied at all. Partnership no one is happy to take partnership simple because of the patient population we are dealing with". Participant 7.

"…if I talk to colleagues they're much happy to go to America, Canada and Australia. They've made it so difficult now that people don't see Britain as a good place to go and work so we've lost that. And these guys worked in very deprived deep end practices and you haven't got that replacement". Participant 6.

5.4 CPD/Career progression

5.4.1 Portfolio careers

Participants cited the presence of variety within the practice workload and facilitation of external commitments as part of additional roles as being fundamental in ensuring optimal recruitment and retention of GPs.

"But you know within a large practice we've got to spread special interests. We enable them to pursue their special interest. Or their outside commitments. Whatever it is that gives them variety in their week". Participant 1

5.4.2 Training practices and recruitment

Participants highlighted that being a formally accredited GP training practice was pivotal in identifying, moulding and ultimately recruiting future GPs. It was felt this strategy was particularly necessary for 'Deep End' practices as trainees are provided the supervisory scaffolding whilst they navigate the associated unique challenges during their training period, allowing subsequent immersion into the practice community. It was deemed that GPs who were born and bred in the relevant 'Deep End' regions were attracted to return to serve their communities and have a vested interest in retaining their service for the long term.

"The other great thing we've done in recent years is expanded our training. And I think GPs who train in deep end practices again have a true understanding of what it involves. And also the wonder of the intellectual challenge. And a lot of our recruitment have come by word of mouth actually. Advertising has stopped being that beneficial". Participant 1

5.4.3 Mid/Late career opportunities and Seniority

Participants lamented the lack of career progression opportunities within General Practice particularly for those in their mid or late career stage. This was often cited as a significant factor in GPs pursuing other external roles and early retirement. A lack of appreciation for the skillset afforded by seniority in terms of aspects such as handling complexity, risk management, mentoring, service innovation and human resource management were highlighted. The NHS policy to cease seniority payments was considered derisory.

"But we are the only sector where actually you could be working for 25-30 years and tomorrow a new person will join you and have exactly the same things as you. We're not recognising the experience

part of it or the privilege which one should get. To recognise their personal skill who has worked 20-30 years in the system. How do you best utilise their skill?" Participant 8.

5.5 Resources/remuneration

5.5.1 Incentives/Income

It was contented that 'Deep End' practices are penalised in terms of overall resource allocation as a lack of recognition is afforded to the exceptional difficulties faced by practices serving the most marginalised in society particularly when remuneration is linked to achievement of standardised targets.

"You know in a deep end practice you probably need at least twice the amount of work force to undertake the same work. Because the consultation rate is higher. The time to educate takes longer. The language all the rest of it. So at least twice. Probably more than that". Participant 1

"I don't thing when we start when the wider enhanced services come down it's ever taken into fact what you're practice population is. It's just a blanket approach. So I think we are penalised on most of the things that come down. So childhood immunisations we used to get paid". Participant 3.

5.5.2 Staff supply/MDT

Participants expressed high desirability of working as part of a multidisciplinary team with appreciation for the supply of an increasingly diverse range of allied health professional roles in optimising patient safety and care. Over time it was perceived that the communication with members of the external primary care team (e.g. district nurses) had become disjointed coinciding with the increased prevalence of often non-verbal unclear inconsistent channels of communication leading to duplication/triplication and constant re-delegation of tasks creating additional unnecessary workload and inefficient care. Participants reflected on the irony of this practice as in the distant past

professionals such as district nurses, were once co-located and intimately embedded within the GP practice team aiding effective coordination of care. Participants were unclear about the cost effectiveness of certain roles relatively new to General Practice such as physician associates (PA). GP surgery partners also evidenced a significant increase in requests for patient clinical reviews from allied health professionals via tasks resulting in unmeasured increased workload with no supplementary time apportioned to conduct such reviews.

"You know in the past it was a district team that was attached to your practice and you knew the district nurses they had your number you had their number. Whereas now it's a task …you want to talk to that person it takes ages to talk to that person. And that all adds to your workload. And where do you measure that? Yes that one person has taken six or seven phone calls". Participant 6.

Additionally concern was expressed that it had been difficult to retain allied health professionals within 'Deep End' practices often after the practice had invested in their additional training/qualifications, with alternative employment being pursued within non-'Deep End' surgeries.

5.5.3 Carr-Hill formula

Participants felt the Carr- Hill funding formula is unequitable to 'Deep End' practices, discriminating against the service needs of such populations and exacerbating health inequalities.

"There is also a lot of demand in the younger age groups who attract very little funding. And who might take a lot of work for example in ensuring that they engage in screening processes." Participant 2

"So the funding doesn't quite match the deprivation. And if you look at the Carr-Hill formula the deprivation part is lower weighted than age for instance. So it's not quite catching up. So we only get like 90 per cent of our core funding". Participant 5

5.5.4 Pension/Tax

Participants highlighted the introduction of the NHS pension annual cap and lifetime allowance as a disincentive for GPs to continue to operate on a full time basis and as contributing to early retirement. The future viability of the NHS pension scheme as a lucrative incentive to attract GP salaried/partner roles was questioned. Furthermore it was contended that the introduction of the intermediaries (IR35) legislation has had no material impact on the attractiveness of functioning as a GP locum.

"We thought the government might have helped with the IR35. And looking at that tax but that doesn't seem to have worked. People can form limited companies. They can get around the issue that way. We know that the pension tax also affects GPs who are coming towards their end of their career. They might just say you know enough is enough". Participant 3

"I think it is our belief that the NHS pension is the best pension. It is no more. We all know that because of the state pension age and all that has changed in the last few years. So we need to think outside the box". Participant 7.

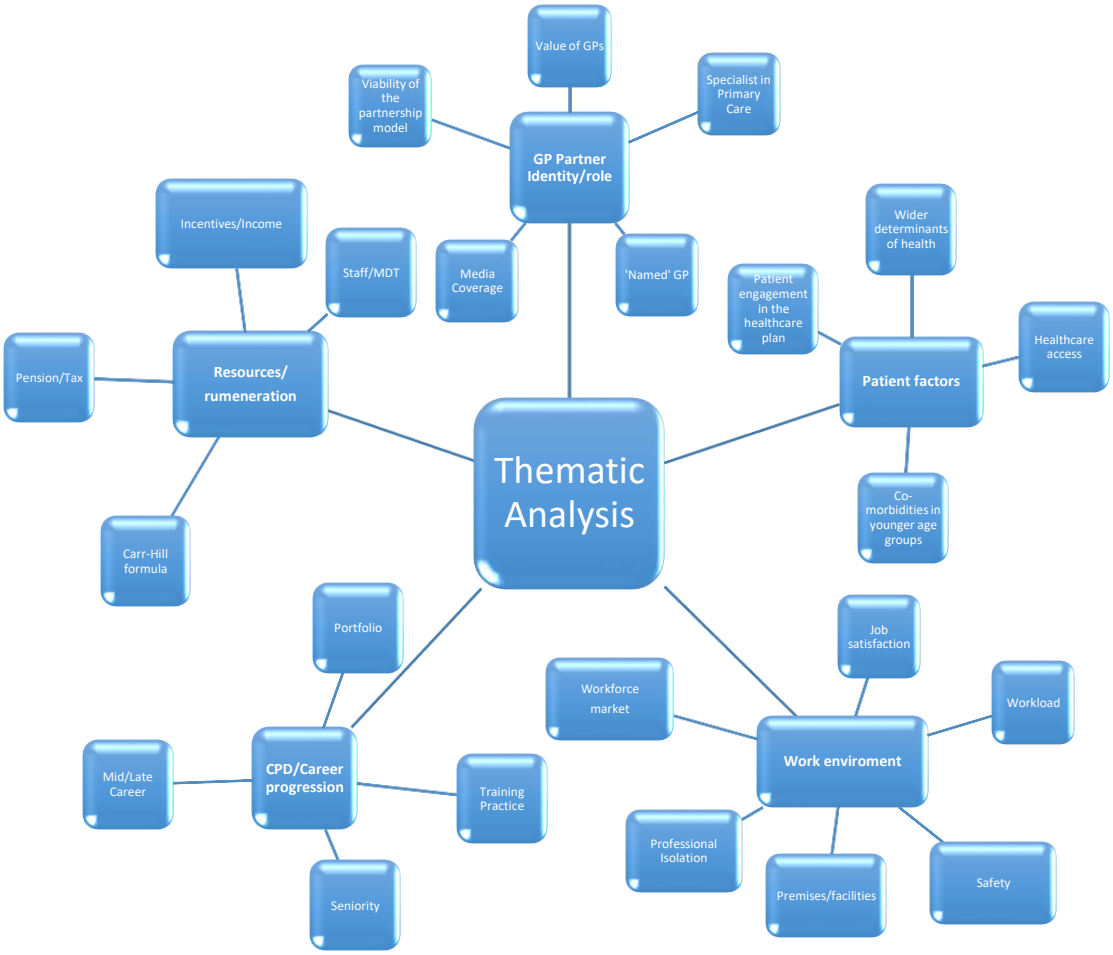

Figure 2: Concluding themes/subthemes

6.0 Discussion, Conclusions and Recommendations

The House of Commons (2022) highlights a recent 5.6% reduction in FTE GPs in England, from approximately 29,403 in 2015 to 27,750 in 2021 in the context of a global shortage of GPs. Moreover 70-80% of UK GPs report regularly working beyond their contractual requirements, with average actual working hours consisting of 40 hours/week despite average contracted hours being 31 hours/week, with 19% working 50 hours/week. These additional non-contractual hours of service provision are considered essential for coordinating patient care to optimise health outcomes. Alternatively GP locums who are remunerated characteristically on predefined hourly rates and levels

of workload are overrepresented within GP practices with inadequate care ratings as adjudicated by the CQC, the UK health and social care regulator (Grigoroglou et al, 2022). This may reflect such practices experiencing workforce difficulties, becoming dependable on locums leading to excessive costs of GPs and thus reduced financial turnover limiting investment in service innovation leading to 'inadequate' outcomes. It is reasonable to conclude that the 'goodwill' hours of service predominantly operating within a partnership structure are essential in improving care provision, the continual survival of primary care and thus the NHS. Furthermore international analysis reinforces the notion that those health care systems that provide effective universal primary care services to all communities have superior public health outcomes (The Commonwealth Fund, 2021).

Barry and Greenhalgh (2019) outline overwhelming negative newspaper coverage of GP surgeries in recent years, depicted as understaffed, unorganised and inefficient with GPs lacking clinical acumen and being self–centred and gluttonous. In comparison secondary care is portrayed in crisis due to government policy with hospital consultants designated as heroically attempting to keep the NHS afloat. This unbalanced coverage denigrating GPs has influenced a perception amongst medical students that a career in General Practice entails lower intellectual stimulation and professional status as compared to hospital consultants (Barber et al, 2018). Additionally, the UK government has introduced plans compelling 'named' GP Partners to publicly declare any NHS earnings over £150,000, a policy specifically targeting GPs and not applicable to any other NHS staff (including hospital consultants) or indeed anywhere else in the UK (BMA, 2022b). The income declaration plan appears to have been influenced by the unjustifiable media coverage potentially demoralising GPs already largely feeling devalued whilst their goodwill' hours worked to ensure ongoing NHS survival remain unappreciated. The GMC (2019) recognises GPs as specialists in general practice and has recommended the UK government amend legislation to allow GPs to be formally included within the

specialist register alongside their secondary care consultants. This will aid in equalising parity of esteem amongst medical colleagues and enhance collaborative working.

International medical graduates (IMGs) comprised 47% of junior doctors entering specialist UK GP training schemes in 2021 (House of Commons, 2022). Furthermore it is contended that IMGs GPs favourably choose to practice within 'Deep End' GP surgeries. It is essential that in addition to support for UK graduates, bespoke provision for IMGs should be considered to enhance FTE GP numbers within 'Deep End' practices. The UK health and care worker visa allows IMGs to work within the UK with separate provision for their dependants (partner and children) to reside with them (GOV.UK, 2022). Applicants for a UK health and care worker visa require a prior job offer/training scheme acceptance from a home office approved sponsor. IMGs are required to re-apply for a visa if they change their job within 5 years of entry, after which they are eligible to apply for indefinite leave to remain in the UK. This immigration process provides a unique challenge for GP trainees as their FTE equivalent training lasts 3 years, after which they must seek employment from a home office approved visa sponsor for a further 2 years to continue to reside in the UK. Additionally adult dependants such as elderly parents are not eligible to join the IMG under the health and care visa scheme. IMGs on nearing the completion of the 3 year GP training programme, a time coinciding with summative professional licensing exams, are faced with undue stress as they forced to determine their immediate future employment, the dilemma of relocating their families to areas a UK visa sponsor exists or indeed internationally, faced with the possible risk of deportation due to UK immigration rules (Thornton, 2022).

In comparison, Canada operates a point based system under the Federal Skilled Worker (FSW) program allowing a pathway for permanent residency of the applicant and their dependants (child and adult) at the visa acceptance stage (CANADIM, 2022). The process adopted by Canada provides

proactive long term residency reassurance at the outset allowing GPs to plan for their families for the foreseeable future. The RCGP (2022) continuously hosts adverts of GP vacancies internationally throughout the year, with potential incomes of £200,000-£300,000, flexible working, purpose build infrastructure, scenic views and various personalised support with accommodation, schools, visas and general finance cited. A strategy to enhance the recruitment and retention particularly within UK 'Deep End' practices must acknowledge the intense market for GPs and seek to remain internationally competitive with a focus on the financial package, working conditions, training and development, advocacy on inclusive residency rights, accreditation of home office approved visa sponsors and personalised support for GPs and their families. UK stakeholders must urgently seek to collaborative to reflect on optimising the GP job specification and terms of conditions to ensure that the UK is able to positively compete in the international market in order to recruit and retain GPs particularly within 'Deep End' areas.

The Bank of England (2022) UK economic outlook reveals a cost of living predicament with current inflation at 9.4% (projected to increase to 13% in October 2022) fuelled primarily by rising energy prices. Additionally the price of imported/domestic goods and services has increased reflecting the rising costs of production/operations in order to maintain profit margins. In compensation the bank interest rate has escalated to 1.75%, exacerbating the cost of borrowing including mortgage repayments. The labour market is deemed as taut with employers finding it difficult to fill vacancies, necessitating wage/salary upturns. A recession is forecasted by the end of 2022 with unemployment set to increase in mid-2023. The impact of a rise in the cost of living is disproportionately experienced by those at the lowest income decile due to a higher relative total spend on gas and electricity, reduction in real terms pay and less pre-existing savings (Institute of Fiscal Studies, 2022). The Royal College of Physicians (2022) highlight the adverse health outcomes due to the current UK cost of living with a survey revealing 55% of the UK population stating their physical and mental health had

deteriorated. Of those surveyed the following costs were cited as reasons for their health deteriorating: 84% heating, 78% food and 46% transport.

Moreover it appears particularly those with least incomes are having to make hard choices between prioritising eating and/or heating and paying debts in order to avoid a state of destitution (Joseph Rowntree Foundation, 2021). Curl and Kearns (2013) outline the negative impact on the mental health of people from more deprived backgrounds during times of economic recession and when austerity is adopted as the foundational fiscal policy of a government. Overall the baseline healthcare needs of patients within 'Deep End' practice communities are significantly higher with comorbidities presenting in younger age groups. The premorbid health status of these communities is subject to continually acute deterioration due to enhanced sensitivity to the influence of the wider determinants of health. As cited earlier in the dissertation (see the Introduction chapter), 'Deep End' GP practices receive on average 7% less funding per need weighted registered patient as compared to those serving the least underprivileged (Fisher et al, 2020). The BMA (2018) survey highlights 80% of GP practices perceive their premises as inadequate to meet future demands with consultation room space, meeting rooms/reception area renovation, enhanced access for disabled patients and improvements in lighting, ventilation and heating mentioned as requiring prompt financial investment. Optimised indoor physical working conditions such as ensuring adequate ventilation, heating, lighting and noise protection, aids cognitive function and productivity (Frisk, 2000). Public Health England (2020) stress the vital contribution of greenspaces in improving mental and physical health, with an acknowledgement of the disproportionate lack of access to green spaces for those residing and working in relatively deprived areas.

Health literacy is defined as the ability of an individual to navigate and function within the healthcare system (Baker, 2006). Components of health literacy skills consist of print literacy (ability to locate,

read, comprehend and interpret written text), numerical literacy (ability to use numerical information for tasks such as measurement of blood pressure/blood glucose or concordance with prescription regimes) and oral literacy (listen and speak effectively). Berkman et al (2011) states health literacy rates are lower amongst those in lower income deciles, immigrants and elderly patients. Furthermore lower health literacy rates are associated with higher rates of A&E attendance, hospital admissions, non-participation in primary health prevention such as screening programmes and vaccination uptake, non-concordance with medication regimes and avoidable mortality rates. Digital inclusion includes both having access to and the ability to navigate the use of the internet in order to aid daily functions (ONS, 2021). The ONS (2021) identifies 10% of the adult population within the UK as non-internet users, with use directly proportionally linked to income levels, with those earning higher incomes more likely to utilise digital means to achieve outcomes. Bauerly et al (2019) consider digital access via digitally enabled education and employment functions as a 'super-determinant' of health.

It is contended that digital exclusion leads to social exclusion and subsequent poverty, and ultimately suboptimal health outcomes and health inequality (Watts, 2020). A lack of proficiency in the national language is associated with a lack of healthcare access and subsequent relative poorer health outcomes (Clarke and Isphording, 2016). Language barriers contribute to difficulties in requesting appointments within primary care in the UK due to a lack of interpretation services available at that stage of the patient healthcare journey (Gaiser, 2016). NHS England (2018) recommends a doubling of the usual consultation length when an interpreter is required. Overall the evidence suggests that 'Deep End' practices face several disproportionate challenges in terms of complexity of caseload with patients presenting with various comorbidities at younger age groups, multi-service case coordination as the norm especially in the context of the impact of the wider determinants of health, lower health and digital literacy levels, difficulties in workforce recruitment and retention, relative reduction in financial resources particularly related to the Carr-Hill formula, inadequate premises and a lack of

regional greenspace capital. 'Deep End' practices require comparative increased investment via several mechanisms including a review of the outdated Carr-Hill funding formula to further appreciate the relative impact of deprivation, additional bespoke resources to address unique service needs and innovation, exclusive workforce planning, capital infrastructure and greenspace investment to reduce health inequalities and ensure genuine 'levelling up' is realised.

Sinnott et al (2022) outline the daily nature of GPs workload and obstacles faced leading to operational failures (work system design that impair task completion) and thus undue stress, burnout and patient interactions. GPs face operation failures affecting direct clinical patient care due to interruptions from practice colleagues seeking advice or requesting an action both via their physical attendance and electronic instant messages during a consultation, lack and/or inadequate equipment including IT software, structural impediments in enacting coordination of care and lack of standardised practice process protocols such as the fair allocation of tasks and receiving multiple requests for inputs via tasks predominantly from the MDT without additional time allocated. The 'official' GP sessional schedule poorly reflects the actual workload and can be described as being 'fictive'. GPs adopt multi-tasking for approximately 20% of tasks in order to manage this fictive schedule, contributing to work pressure, divided cognition and potential medical error. Furthermore GPs function at the nexus of a highly complex, multi-individual, multi-service, multi-organisational, interconnected and distributed system in their role as 'named' coordinators of individual care regularly involving the evaluation of large volumes of often incomplete information albeit with no control over many elements of this dispersed NHS system. Thus the subsequent synthesis of an effective management plan requires additional clinician administrative time allocation particularly for those serving 'Deep End' populations with a relatively more advanced complex case management workload and staff shortages.

Burton and Obel (2018) argue implementation of an organisational design which seeks to optimise the connection between the organisational structure and coordination of tasks is vital in limiting operational failures and achieving strategic objectives. Moreover the organisation design must align to the structure, systems, staff skills, leadership style, values and culture to meet the strategic objectives and overall organisational mission statement. Mahoney and Kor (2015) contend an organisation's intellectual capital consisting of the abilities and skills of its workforce (human capital) and inherent knowledge built within its structures and processes (structural capital) is foremost in achieving organisational success in a knowledge economy. Social capital referred to as the assets arising due to innovation and creativity developed via opportunities for individuals to interact is crucial in linking human and structural capital (CIPD, 2017). Continuous professional development (CPD) is essential in maintaining performance of individuals and teams to ensure preservation of patient safety (GMC, 2012). Additionally peer to peer mentoring is central in supporting colleagues and CPD. Mentoring provides an opportunity for senior colleagues to share their expertise whilst providing variety in their workload, and to partake in social capital activities leading to enhanced organisational intellectual capital. GP practices need to consider reviewing their organisational design to allow optimisation of efficient practice to limit the impact of operational failures and consider investment in creating an environment facilitating enhanced social capital whereby individuals can interact to innovate.

Senior GPs are increasingly taking early voluntary retirement, 82% retired on age grounds and 17% retired early in 2007-08, whilst 33% retired on age grounds and 62% took early retirement in 2016-17 (Moberly, 2018). Early retirement and reluctance to increase working hours is in part fuelled by recent changes to the NHS pension scheme (Dale et al, 2015). Over several years revisions to the NHS pension scheme lifetime allowance and introduction of the annual allowance taper based on the annual growth in pension contributions within a defined benefit scheme, with difficulties in GPs accessing up

to date pension statements to allow future planning, has led to unexpected annual tax bills. Moreover NHS doctors have perceived the pension changes as a disincentive to pursue additional work given an overall reduction in net pay once the additional pension tax is applied. Despite recent changes to the annual allowance threshold intended to eliminate the additional tax for most individuals, significant concerns remain due to taxable pensionable pay contributions increasing on promotion and limits to the lifetime allowance (BMA, 2020c). Liz Truss MP, candidate to become the next UK Prime Minister acknowledges that the NHS pension changes have led to clinicians retiring early and wishes to pursue making policy amendments to rectify the problem (Pulse, 2022). The UK government needs to urgently review the NHS pension scheme annual allowance and lifetime allowance to ensure it incentivises clinicians to remain in practice and increase working hours, the impact of which will be felt more acutely within 'Deep End' practices faced with disproportionate recruitment and retention challenges.

Key study recommendations are outlined within the table below utilising the subcategories of Maslow's hierarchy of needs theory albeit with cessation of the pre-potency principle but rather a recognition of the equal importance of each category for each individual, organisation and healthcare system. The recommendations in regards to the recruitment and retention of 'Deep End' GPs allow various stakeholders to consider each and every proposal to be enacted synchronously in full to reduce heath inequalities and ensure health justice for all in order to truly realise meaningful 'levelling up' of all communities.

6.1 Table 4: Recommendations

Category	Recommendation
Physiological	1: GP surgeries to facilitate the creation of bespoke voluntary annual individualised 'care plans' for all GPs that seek to provide support for both

	professional and personal needs within their portfolio careers (separate from annual appraisal conducted for regulatory purposes). 2: NHS/UK government to invest in free English and healthcare service navigation lessons for those residing in 'Deep End' localities 3: UK government to invest in greenspaces within 'Deep End' localities.
Safety	4: An adjustment of the Carr-Hill funding formula to more accurately reflect the service demands attributed to deprivation with a focus on consultation frequency and co-morbidities at younger age groups. 5: Bespoke additional NHS financial and non-financial resources to 'Deep End' practices to address unique practice service needs and innovation, exclusive workforce planning and capital infrastructure. 6: Additional 'clinical' administration time coordinating care allocated to GPs working within 'Deep End' practices to better reflect GPs actual working hours rather than the 'fictive' sessional schedule. 7: UK government to invest in providing means tested digital infrastructure and digital training within 'Deep End' localities. 8: UK parliament to amend immigration rules allowing medical IMGs to apply for automatic residency rights for themselves and their dependent children/adults as part of their initial visa application stage.

	9: UK government to provide bespoke support to all 'Deep End' practices to become accredited visa sponsor employers. 10: UK parliament to amend NHS pension regulations to remove the annual and lifetime allowance thresholds
Belonging	11: GP surgeries to invest in facilities/activities to enhance social capital i.e. opportunities for staff to meet formally and informally to provide peer support and innovate as part of their formal work structure. 12: NHS organisations to be fully IT enabled and compatible to allow information sharing in real time to allow efficient coordination of care
Esteem	13: An official announcement by the UK Health and Social Care Secretary acknowledging the vital contribution of GPs including the 'goodwill' hours provided in ensuring the ongoing survival of primary care and the NHS. This would act in countering the negative media coverage of GPs. 14: UK parliament to introduce legislation to allow the GMC to include GPs onto the specialist medical register. 15: The formal change in the role of a GP as a specialist leading a team of junior doctors and allied health professionals as part of multi-disciplinary teams akin to hospital specialists.

	16: UK government to withdraw plans to force GP Partners to publish their annual incomes.
Self-Actualisation	17: GP surgeries to implement organisational designs aligned to their structure, systems, staff skills, leadership style, values and culture to meet the strategic objectives and the overall mission statement. Provide double consultation times when an interpreter is required. 18: GP surgeries to provide a formal in-house mentoring programme linked to individual personal development plans for all GPs as part of their formal work schedule. 19: GP surgeries to implement proactive regular CPD opportunities for all GPs as part of their formal work schedule. 20: Training: i) Medical Schools to formally collaborate with 'Deep End' practices to ensure all medical students receive placements within these GP surgeries ii) GP specialist training schemes to provide bespoke support to 'Deep End' practices to become accredited training practices

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8.0 Appendix A: Participant Information Sheet

Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David
200
1822 - 2022

Participant information sheet (Version 1: 26/02/2022)

Title of study

Recruitment and Retention of 'Deep End' General Practitioners

You are invited to participate in an educational research study. Before you decide whether you wish to participate, it is important to understand what the research entails and why it is carried out. Please take a few minutes to read this information leaflet carefully. Please do not hesitate to contact me if you need further information.

What is the purpose of this study?

This study aims to determine the perceptions of GP Surgery Partners with regards to the factors that influence the recruitment and retention of GPs. Primary care within the UK National Health Service (NHS) continues to experience unprecedented challenges in relation to the recruitment and retention of General Practitioners (GPs). 'Deep End' GP Practices consist of GP surgeries providing healthcare services to the 15% most deprived populations as per the Index of Multiple Deprivation (IMD). Areas that are relatively more socioeconomically deprived experience disproportionate GP shortages. No studies exist which define the factors that influence the recruitment or retention of GPs working in 'Deep End' practices within the UK. The study will be a qualitative study as the perceptions of participants will be sought. The data collection method will be the use of semi-structured interviews.

Who is conducting the research?

This study is being undertaken by Yasar Khan as part of my Master in Business Administration (MBA) course at the University of Wales, Trinity Saint David. I will be supervised by Glenn Behenna.

Why have you been approached?

You have been approached as you are a GP Surgery Partner in Luton, England, UK. The GP Surgery at which you are Partner has been identified as a 'Deep End' Practice. Your insights will be invaluable for this study.

What do I have to do?

You will be interviewed remotely using video teleconferencing software for approximately 30-45 minutes. The interview will take place at a mutually convenient time and setting.

Will my taking part be confidential?

The completed interviews will be anonymised but they will have the number allocated to you upon arrival at the course. A file containing your name and your corresponding email address will only be accessible to me and will be kept securely in a password-protected excel file. This will be destroyed upon completion of the project dissertation.

What will happen to the information that I give?

The completed audio-taped interviews will be kept securely as described in the previous section. An analysis of the anonymised data will form part of my dissertation and so anonymised data will be shared with MBA course supervisors at the University of Wales, Trinity Saint David and also with external examiners to fulfill the requirements of the Masters course. Occasionally, external examiners may request to view the primary data (i.e. audio-tapes) although no names will be attached to any primary data. The anonymised data from this study may be published in a peer-reviewed journal and at a conference. You are welcome to see a summary of the findings at the conclusion of the study.

What if I wish to withdraw?

Your participation in the course is entirely voluntary and you can withdraw at any time you wish without providing a reason. If you decide to withdraw from the course after data has been collected and anonymised it may not be possible to remove your data from the study.

Expenses

There is no fee required for your participation in this course.

Contact Details

If you have any questions about the study please contact me:

Dr Yasar Khan
University of Wales, Trinity Saint David
IMH Carmarthen
Email: 1905468@student.uwtsd.ac.uk

Thank you for taking the time to read this participation information sheet.

9.0 Appendix B: Consent Form

Title of Project: Recruitment and Retention of 'Deep End' General Practitioners

CONSENT FORM

University of Wales, Trinity Saint David Research Ethics committee approval number:

Lead researcher: Yasar Khan

Participant Identification Number:

Please initial box

1. I confirm that I have read and understand the information sheet dated 26/02/2022 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that this study is to determine the perceptions of GP Surgery Partners with regards to the factors that influence the recruitment and retention of GPs. ☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my training or legal rights being affected. ☐

4. I consent to use of audio taping and I agree that anonymised verbatim quotations may be used in the final written dissertation which will be available in the University library. ☐

5. I agree for anonymised data from the study to be potentially published in a peer reviewed journal and to disseminated at a conference. ☐

6. I agree to take part in the above study. ☐

.....	.....	.....
Name of participant	Date	Signature
.....	.....	.....
Name of Person taking consent	Date	Signature

When completed: 1 for participant; 1 for researcher site file

10.0 Appendix C: Interview Proforma

Interview Proforma: Recruitment and Retention of 'Deep End' General Practitioners

Interviewer: YK

Interviewee: Anonymised code provided

Questions:

1:

- What is your current role within the GP Surgery?

2:

- From your perspective, what factors do you feel influence the recruitment of GPs generally?
- What particular factors if any, do you feel influence the recruitment of GPs within 'Deep End' practices?

3:

- From your perspective, what factors do you feel influence the retention of GPs generally?
- What particular factors if any, do you feel influence the retention of GPs within 'Deep End' practices?

4:

- What do you think is the impact of reduced GP availability for direct patient contact?

5:

- In what ways do you feel your GP Surgery has been impacted by the recruitment and retention of GPs?
- From your GP Practice perspective, can you give me any examples of how the impact has been managed?

6:

- More generally, how else do you feel the challenges of GP recruitment and retention can be addressed?

7:

- Anything else you want to tell me about your perceptions on the recruitment and retention of GPs within 'Deep End' practices?

8:

- Do you have any other questions?

9:

- Would you like to receive a summary of the research findings once the study is complete?

11.0 Appendix D: Transcript of an interview

Some of the transcription has been redacted to preserve anonymity.

INT: Yes so thank you very much for partaking in the study. So first of all just wanted to understand what is your current role within the GP surgery that you work within.

RES: Response removed from sharing to preserve anonymity.

INT: Thank you very much. And that's going on to my second question. From your perspective what factors do you feel influence the recruitment of GPs generally.

RES: GPs they want to join a practice. Work in an environment where they feel they can make a difference. They can contribute. I think they are looking for a degree of job satisfaction. Shall I put stroke intellectual challenge. So that they want something that keeps their medical skills up to date. That spurs them to keep up to date and to continue learning. So I think they're looking for a learning environment. And they want to feel safe. They want to feel that it's a safe environment to work in. So for many they don't shy away from hard work but what they really want to see is a safe workload to work in. And I think they wouldn't necessarily describe it initially when they're applying for something. But I think once they've been somewhere for a while I think they would describe a practice that's well managed. But they just have a sense of it when they're applying. Rather like when you go to medical school. Do you like the look of this or not? And it gives them that sense of this seems a good place to be. And I think eventually what makes them stay is they want to belong.

INT: Sure. Thank you very much. And what particular factors if any do you feel influence the recruitment of GPs within deep end practice specifically? If you think they are any further aspects

RES: Being able to describe. If a practice can describe its culture. You know it's values. What matters to the team? Then being able to describe that and have a sense of optimism despite all the challenges that working in a deep end practice might bring. If they can describe a sense of moving forward and positivity. That will attract people. I've experienced it myself when I moved to Luton, and I've shopped around a little bit to see where I wanted to be. Hearing

discrimination. Hearing negativity. Hearing a litany of how bad things are is a real turn off. So hearing the positivity and an honesty about the situation.

INT: Sure. There was a later question but because you alluded to it right now I will ask you at this stage. You mentioned the challenges in working in deep end practices. What other challenges do you feel exist working in a deep end practice?

RES: Principally we're working with people with whom the wider determinants of health. The basics of living as in having enough money to be able to buy enough food. Having an environment to live in that's decent. You know it doesn't have to be super it just has to be decent. Dry clean or able to keep it clean. Able to keep it a reasonable temperature and safe so that things are not going to fall down from the ceiling. Or they're not going to be harassed by disturbance of gangs or anything rife in the area. Those are the fundamental. How connected are people? You know are they lonely. It's not uncommon for a people who are living in difficult circumstances to have lost their family connections for whatever reason. And therefore they can gravitate to health services. The doctor typically but it could be the nurse it could be the receptionist. As their significant other you know their significant person in their life. They would share things. Which is in some ways a great privilege but also you know they're coming and talking about things that actually aren't the doctors or the nurse's domain really. And if they think then the educational attainment and literacy and health literacy. So really lacking knowledge either because they've come from an environment where they've never had the opportunity to learn it or they've struggled with their education and therefore find it difficult to function in that domain. So that's fairly basic. And having to when we're talking to people when we're trying to explain problems we really have to crystalised down and try and work out the language in a way that's going to be appropriate for the individual. And start where they're at. Not where we'd like then to be. So I think that's a real challenge. And certainly somebody who's come from an environment that's not like that it takes a while to actually adjust your expectations and adjust your technique and your consultation technique. And for us in Luton I mean it wouldn't necessarily be the same in other parts of the country but in Luton we've got such a diverse population. 150 languages are spoken in Luton and we've probably in …….. (response redacted). So actually language is a real challenge because each consultation with somebody that doesn't speak English as their first language takes twice as long. And then people are getting sick younger in that demographic. So that can you kind of get the unexpected and being alert to the unexpected. And I think also it does take an emotional toll really when you have a younger person dying of something

or have a severely divellicated by a condition that actually we think of as a condition of old age and yet they're not. I think that's quite a challenge to GPs in that centre of environment.

INT: Sure. And you mentioned the emotional toll. In the end, how does that when you're going home make you feel sometimes?

RES: I've been consciously trying to switch off and stick to hours. Because I do another role as well as you know …….redacted ….. Stick to hours and get more rest. And actually as I do that and get more rest. Actually I think I'm feeling more. I think you do get to a point of emotional fatigue. Which again it can be a dangerous sign to be honest. So actually looking after self and finding a way to decompress is important. Having said there's a lot of challenges. When a job well done is immensely satisfying so you know taking somebody to a level of understanding with their condition or actual where they do start to take control of their own health and their livelihood. And maybe they stopped smoking, or you know to cut their drinking down. You feel so proud as if they're one of your own. One of your own children really. When that's happened. And so I think it does give an immense satisfaction.

[0:10:56]

INT: Sure. Thank you and I'm just going to go back and ask you about retention. And it may apply similarly to recruitment. But from your perspective what factors do you feel influence retention of the GPs generally?

RES: Okay. So generally retention there's a lot of evidence that having a variety of the working week is helpful. And being able to influence what the working week looks like. So if someone chooses to work six sessions a week. Also being able to choose more or less within you know servicing the wider team and what the practice needs. But having some influence over what that looks like. So whether that's start times. Whether it's spread over three days or five days. You know being able to influence that is really important. And there's got to be compromise. But having some degree of control over that I think is important. So the fairness in workload. So feeling that we're all in it together and we're all pulling in the same direction. And that others you know somebody else isn't being favoured or having an unusually lighter workload. I think that's important as well. Then I think it's being heard. Being able to shape the way the practice develops and the way we're talking the practice here, but I think you know the wider team as well that interacts with us. So being heard being able to contribute

a view being able to hear how decisions are made is important. And I've worked places before where that's not been the case at all, and I've made decisions and I've walked personally. And I've seen it happening elsewhere as well you know. But this is kind of 25 years ago I've done that personally. So that's one aspect of things. And then I come back again to feeling safe. So in the first part of someone's career. Of them finding their feet. Would be educated and taught to work to protocols and guidelines and then when you're released into the big wide world of general practice you suddenly find that patients don't always fit into the guidelines very well. And end up feeling with multiple morbidity multiple risk and learning how to balance that. And some people you know adapt and adopt and have a mental and navigate that well. Others find that really really really difficult. In ……redacted ….we've made an informal arrangement trying to buddy people. Trying to mentor them and when we first started doing that it was informal and open offers. You know anything you know let's have a chat. How's it going? And even that didn't work very well, and we found that we lost people. And we think because I think some of it was because of managing risk and managing workload and feeling that it was all on that individual shoulders. Whereas the intention was not that at all. The intention was to have someone to share that with in a safe environment. So we've moved towards a more formal arrangement, but we're still not perfected that. I think it gets squeezed if workload is heavy. But actually to have a formal time with people and hopefully build that relationship and build that opportunity to share. And I think that's one of our success factors actually. Because we are an environment in which people feel safe to raise things to talk about it. Redacted …….And some of that we've worked on consciously and others it just happens because of the way we interact. As I say it's not just by chance it's because we've cultivated that constantly through the life of the practice. As I say we've still got a journey to go. I think we've still got further we can take this. But I think it's palpable for others looking at it. And that's what we need to have. That's how people will feel safe. And feel able to keep going. Despite whatever else happens externally that's out of their control.

INT: Sure. Thank you and you may have already answered the next question. But it gives you the opportunity to say something more if you wish to. What particular factors if any do you feel influence the retention of GPs within specifically to deep end practices?

RES: So they arrive in deep end practices. They chose deep end practices because they want to make a difference. They want to address the inequalities. They are motivated by trying to work with the least advantaged in society. Again I think they stay I think when they can start to see the work they're doing is recognised by others. And I'll say the local system it's been

CCG's it's the integrated care system. But actually recognition that you are doing a great job in difficult circumstances. And you can see the outcomes for your population are improving. That's motivating. What will help in the longer term is actually seeing a redress in the funding. You know the resource. Not just money but people. You know in a deep end practice you probably need at least twice the amount of work force to undertake the same work. Because the consultation rate is higher. The time to educate takes longer. The language all the rest of it. So at least twice. Probably more than that. And maybe somebody's who's done some research on that. I don't know. But we need more resource and if that's recognised and that starts to get more resource then that feels like making headway. And if you're making headway then I think that's helpful. On the counter side constant criticism and lack of appreciate of the challenges that the population are dealing with becomes demotivating.

INT: Sure. Thank you very much. Again you may have already answered this question. What do you think is the impact of reduced GP availability for direct patient contact?

RES: If we look at it from the patient's point of view and particularly it depends on the patient. And there are many who don't have digital phones don't have digital access. Don't have enough money to even put enough credit on their phone to sit on it long enough for the phone to be answered. So therefore their ability to function and get the help that they are needing and to share their concerns with the health team is reduced. And I think we have seen that and certainly I was very very concerned about reports that we had around Luton in a door closed. So that the only possible way of communication was over the phone. And that can't be right for people who can't function with phones. Through no fault of their own. So I think that's part of what would have widened the divide actually between the most and the least advantaged in society. We made a conscious effort in the practice to keep our doors open. While also managing as many as we could over the phone remotely. I don't feel that the health professional has to be a GP. So health professionals the practice being accessible at patient level is really important. The rest of the team who do a huge amount of great work. So I think it has exacerbated and clearly what we saw with the benefit system and the increase in the Universal Credit that definitely helped out patients. That 20 pounds a week more made a difference to them. Where we are now I expect a significant step change in our patients' circumstances and how they cope. And their health impact really.

INT: Thank you. And in what way do you feel your GP surgery has been impacted by the recruitment and retention of GPs?

RES: Well I'm going to polish my badge and say I think we're doing alright. So we went through a very difficult phase. And probably I'm just trying to remember back now it might be five or six years ago where we couldn't recruit. And it was really dire. And so we recruited other professionals because that's what we could do at the time. So we took the approach of what can you do as appose to what can't you do. And as we gradually adapted and adjusted and created an environment where the workload is manageable. It does feel measured. It's hard work it's challenging work. It's exciting work. But actually it feels safe, and you know it has become more doable and over the last three to four years. And by doing that and that's largely down to management team and expanding our management team and taking away from GPs the stuff that we were not good at or we can't influence anyway. And then we do the stuff that we are good at and then we feel better because we're good at it and we make a difference. So that's something about given the right workload to the right people. It is something that we've achieved, and I think continue to achieve. And because of that I think when we're advertising, and people look and they test out. I mean we always say to people come and do a few sessions. Have a look first. When they come and they look and they test then a proportion of them will stay. For others it's still not for them. Clearly not for them and they don't stay. The other great thing we've done in recent years is expanded our training. And I think GPs who train in deep end practices again have a true understanding of what it involves. And also the wonder of the intellectual challenge. Which I think again is something I didn't mention earlier on but I think that does inspire people that they see textbook medicine that you don't see elsewhere and that's a sort of intellectual stimulus for them. So expanding the training has helped us because a number of people have come because they've trained with us and they've stayed with us. We need to see further expansion of training in deep end practices I think.

INT: Sure. And you may have already answered this question. It gives you an opportunity if you want to say anything more. From your GP practice perspective can you give me any examples of how the impact has been managed? You've already mentioned several things already. But if there was anything else you wanted to say.

RES: Recruitment. Yes. So yes we've- I think definitely the training and then anticipating completion of training and actually not giving our colleagues chance to get a better offer

somewhere else. But getting in early to letting them know that there's a job here for you. What would you like it to look like? So that they know that they can shape what they want for their job for the future. So that's one thing I think that we've done differently. And a lot of our recruitment have come by word of mouth actually. Advertising has stopped being that beneficial. And I know some people are disappointed by that. Maybe because they feel they're missing out. But actually if only they knew there was jobs in a good practice they would want one. Which is great. Fear of missing out is what we are all about really. Getting people to look for the good stuff and to shop around. I think the other thing that we have done in terms of retention is enable everyone to grow. ……..redacted ……So we can't have six dermatologist specialists. But you know within a ……redacted …….. We enable them to pursue their special interest. Or their outside commitments. Whatever it is that gives them variety in their week.

INT: Sure. Thank you very much. And more generally how else do you feel the challenges of recruitment and retention can be addressed nationally/internationally.

RES: Resource needs to follow into general practice. There's a huge amount of resources. I know this because …….redacted ….. There is a lot of money that's come in to work force in recent years. And I don't see that drying up. What also needs to happen is a flow of resource into what you might call general medical services. We need to see the resource to utilise once they're in the practice. So that's important I think. Need to sort out the pensions. The pension cap is a disincentive. We need to retain experienced GPs. Doing something that inspires them which is not necessary the same as they did in mid-career or early career. But they will feel valuable and feel they're making a good contribution. And they're supporting the early career people to find their feet and to manage risk. And manage complexity. Because that's what an experienced GP does really well generally. And helping someone who's embarking on their career to navigate that is really really important. So we've got to retain the experience in order to help the mid and early career GPs. And also just the ability to manage risk surpasses any other group in the workforce really. So resources. And we need to change the public narrative. We need to change the media messaging. We need to value GPs if we talk specifically about GPs which is probably one of the most critical groups. As being an expert generalist as opposed to just a GP.

INT: Sure. Absolutely. And anything else you want to tell me about your perceptions on the recruitment and retention of GPs within deep end practices.

RES: There's something about normalising wellbeing offers and the access to utilising wellbeing offers. And I think it's a professional trait that we kind of think that we're alright and we're fine and we don't need anything. And we just keep working and eventually we'll get there. Whereas actually it's redressing the balance and getting a work life balance and learning some techniques about decompressing and just finding joy in other things really. It's something that we as a profession we ought to pay a bit more attention to. You know I would say it's a professional trait that we don't. So maybe that needs to start in medical school really. And then we stand some chance of people- there's lots of offers available but the take up is not as great as one would have expected.

INT: Sure. Thank you very much for your time today. Did you have any other questions or comments you want to make before I stop the recording?

RES: Redacted

INT: Redacted

RES: Yes please. Yes yes. Definitely.

INT: Thank you very much for your time I'll stop the recording.