BMA

Scotland

Scottish GP Contract Survey

Autumn 2023

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Foreword

Six years on from the 2017 special LMC conference that endorsed the aims of the 2018 GMS contract, there have been some significant changes to the landscape of General Practice in Scotland, but also a lot of depressing familiarity about the challenges that threaten our future.

Workload, workforce, financial sustainability and investment in General Practice remain our key challenges and it is clear that progress in implementing the 2018 contract has not been deep enough or fast enough to overcome these.

The unfortunate reality that I think we all would recognise is that the GP whole-time workforce is falling and leaving those of us who are left with an ever greater mountain of demand to manage. It cannot go on and if progress on the aims of the 2018 contract has been insufficient to arrest these challenges, it is absolutely right that we take stock and consider what more can and must be done via the contract to support General Practice in Scotland.

It is essential that we as the SGPC negotiating team and delegates to SLMC conference as representatives of the profession understand the priorities and views of GPs on what all of us want from the GMS contract.

To that end we have carried out this survey of GPs in Scotland, to inform the discussion and debates at SLMC conference that are so important for shaping the future direction of travel for General Practice in Scotland. It is imperative that General Practice in Scotland is moving in a sustainable direction that brings hope for the future and the motions conference passes are one of the key ways in which that desired direction of travel are articulated.

I would like to thank everyone who took the time to respond to what I know was a longer and more complicated survey than those we usually ask. Some of the messages you have given could not be clearer and it is now for us to try and secure tangible outcomes that reflect those aspirations.

Dr Andrew Buist
Chair, BMA Scottish GP Committee

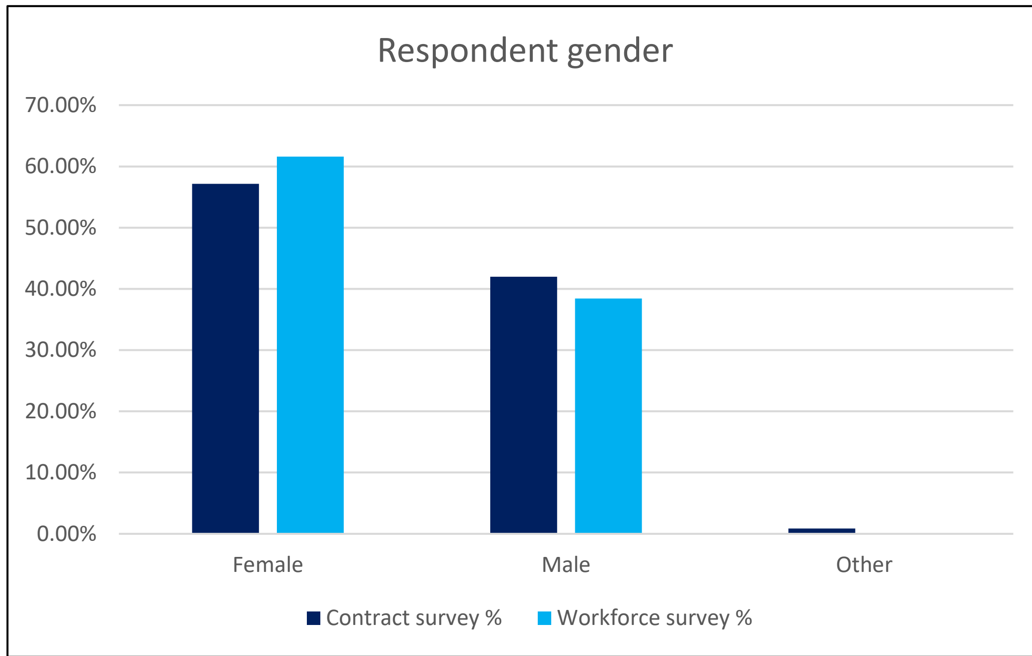
Background, methodology and respondent demographics

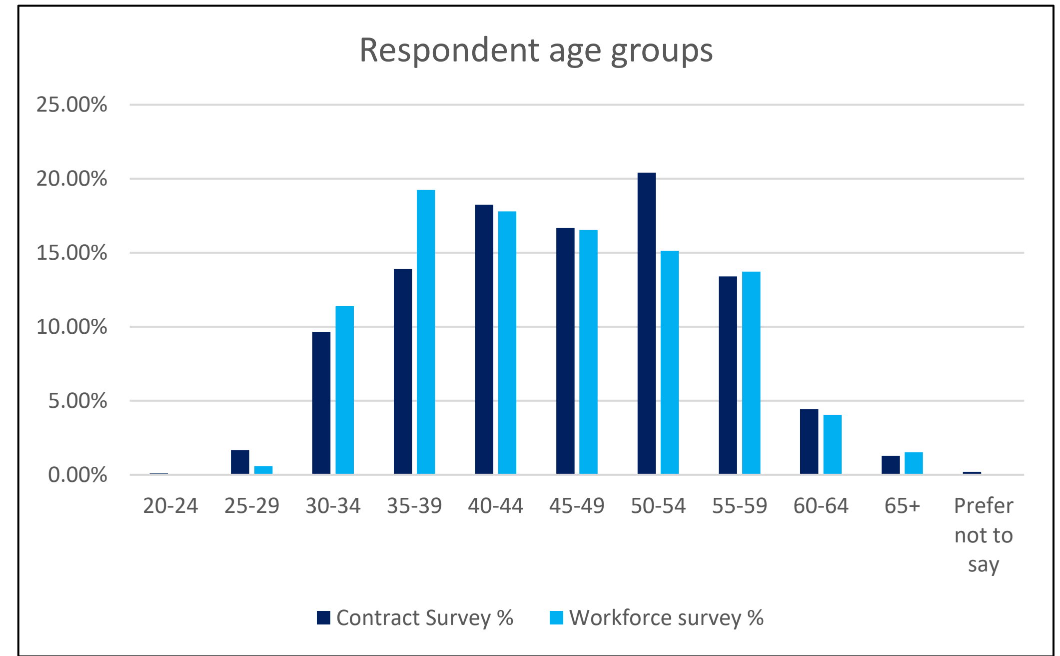
The survey was conducted between 16 October and 6 November and distributed via direct emails to BMA GP members in Scotland, inclusion in BMA newsletters, promotion on social media and was also distributed to practices by LMCs. In total after data cleansing, 1,021 respondents participated in the survey.

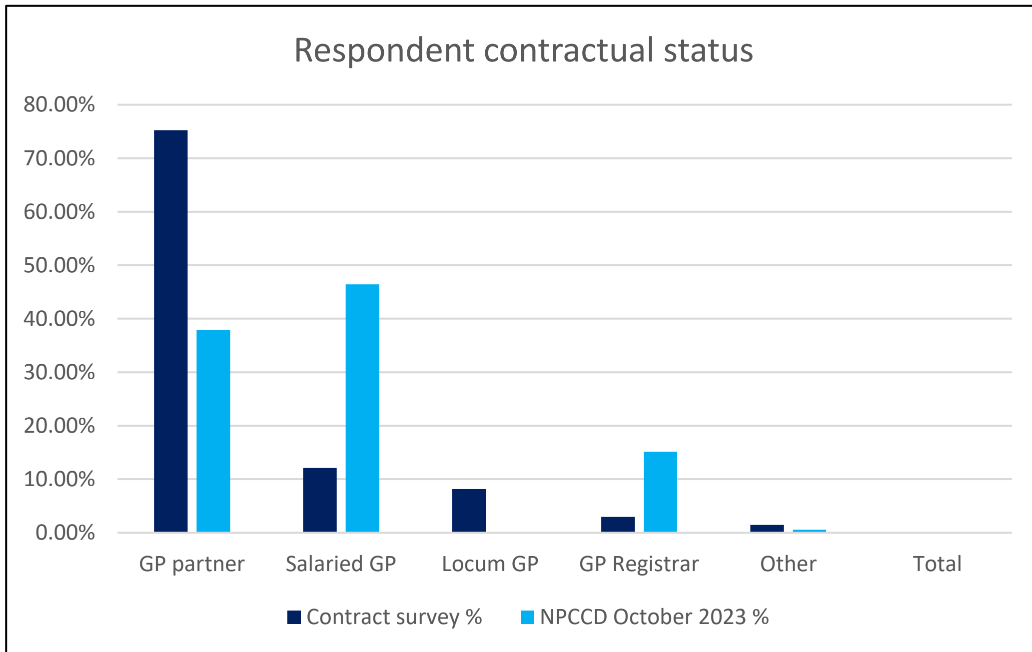
Overall responses to each question were examined before results were filtered and compared to look for differences between male and female respondents; between respondents who were under 45 and those who were over 45; and between partners and non-partners. Non-partner responses were not broken down into categories for salaried GPs, locums and registrars, with the exception of those questions which were only asked of non-partner GP respondents. A final set of questions on premises were only asked of Partner GP respondents.

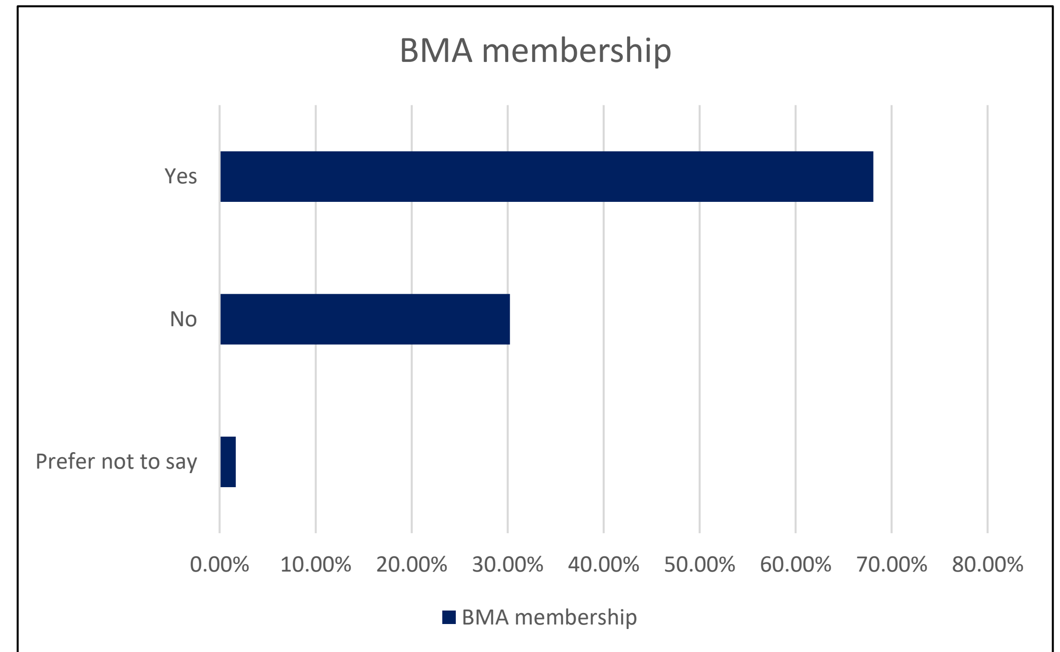
A number of questions included an ‘other’ option and invited respondents to include free text responses to explain what they had in mind. Because of the length of many of these responses and the broad range of topics covered, details of these responses have not been included in this paper but will be studied in detail by the SGPC negotiating team. Where the results are discussed below, the ‘other’ option is included in charts to show frequency with which it was selected by respondents but have been set to one side when considering which option was ranked mostly highly or lowest.

Where results have been broken down by gender, age or contractual status, differences in whether one group was more or less likely to rank an option highly or respond in a certain way are highlighted. This does not necessarily mean that they were ranked more highly in absolute terms, simply relative to the other group being looked at. Across almost all survey questions there is a great deal of homogeneity in responses between GPs of different genders, ages and contractual status and it is important that while what differences that do exist are highlighted below, it should not mean that sight is lost of this consistency in responses.





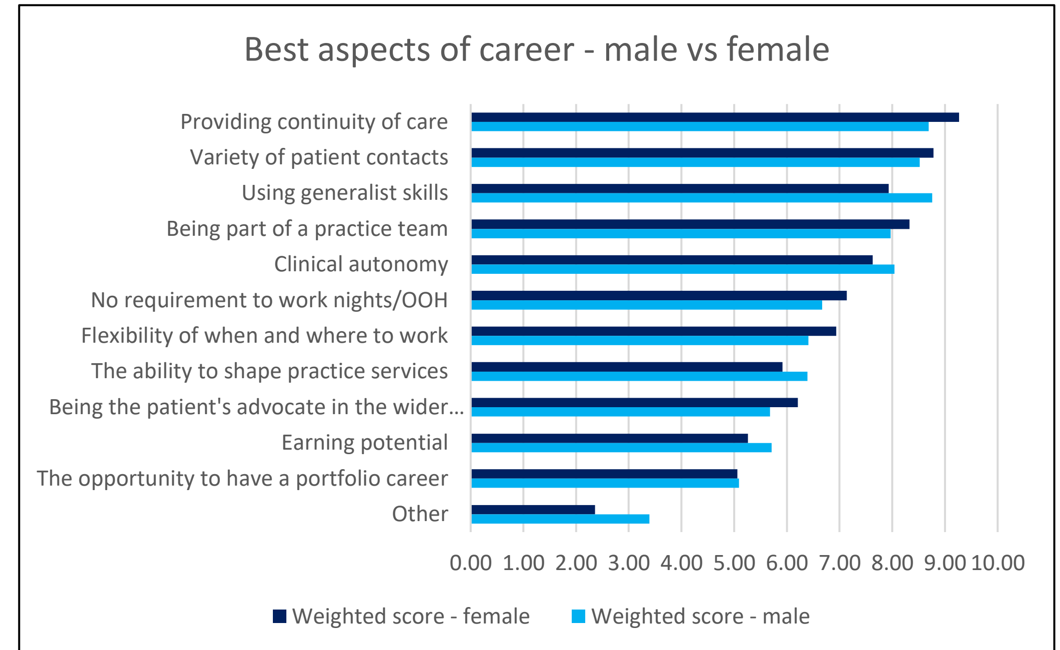




Respondents in the 50-54 age bracket were somewhat over-represented in responses to the survey while those in 35-39 bracket were under-represented. There was also marginal over-representation of male respondents and under-representation of female respondents. GP partners were extremely over-represented compared to their proportion of the headcount workforce, while those holding other contracts – particularly salaried GPs – were heavily under-represented. Just over 2/3rds of respondents were BMA members.

<u>Working life as a GP</u>

Participants were asked to rank a number of positive aspects of careers as a GP in order of what they felt was the best aspects of being a GP. Responses were weighted according to how highly each option was ranked in order to produce a weighted score. Results which show a large variation from the top-ranked score to the bottom would tend to show consistency of what was ranked highest, while those with very little variation in score would indicate far less consistency in how respondents scored options.

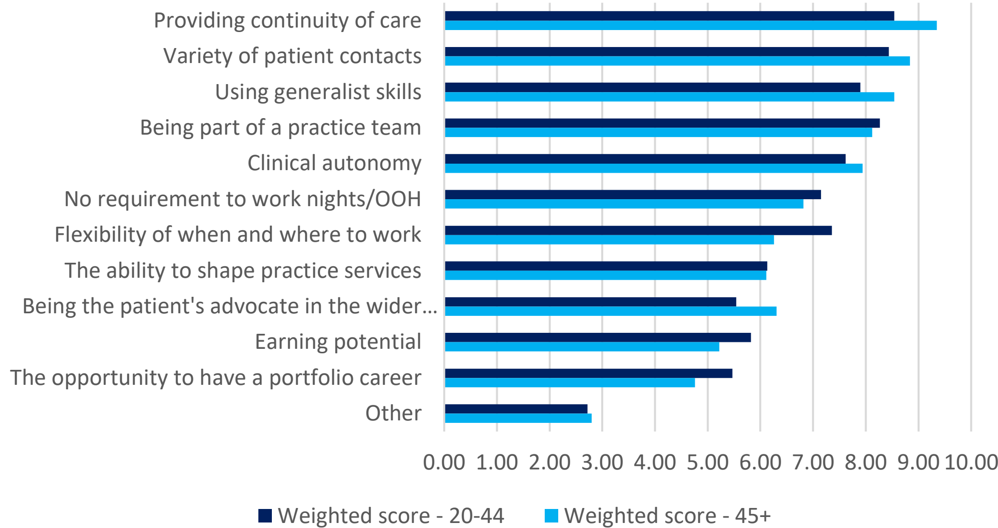


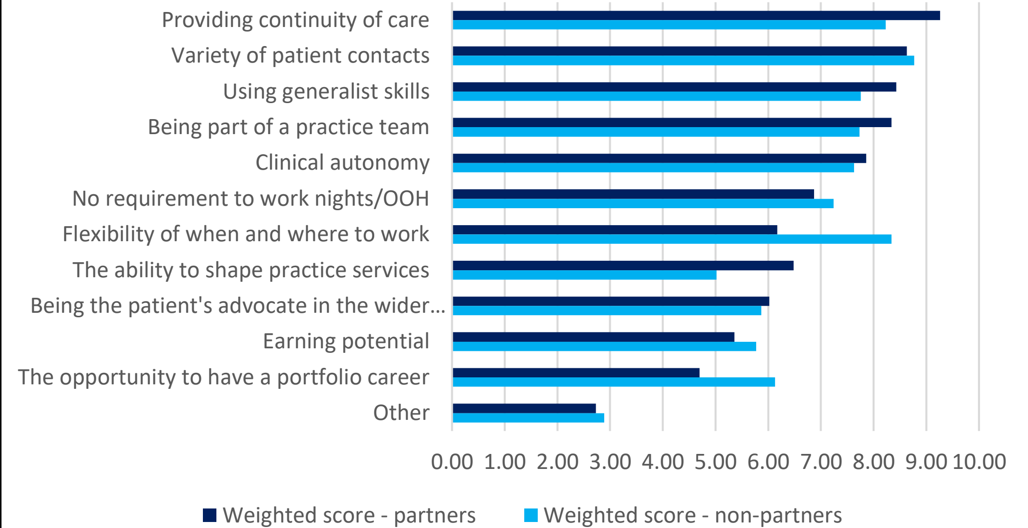
Respondents identified most strongly that providing continuity of care to patients was the aspect of being a GP they ranked as the best aspect of being a GP, followed by the variety of patient contacts, the opportunity to use generalist skills and being part of a practice team. Excluding 'other' free-text responses, the earning potential of being a GP and the opportunity to have a portfolio career were least likely to be ranked highly as the best aspect of being a GP.

There were some small variations between male and female respondents, with females marginally more likely to rank continuity of care and flexibility of when and where to work more highly than male respondents and male respondents slightly more likely to rank the opportunity to use generalist skills, the ability to shape practice services and the earning potential of being a GP more highly than female respondents.

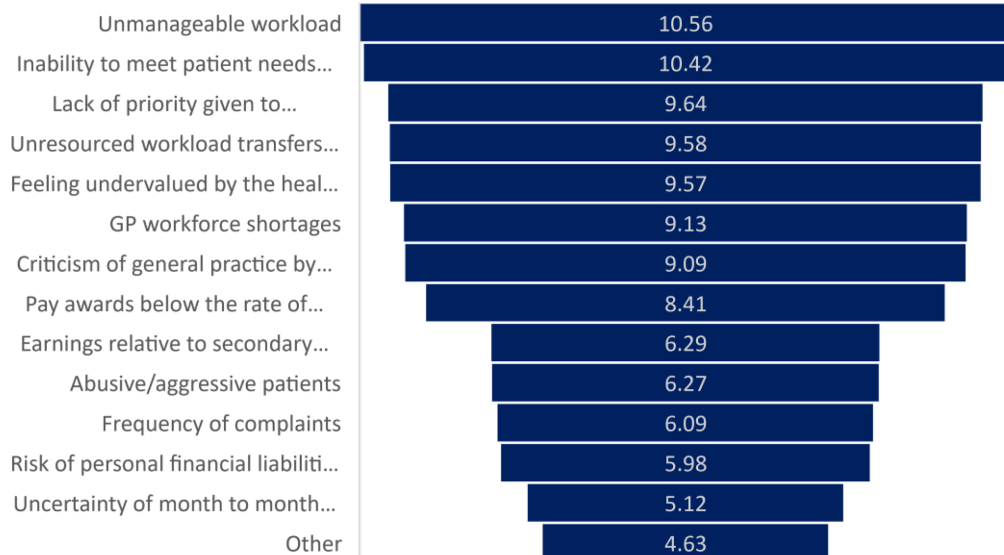
While both older and younger GPs ranked providing continuity of care highest as the best aspect of being a GP, older GPs scored it slightly higher than younger GPs, along with the variety of patient contacts and using generalist skills. Younger GPs ranked flexibility of when and where to work and no requirement to work nights/OOH slightly more highly than older GPs.

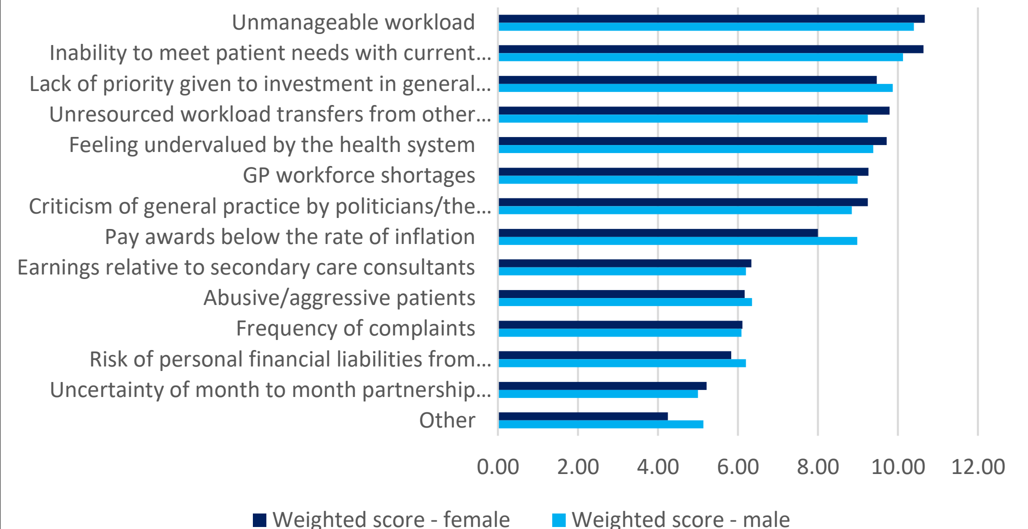
Partners ranked providing continuity of care, using generalist skills and being part of a practice team slightly more highly than non-partners. Non-partner GPs ranked flexibility of when and where to work much more highly than partners. While still not ranked highly, salaried GPs were also more likely to identify the opportunity to have a portfolio career as a best aspect of being a GP.



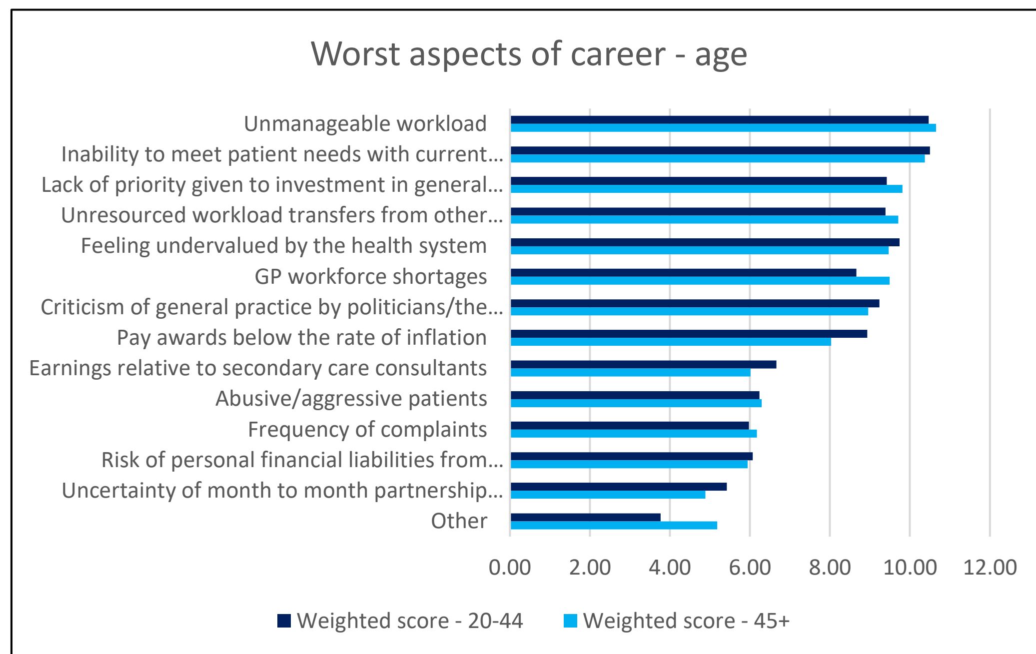


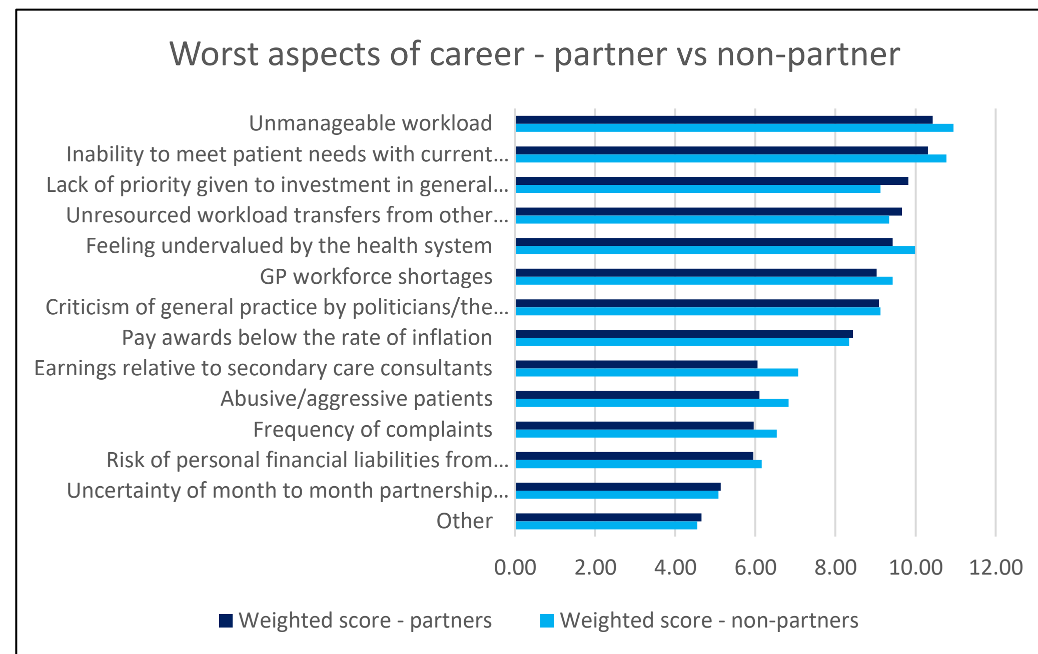
When asked to consider and rank what they felt were the most negative aspects of being a GP in order, GPs' unmanageable workload followed by the inability to meet patient needs with current resources were ranked as the worst aspects of being a GP. Respondents were least likely to rank the uncertainty of month-to-month partnership earnings and the risk of financial liabilities from partnership as the worst aspects of being a GP.





Female respondents were slightly more likely to rank GPs' unmanageable workload and inability to meet patient demand with current resources highly than male GPs, while male GPs ranked the lack of priority given to investment in general practice and pay awards below the rate of inflation slightly higher than female GPs as the worst aspects of general practice.





Younger GPs were more likely to rank pay awards below the rate of inflation, earnings relative to secondary care consultants and uncertainty of month-to-month partnership earnings more highly as negative aspects of being a GP compared to older GPs, while older GPs were more likely to rank GP workforce shortages more highly than younger GPs.

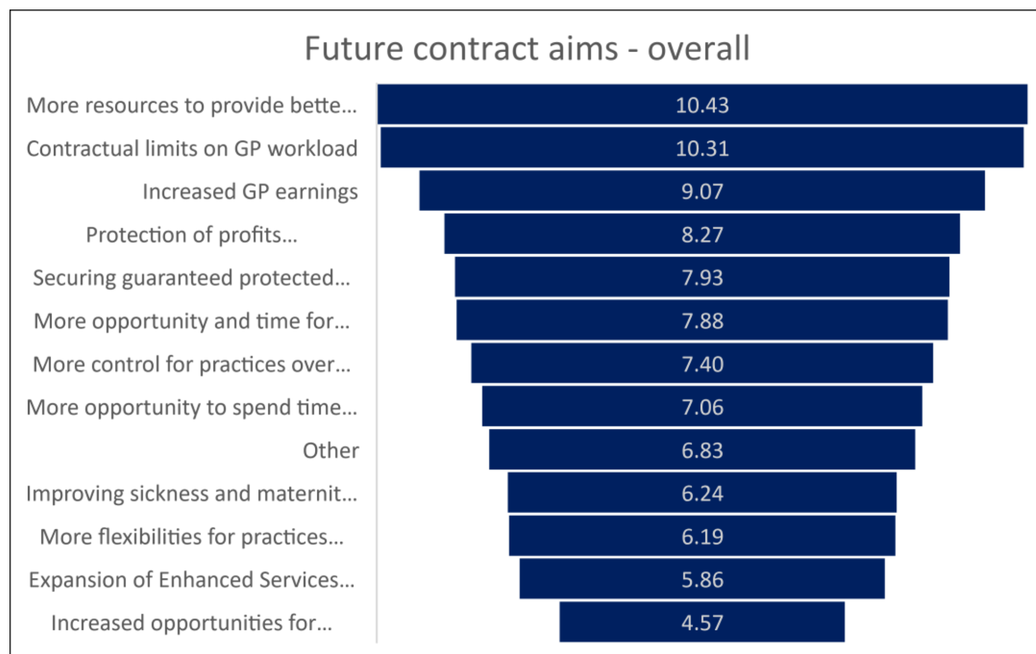
Non-partners ranked unmanageable workload, inability to meet patient needs with current resources, feeling undervalued by the health system, Earnings relative to secondary care consultants, abusive/aggressive patients and frequency of complaints slightly more highly than partners. Partners were slightly more likely to rank the lack of priority given to investment in general practice and unresourced workload transfers from other parts of the health service more highly than non-partners.

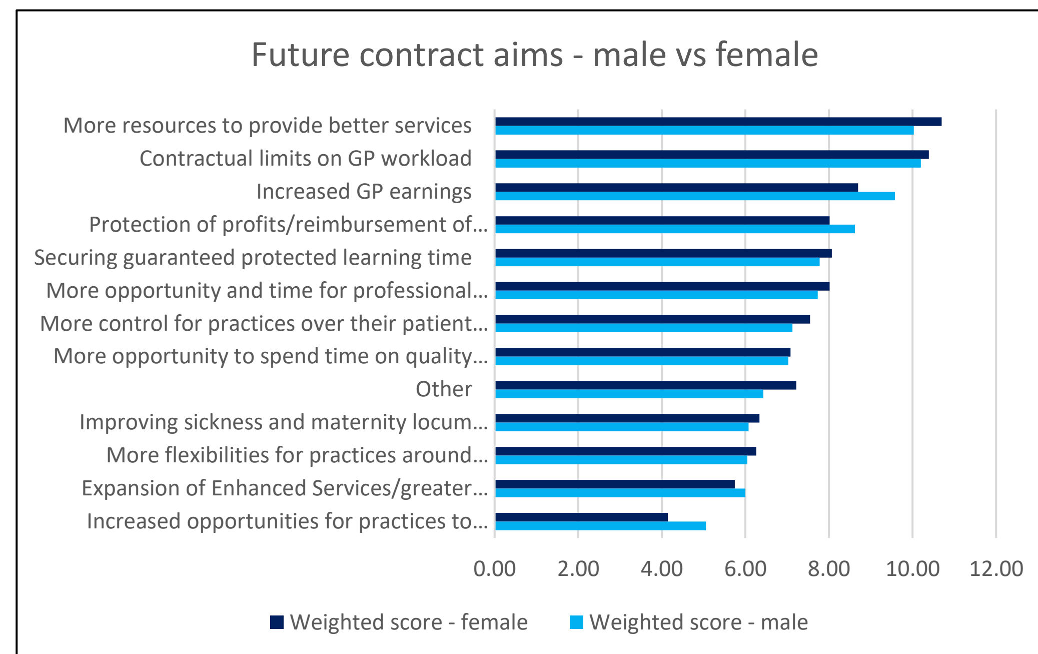
<u>Future direction of the contract</u>

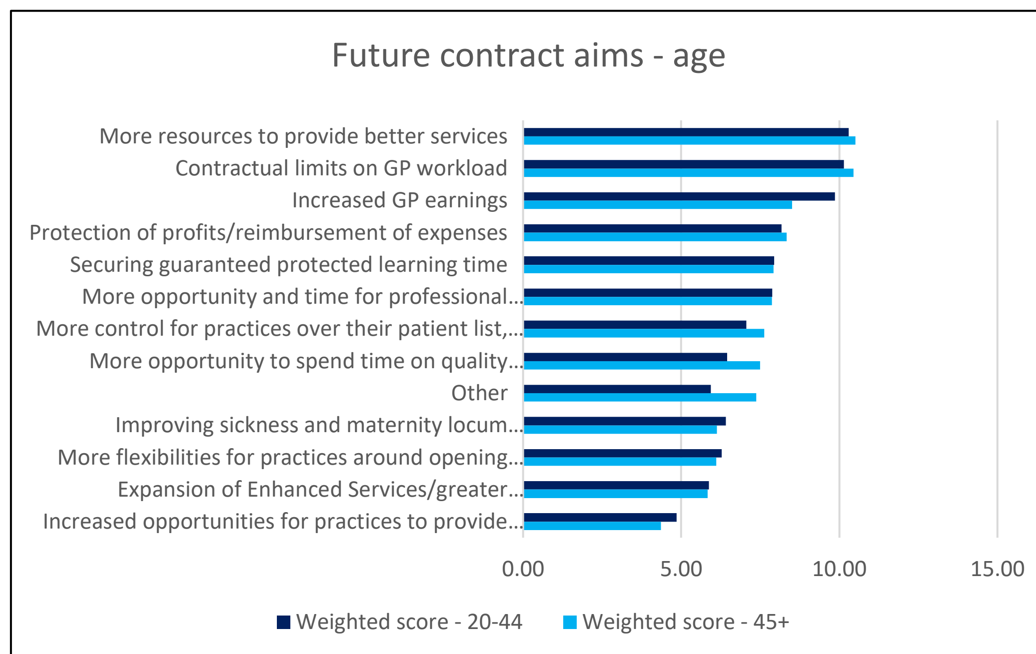
Respondents were asked about the future direction of the GMS contract and asked to rank potential future aims in what they believed should be the order of priority. More resources to provide better services was ranked most strongly as GPs' priority for the future of the contract, followed closely by contractual limits on GP workload and increased GP earnings. An expansion of enhanced services and increased opportunities for practices to provide private services were the least likely options to be ranked highly by respondents as priorities for the future of the contract.

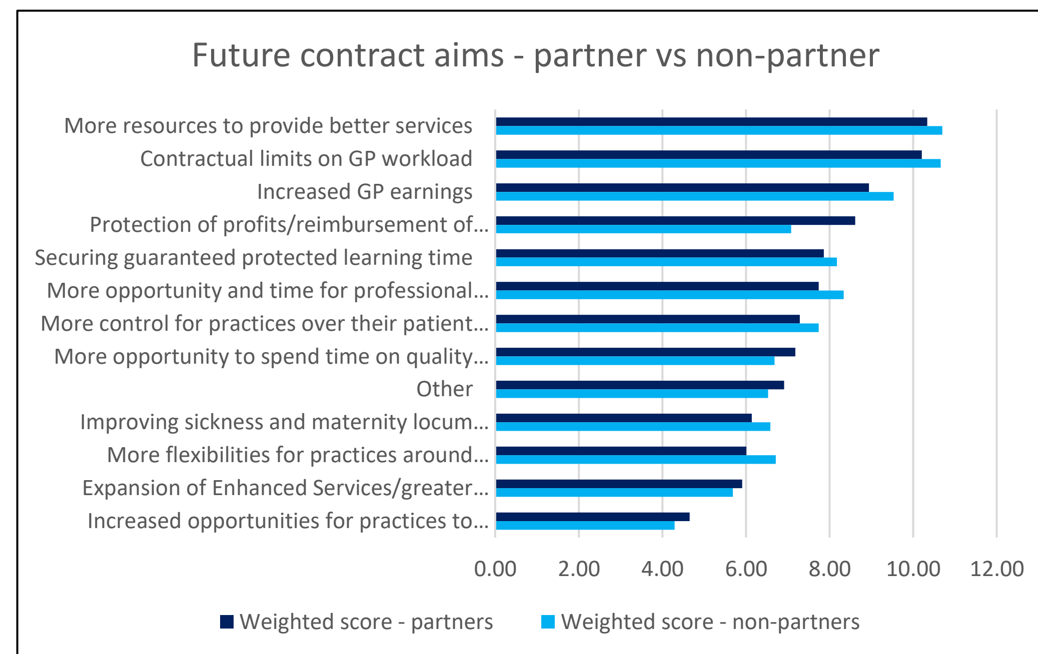
Female respondents were marginally more likely to rank more resources to provide better services and contractual limits on GP workload than male GPs, while male GPs were more likely to rank increased GP earnings and protection of profits/reimbursements of expenses more highly. Although it was still the lowest ranked option, male respondents ranked increased opportunities for practice to provide private services more highly than female GPs.

Younger GPs were by some distance more likely to rank increased GP earnings as a priority direction for the contract than older GPs, while older GPs were more likely to prioritise more control for practices over their patient list and more opportunity to spend time on quality improvement activities. Partners were substantially more likely to prioritise protection of profits/reimbursement of expenses compared to non-partners and also slightly more likely to prioritise more opportunity to spend time on quality improvement activities. Non-partners were amongst other things more likely to prioritise increased GP earnings and more flexibilities for practices around opening hours than partners.

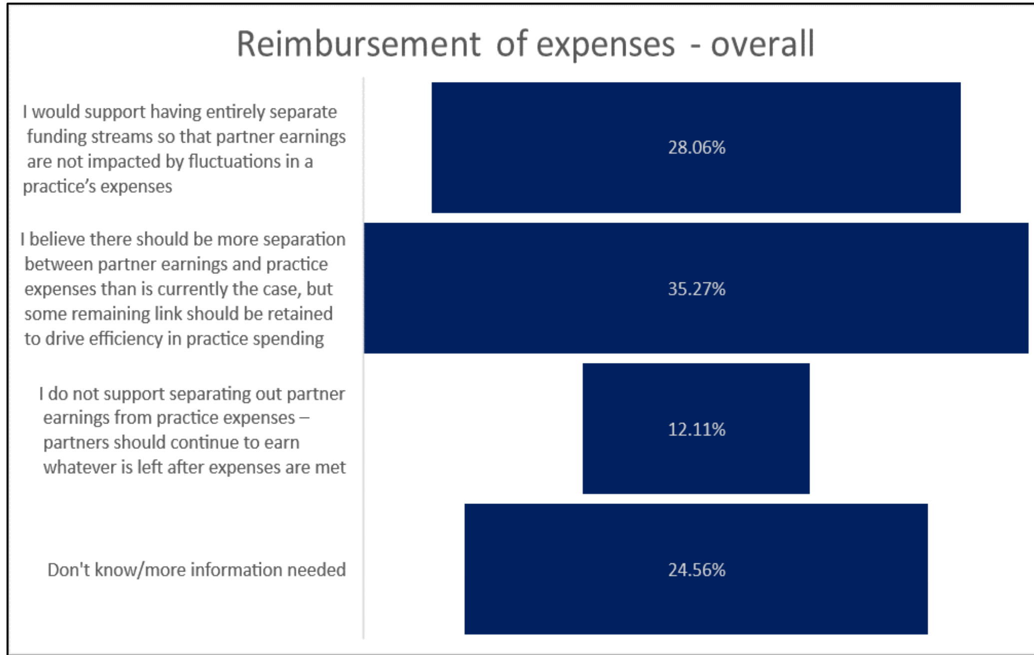


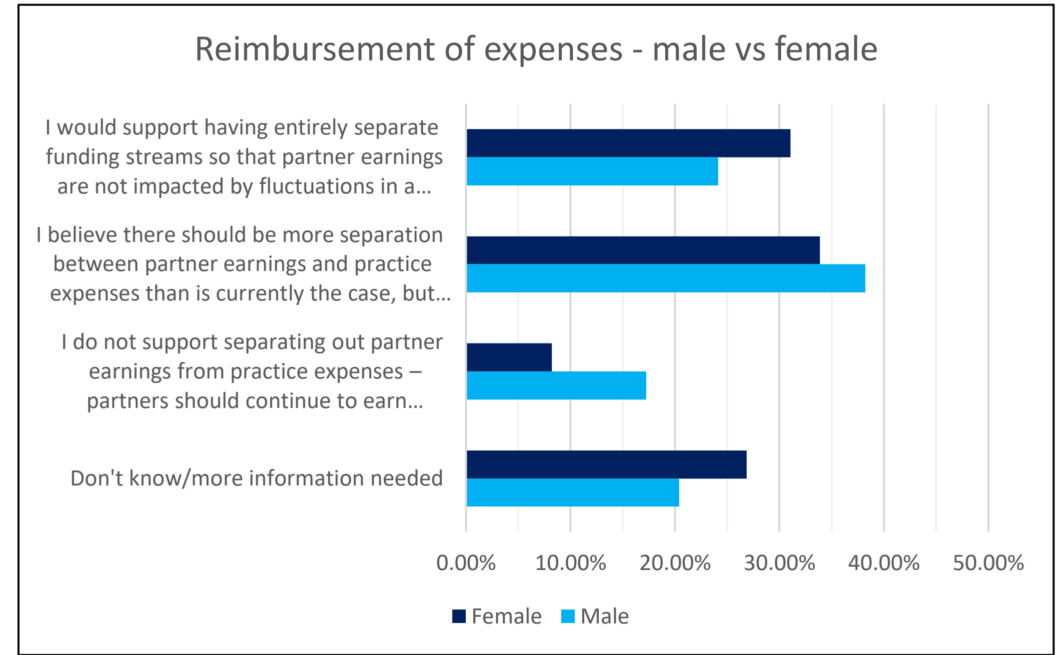


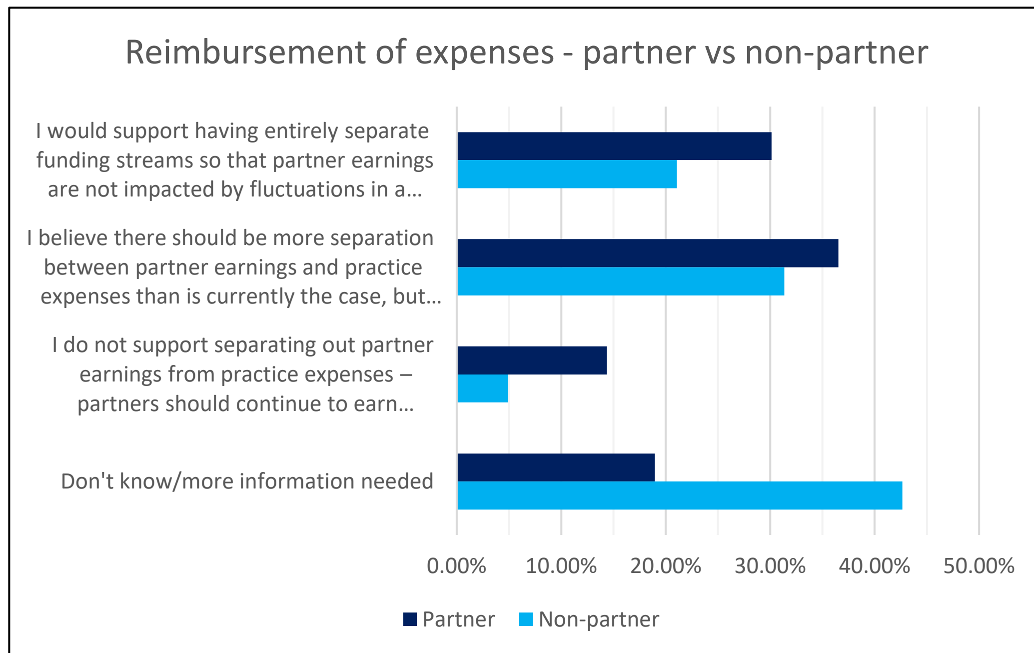


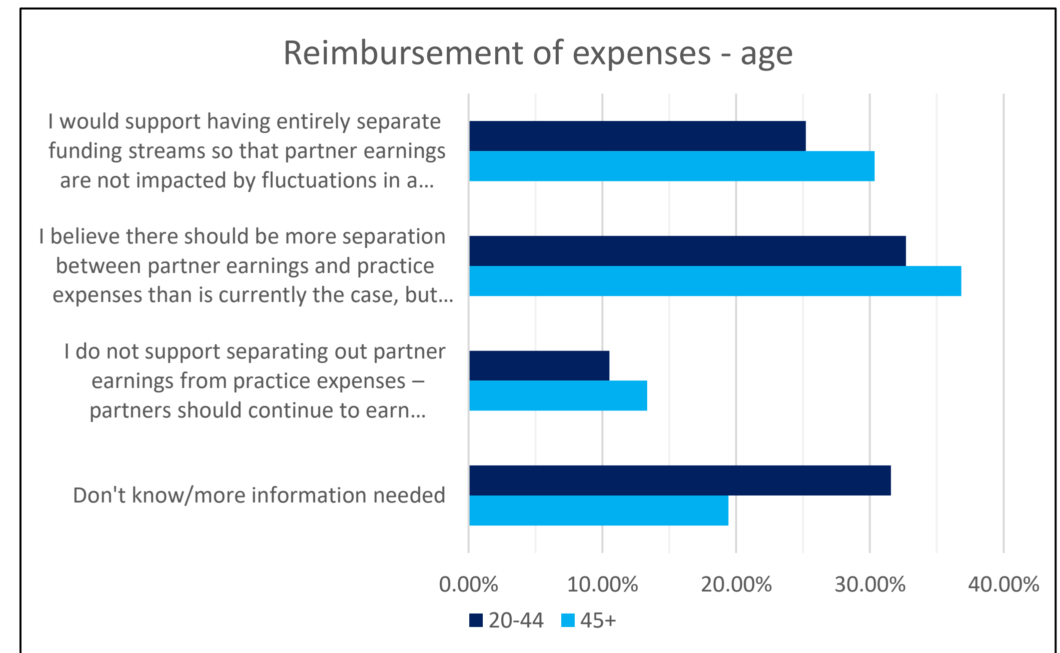


Respondents were asked to consider the principle of reimbursement of expenses and whether they supported or opposed separating out funding steams for GP earnings and practice expenses.





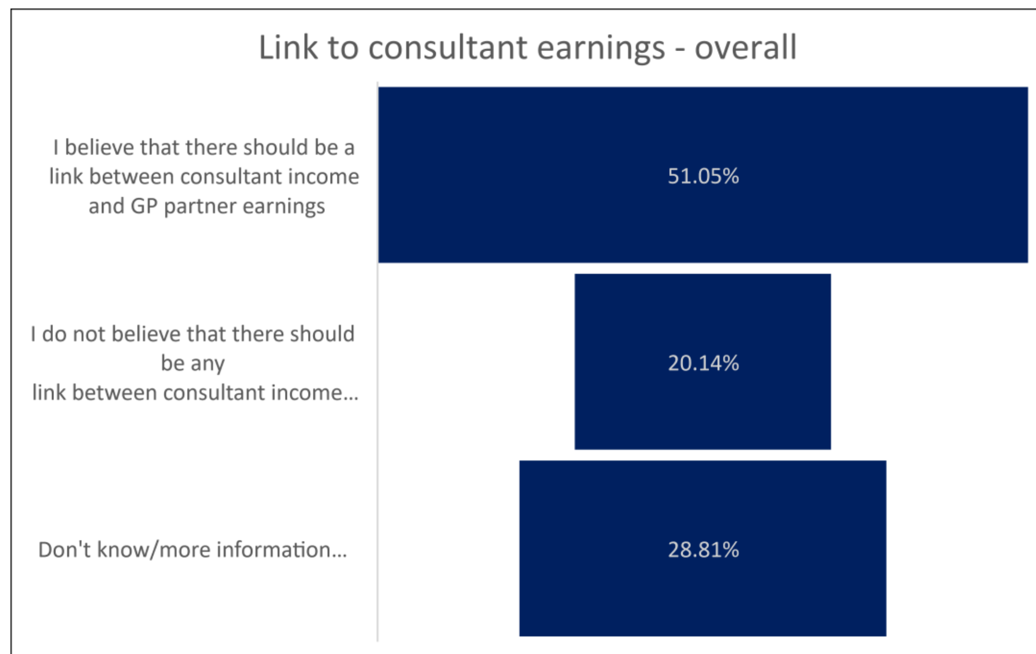


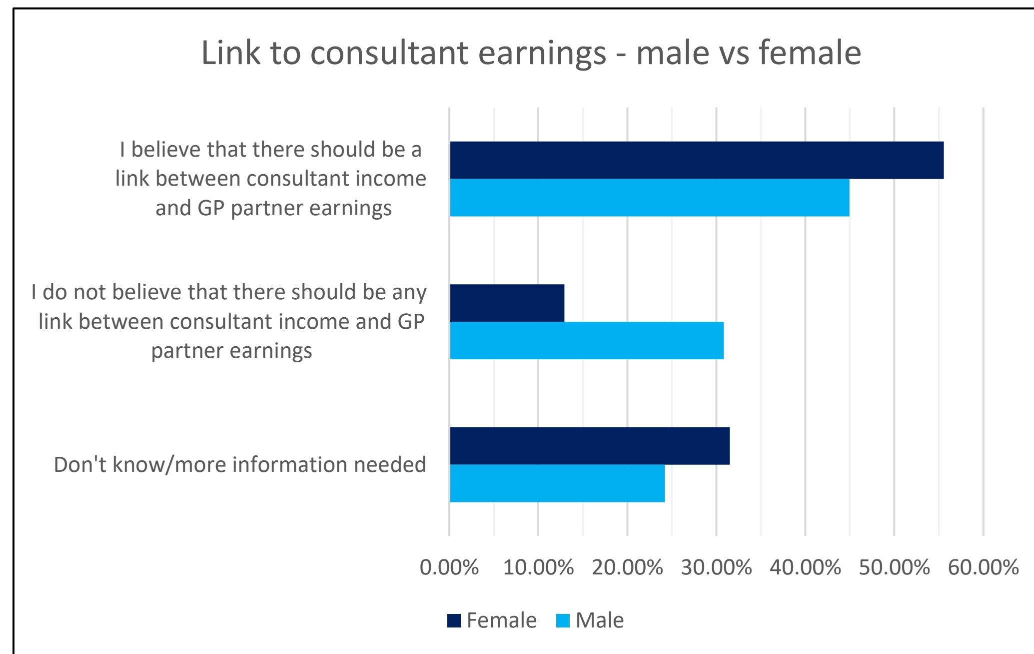


Nearly two-thirds of respondents supported moving in the direction of increasing the reimbursement of expenses, with 28% indicating they would support having entirely separate funding streams so that partner earnings are not impacted by practice expenses and 35% believing that there should be more separation between partner earnings and expenses than is currently the case, but some remaining link should be retained to drive efficiency. Just 12% of respondents indicated that they were opposed to separating partner earnings from expenses and maintaining the status quo, while 25% of respondents indicated they didn't know or needed further information.

Female respondents were more likely than male respondents to support having entirely separate income streams for partner earnings and practice expenses while male respondents were slightly more likely to support more separation of funding streams, but retaining some like to drive efficiency. Male respondents were also more likely to be against any move towards separating funding streams while female respondents were more likely to say they didn't know or needed more information.

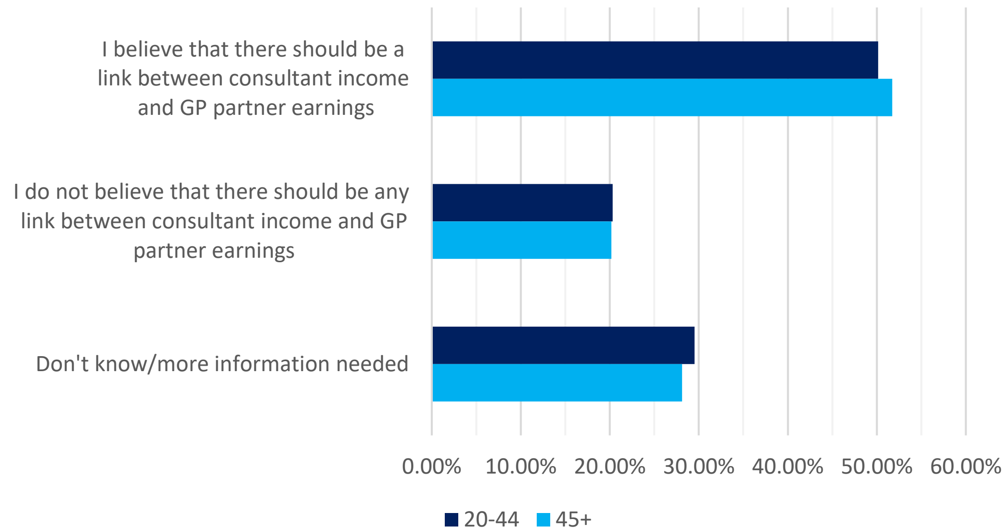
Partners and older respondents were more likely to express a definitive view either for entirely separating funding streams, increasing that separation somewhat or not moving towards separation of funding streams at all than non-partners and younger respondents, who were far more likely to say don't know or that they needed more information.

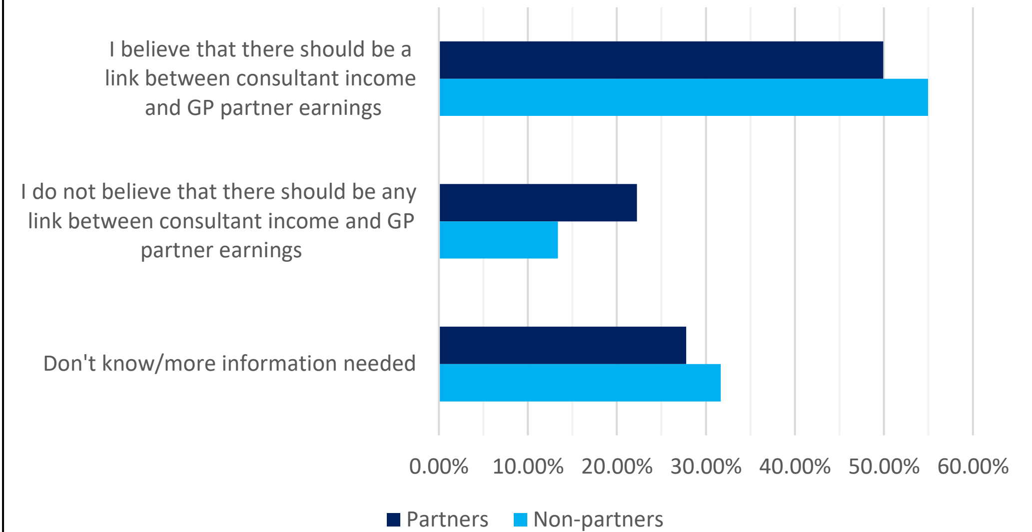




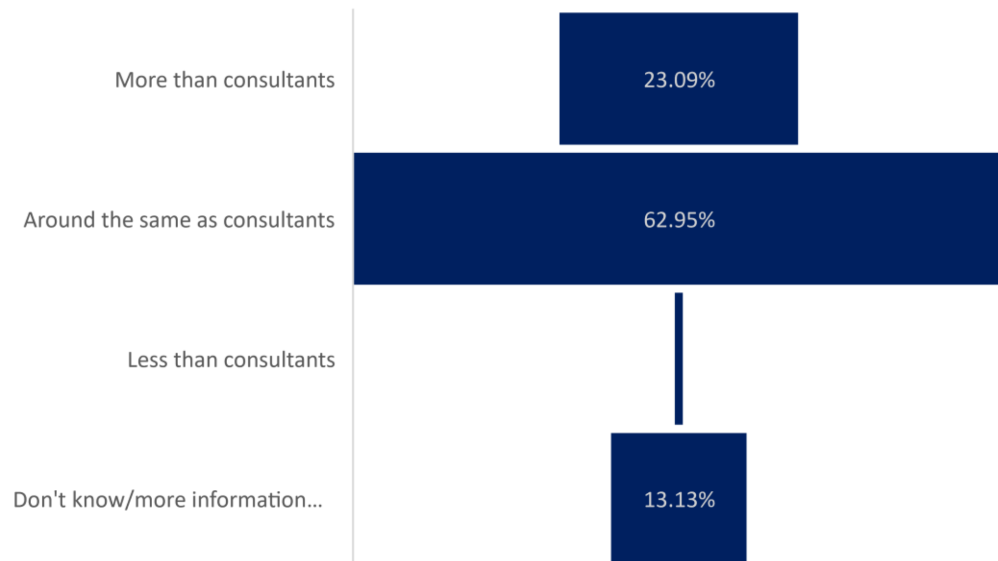
Respondents were asked for their views on whether the earnings of GP partners should be linked in some way to the earnings of secondary care consultants. A majority of respondents (51%) indicated that there should be such a link while 20% indicated that they did not believe there should be any link between GP partner and consultant earnings and 29% said they didn't know or needed further information.

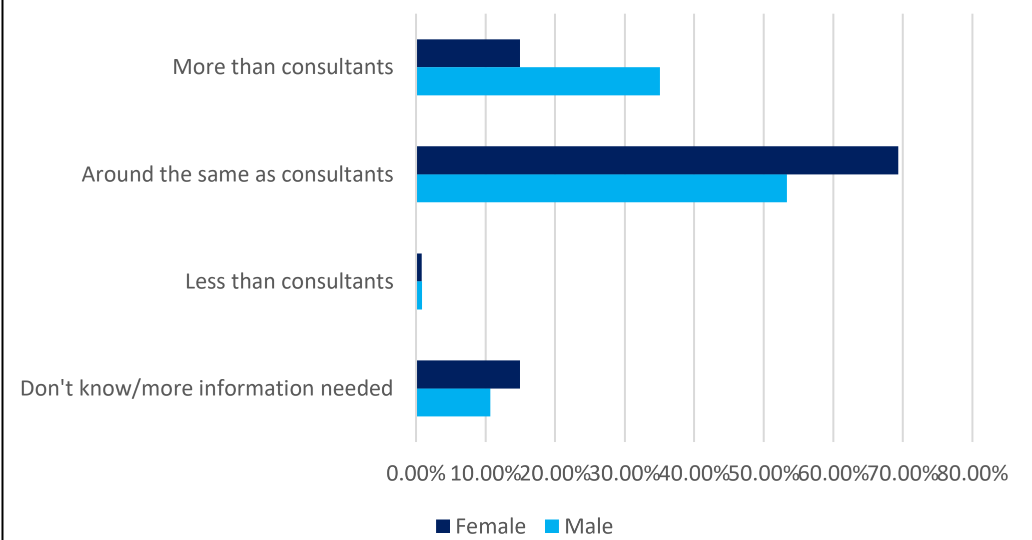
Female respondents were more supportive of GP partner earnings being linked to consultants while male respondents were more strongly opposed to the idea. There was next to no difference in responses based on age, while non-partners were slightly more likely to support partner earnings being linked to consultants than partners.



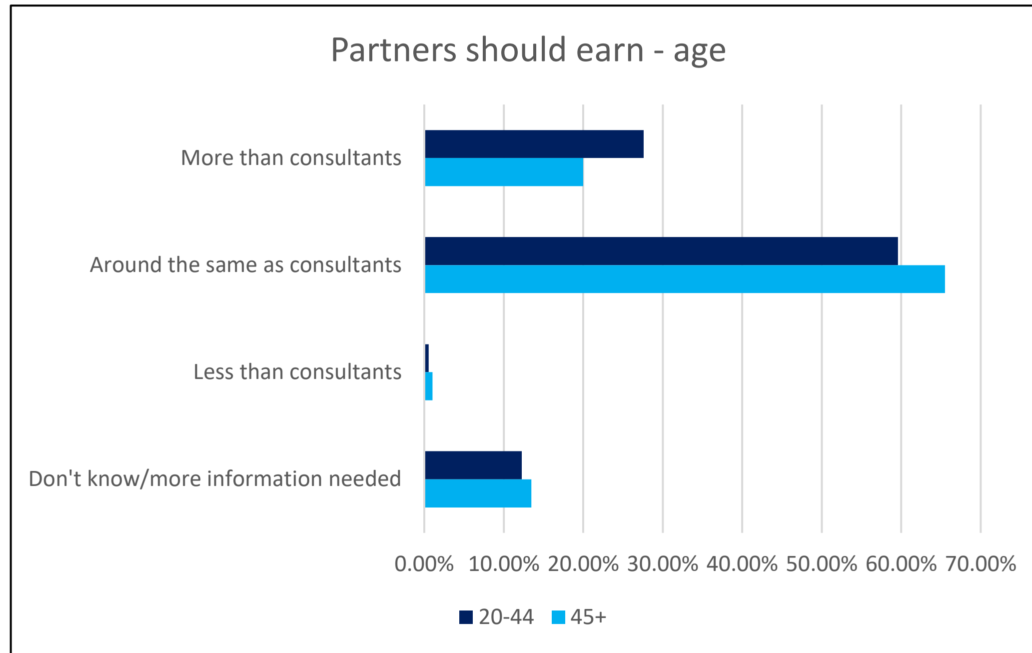


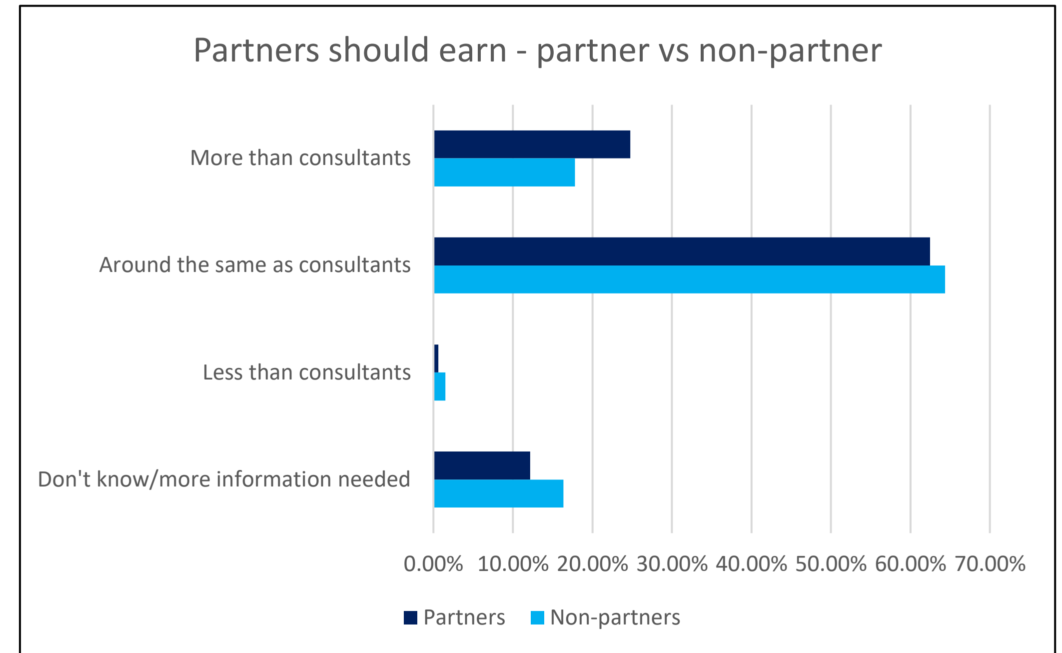
Respondents were also asked whether they believed GP partners should earn more than consultants, about the same as consultants or less than consultants. Overall, 23% of respondents indicated that they believed GP partners should earn more than consultants while 63% indicated that they believed GP partners and consultants earnings should be about the same. Just 1% of respondents indicated that they believed GPs should earn less than consultants, while 13% indicated that they didn't know or needed more information.





Female respondents were more likely to say that GP partners should earn about the same as consultants while male respondents were more likely than female respondents to say that GP partners should earn more than consultants. Younger GPs and partners were more likely to say that GP partners should earn more than consultants than older GPs and non-partners were.

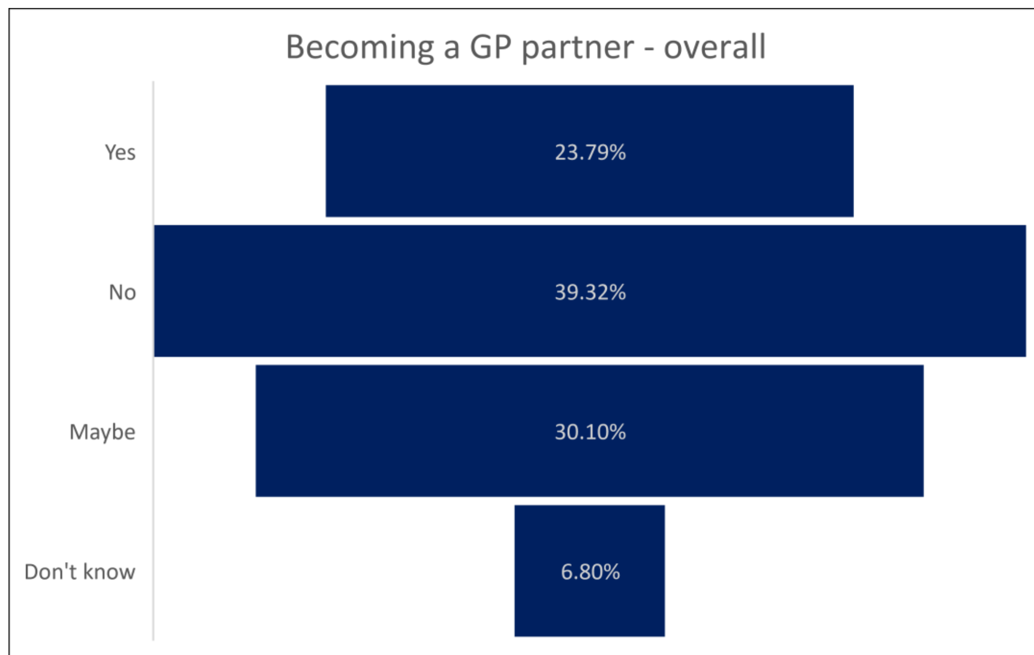


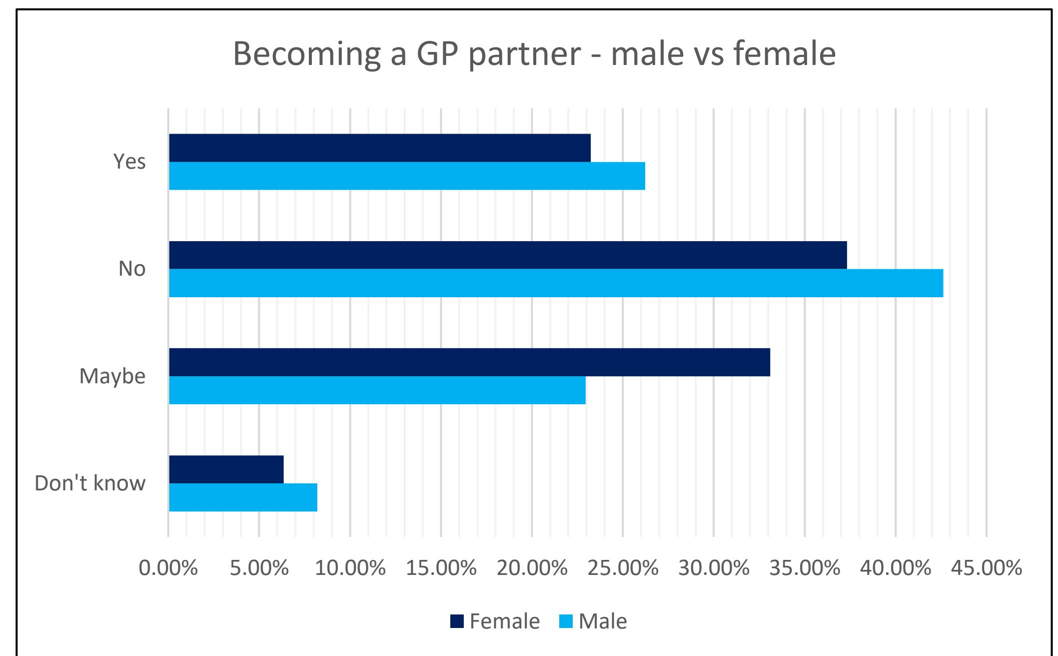


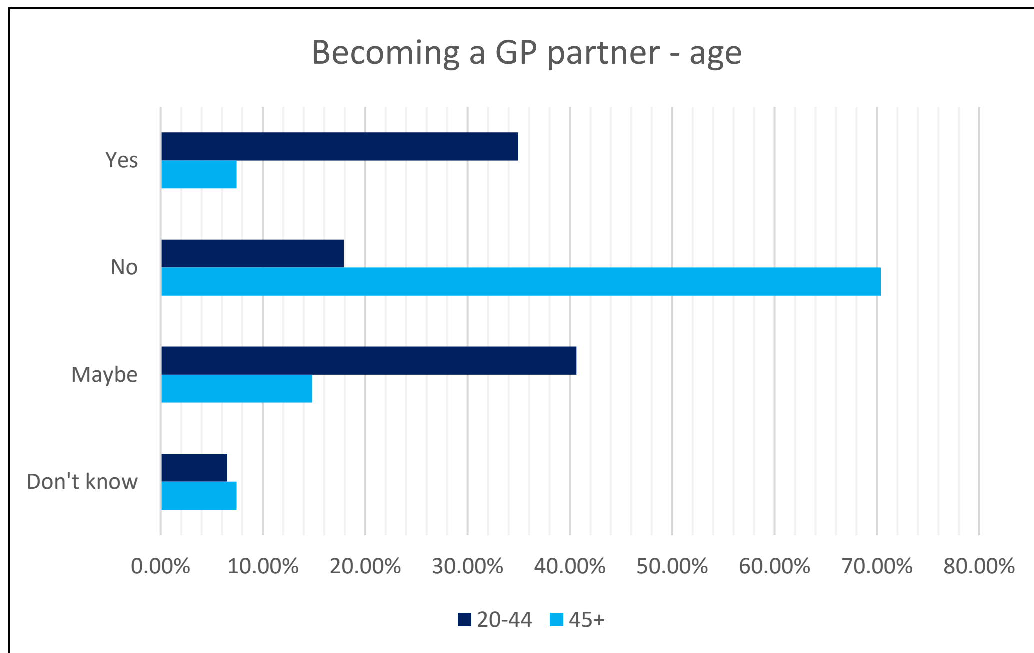
<u>Views on partnership</u>

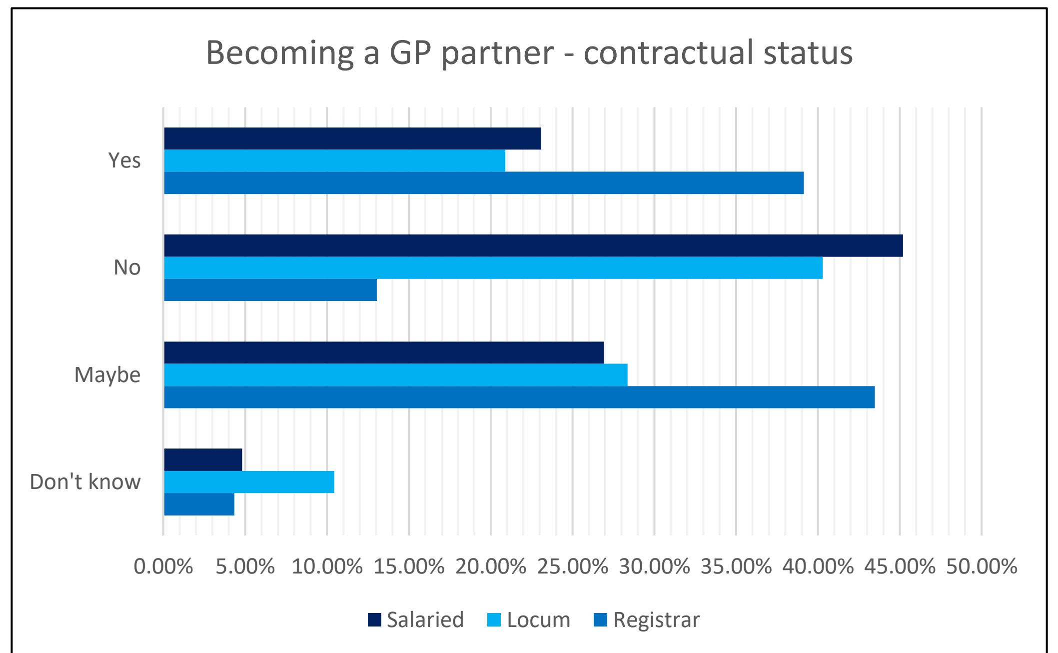
Non-partners who took part in the survey were asked about whether they thought they might become a partner at some point in the future. Overall, 24% of respondents indicated that they did see themselves becoming a partner, 39% said that they did not, 30% said that they maybe saw themselves becoming a partner and 7% said that they did not know.

Male GPs in non-partner roles were more likely than females in similar roles to say that they would not consider becoming a partner in the future, while female non-partners were more likely to say that they would maybe consider becoming a partner in the future.
Older GPs in non-partner roles were far more likely than younger GPs to say that the would not become a partner in the future, while younger GPs were far more likely to say that they did see themselves becoming a partner at some point in their career. Reflecting this, registrars were far more likely than locums or salaried GPs to say that they saw themselves becoming partners in the future or would maybe see themselves becoming partners, while locum and salaried GPs were far more likely to say that they did not see themselves becoming partners.



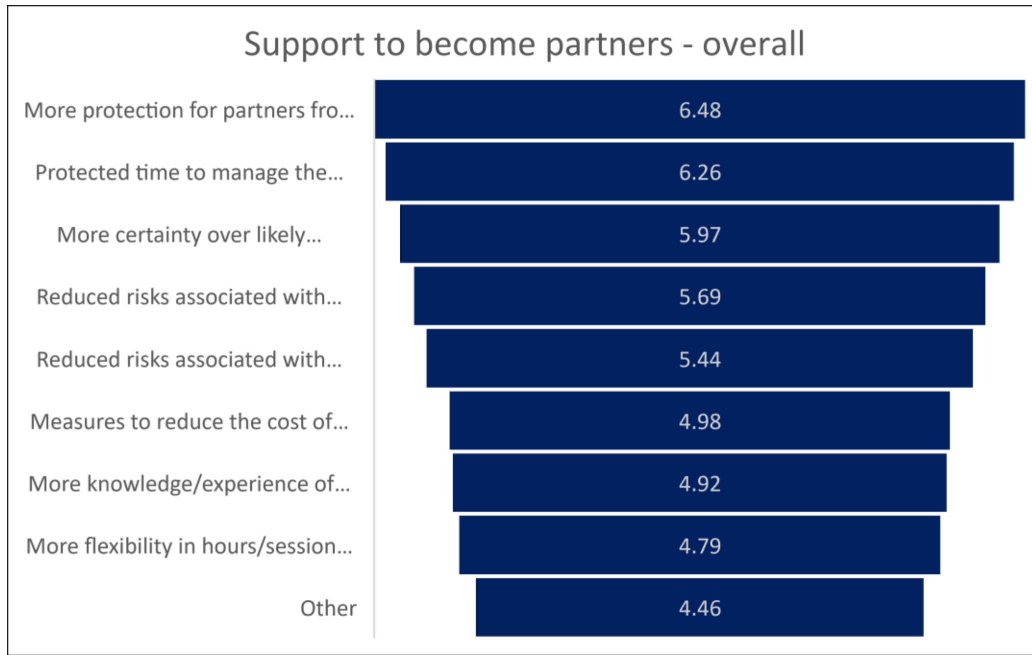


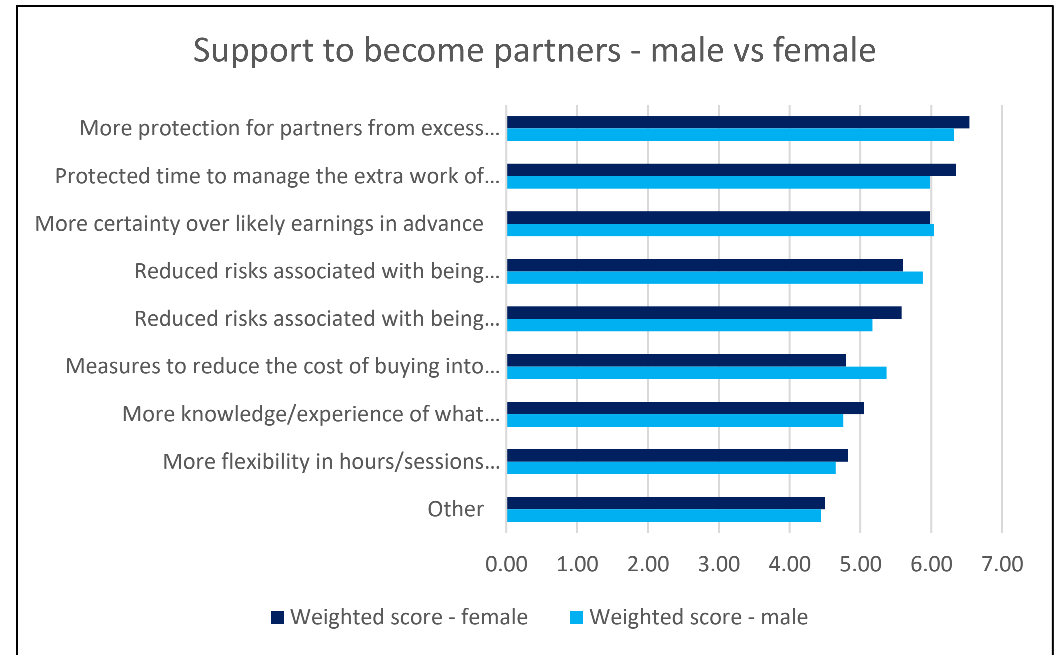


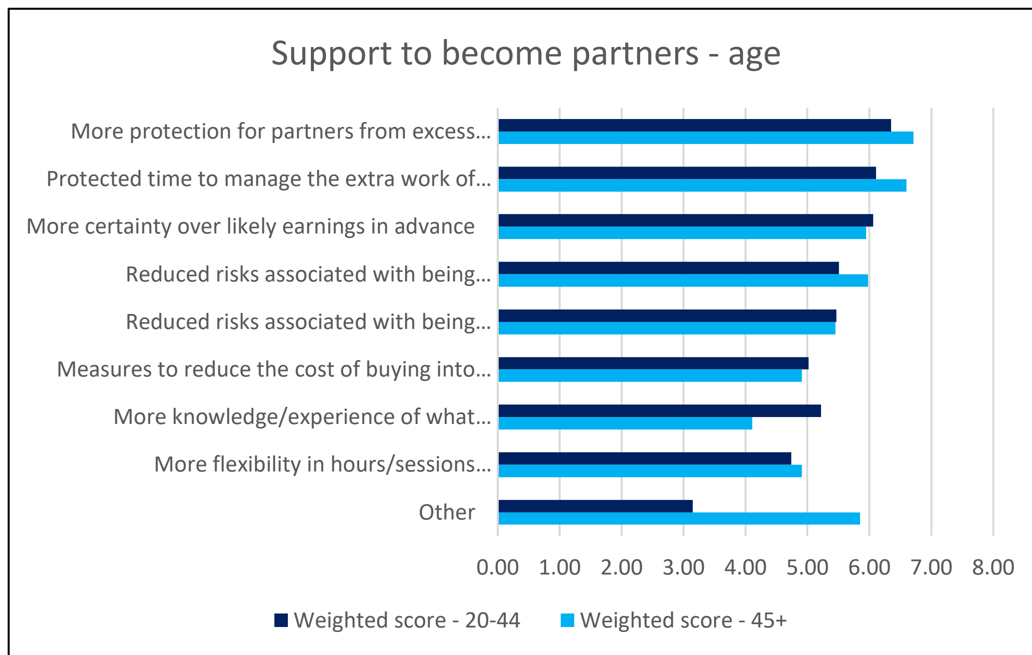


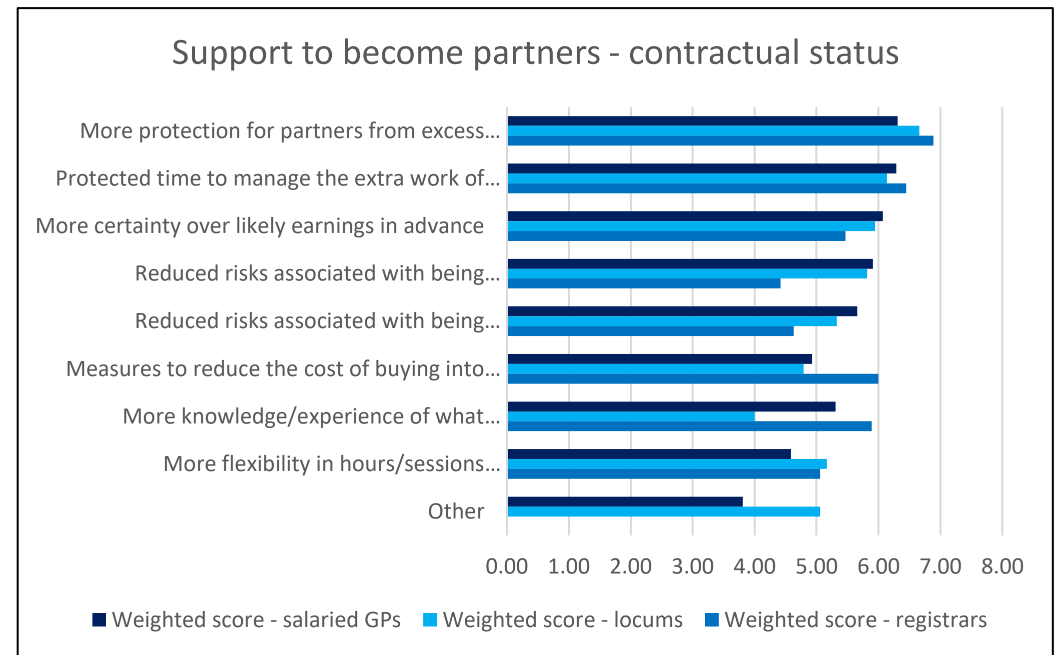
The same group of respondents was then asked to think about the things that might encourage them to become partners in the future and rank potential options for support in order of most usefulness. Overall, more protection for partners from excess clinical workload and protected time to manage the extra work of being a partner scored most highly as the support that might encourage non-partners into partnership. However, the relatively tight score range from first to last option does indicate wide variation in responses chosen.

There was broad consistency of answers between male and female non-partner GPs and between younger and older non-partner GPs, but younger GPs were more likely to rank more knowledge/experience of what partnership entails more highly than older GPs. Registrars were more likely than salaried or locum GPs to rank measures to reduce the cost of buying into partnerships and more knowledge/experience of what partnership entails highly, while salaried GPs and locums were more likely to rank reduced risks associated with employing staff and with premises more highly.

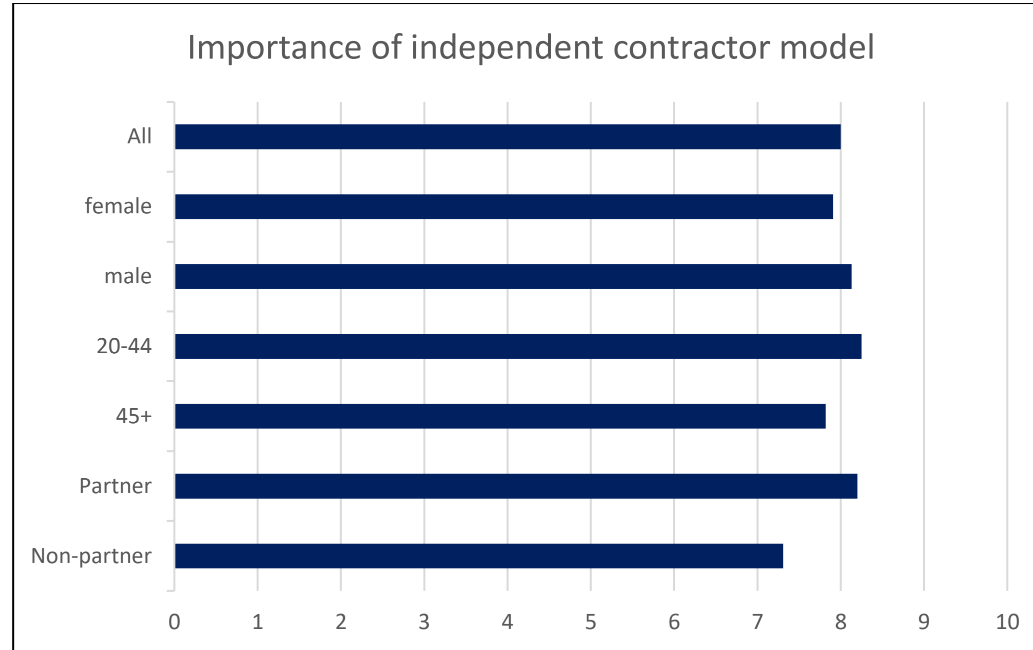




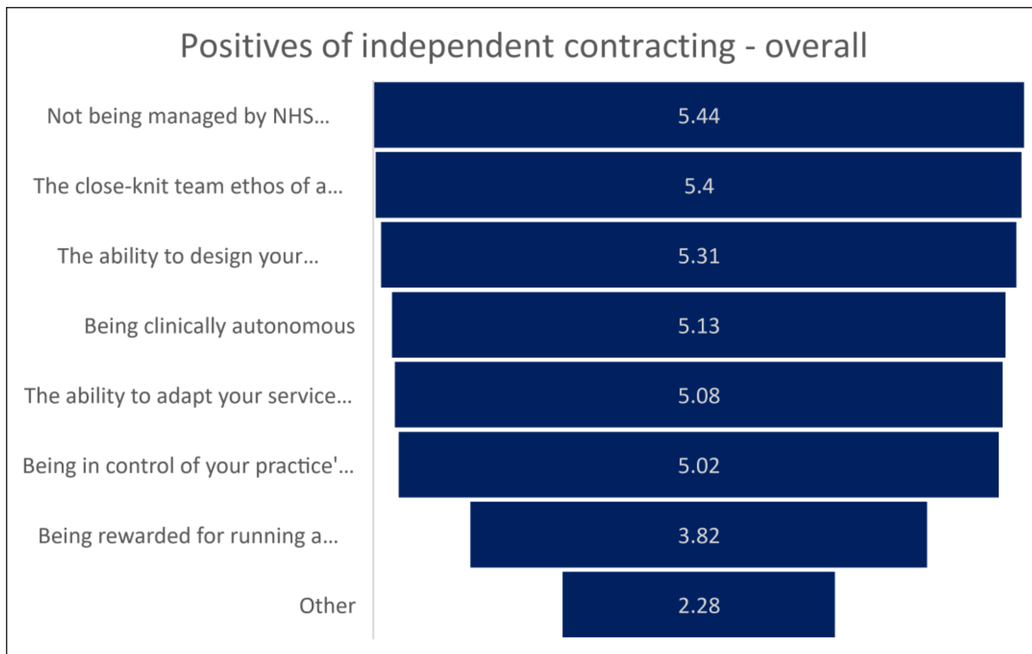


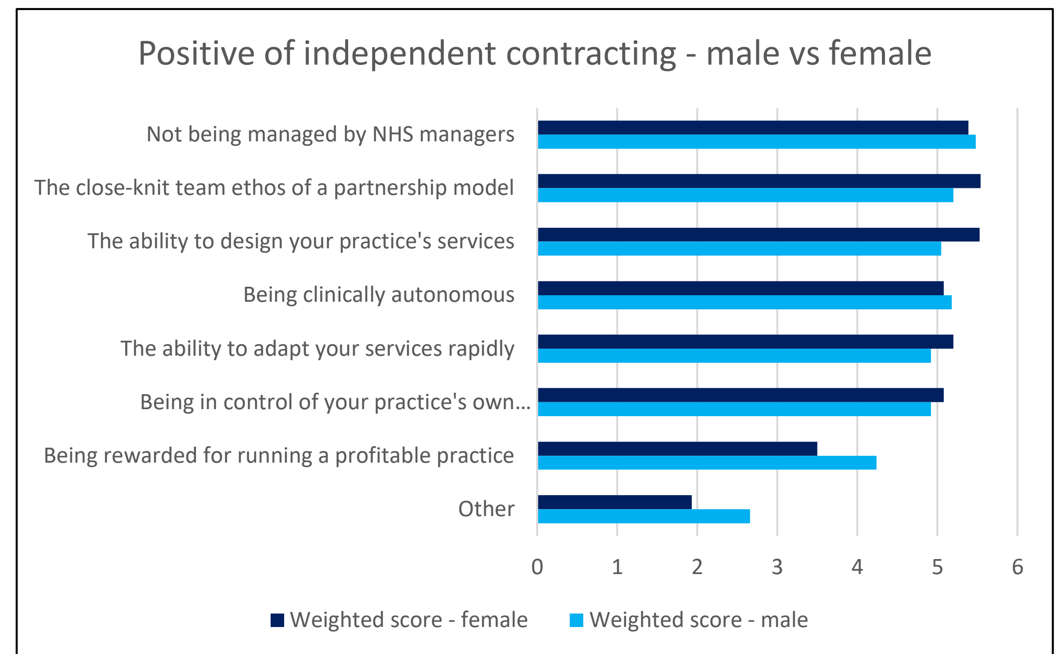


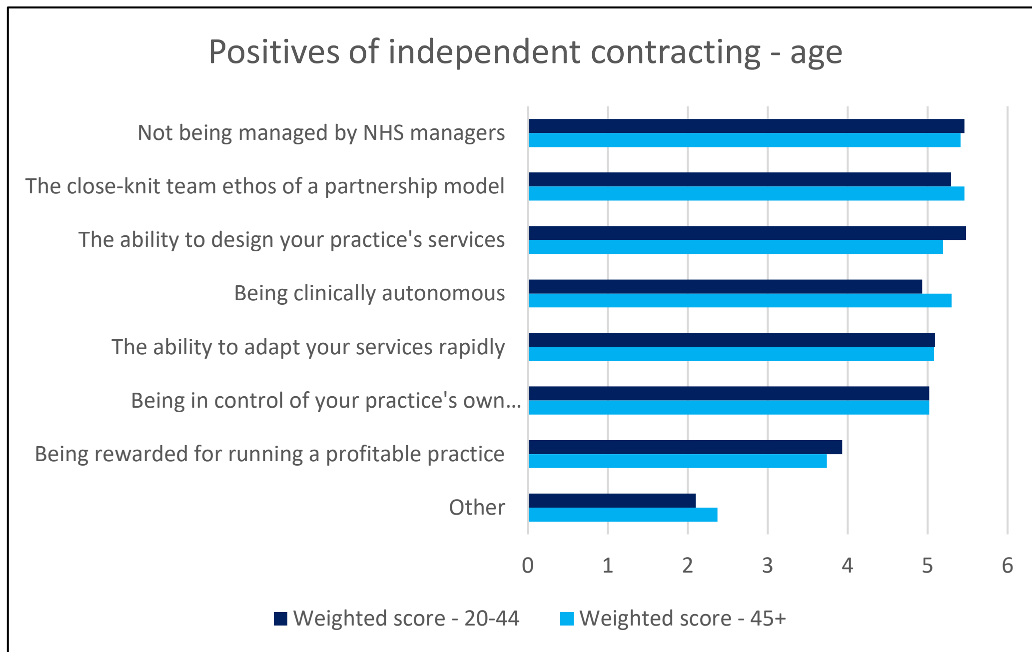
All respondents, including GP partners, were asked to score how important retaining independent contractor status was to them on a scale of 1-10. There was a great deal of consistency across male and female and younger and older GPs who all produced an average score of 8. Only non-partner respondents on average ranked the importance of retaining independent contractor status slightly lower at 7.



All respondents to the survey were then asked to rank what they thought the most positive aspects of being an independent contractor were. Overall there was very little to separate any of the options, with the exception of being rewarded for running a profitable practice which ranked some way lower than the other options. There was broad consistency between older and younger GPs in their ranking and between partners and non-partners, but male respondents ranked being rewarded for running a profitable practice somewhat more highly than female respondents.

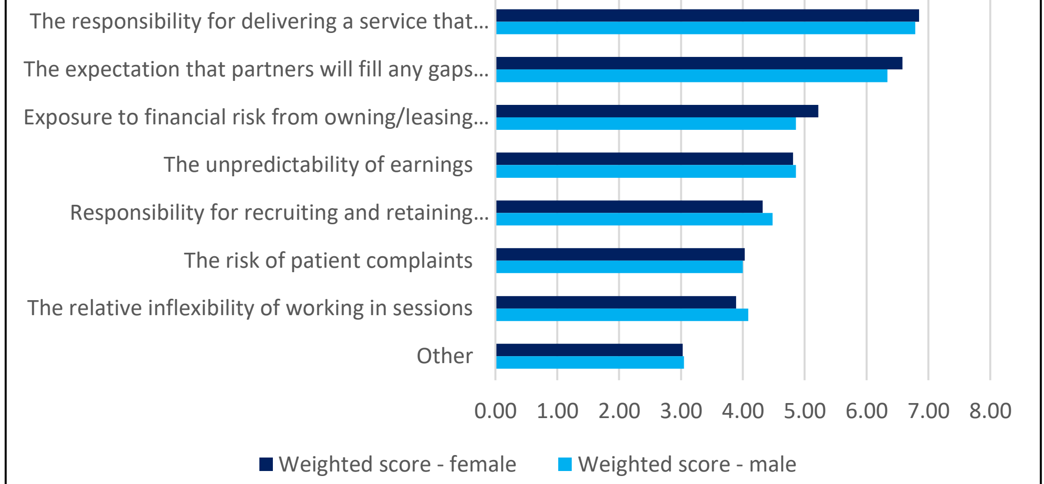




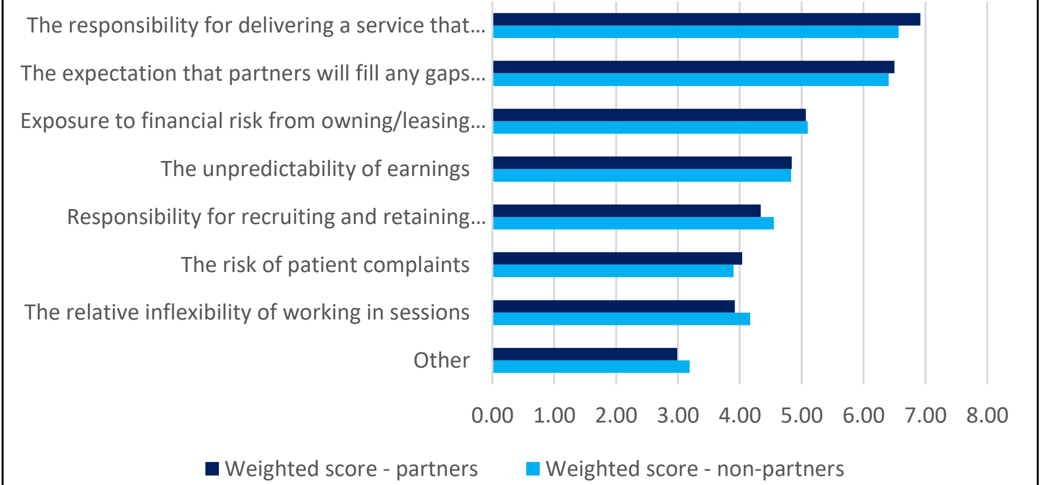


Respondents were then asked to rank what they saw as the most negative aspects of being an independent contractor in order. Overall, the responsibility for delivering a service that cannot keep pace with demand was ranked as the most negative aspect of being an independent contractor, followed by the expectation that partners will fill any gaps in a practice's service. There was a great deal of consistency in the way responses were ranked across male and female GPs, younger and older GPs and partner and non-partner GPs.

Negatives of independent contracting - overall
The responsibility for delivering...
The expectation that partners wi...
Exposure to financial risk from...
The unpredictability of earnings
Responsibility for recruiting and...
The risk of patient complaints
The relative inflexibility of worki...
Other
6.84
6.48
5.07
4.84
4.39
4.01
3.98
3.03

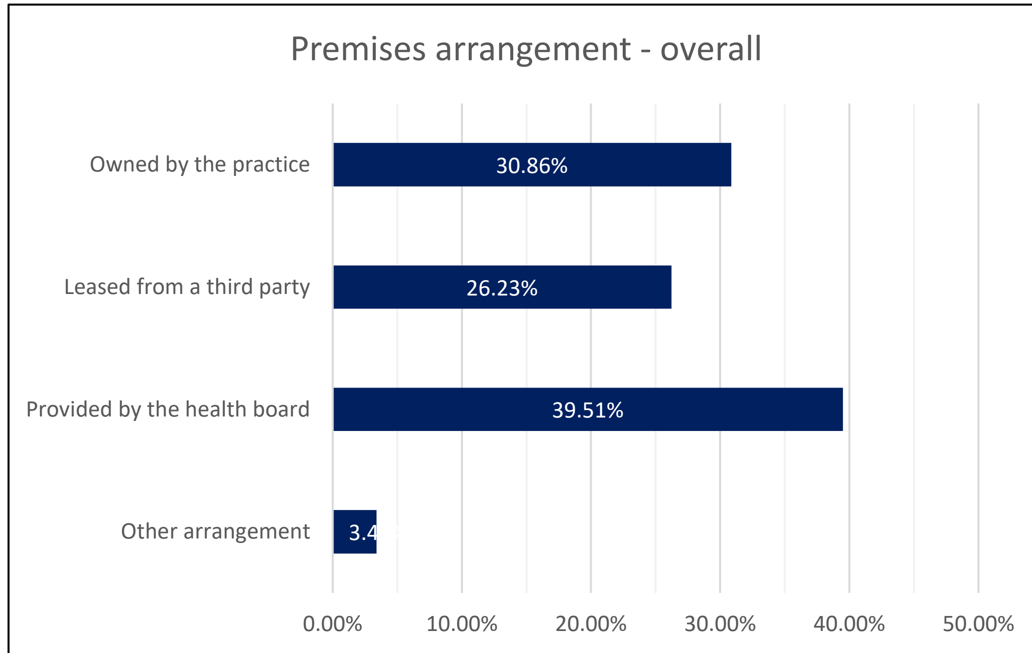

Negatives of independent contracting - male vs female
The responsibility for delivering a service that...
The expectation that partners will fill any gaps...
Exposure to financial risk from owning/leasing...
The unpredictability of earnings
Responsibility for recruiting and retaining...
The risk of patient complaints
The relative inflexibility of working in sessions
Other
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
Weighted score - female
Weighted score - male

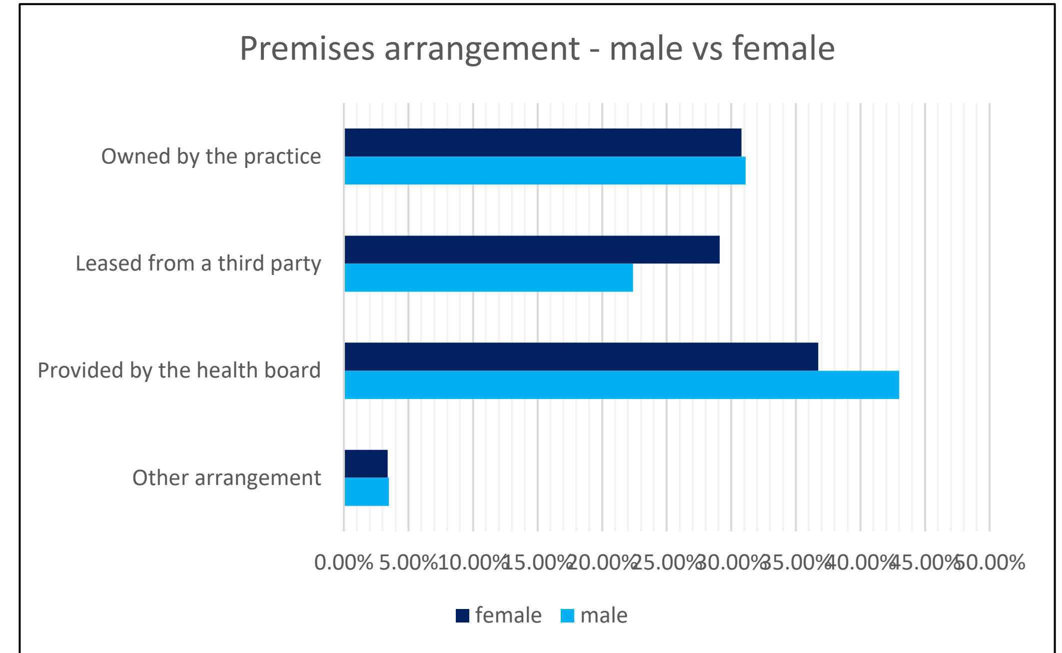
Negatives of independent contracting - age
The responsibility for delivering a service that...
The expectation that partners will fill any gaps...
Exposure to financial risk from owning/leasing...
The unpredictability of earnings
Responsibility for recruiting and retaining...
The risk of patient complaints
The relative inflexibility of working in sessions
Other
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
Weighted score - 20-44
Weighted score - 45+

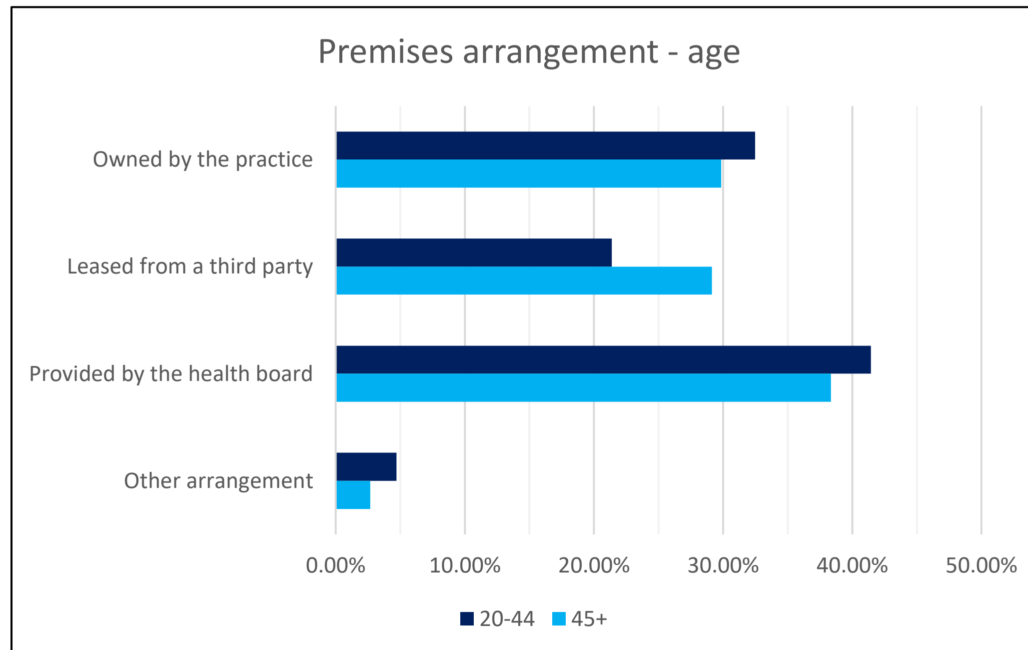

Negatives of independent contracting - partner vs non-partner
The responsibility for delivering a service that...
The expectation that partners will fill any gaps...
Exposure to financial risk from owning/leasing...
The unpredictability of earnings
Responsibility for recruiting and retaining...
The risk of patient complaints
The relative inflexibility of working in sessions
Other
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
Weighted score - partners
Weighted score - non-partners

Premises

In the final section of the survey, GP partner respondents were asked about the premises arrangements in their practice and whether they were owned by the practice, leased from a third-party, provided by the health board or some other arrangement. Overall, 31% of GP partner respondents said that their premises were owned by the practice, 26% said that they leased from a third party, 40% said that they were provided by the health board and 3% said that they had some other arrangement.



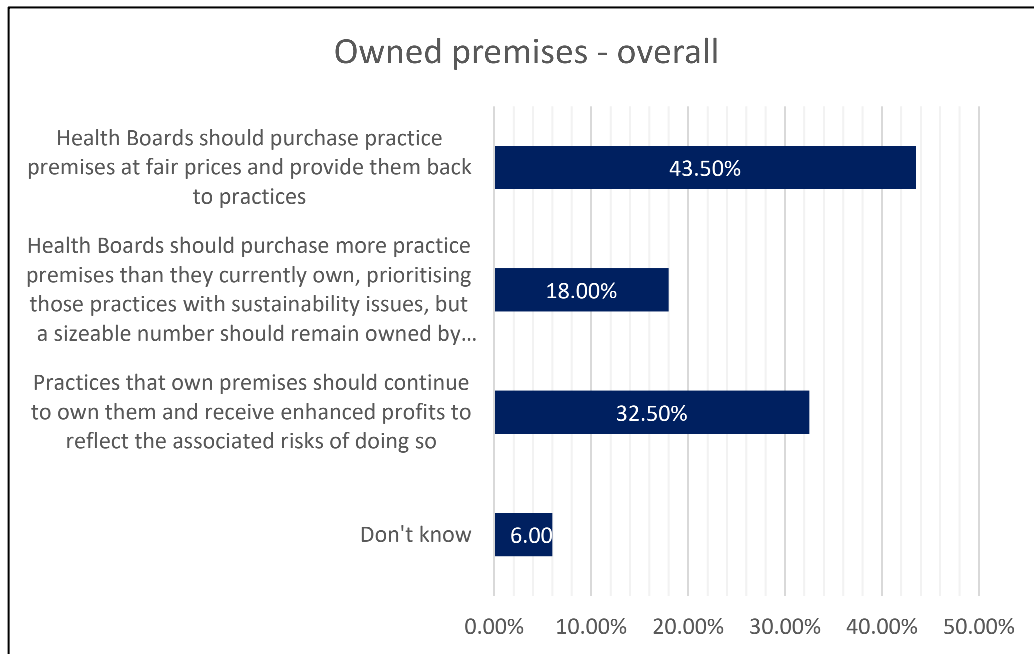


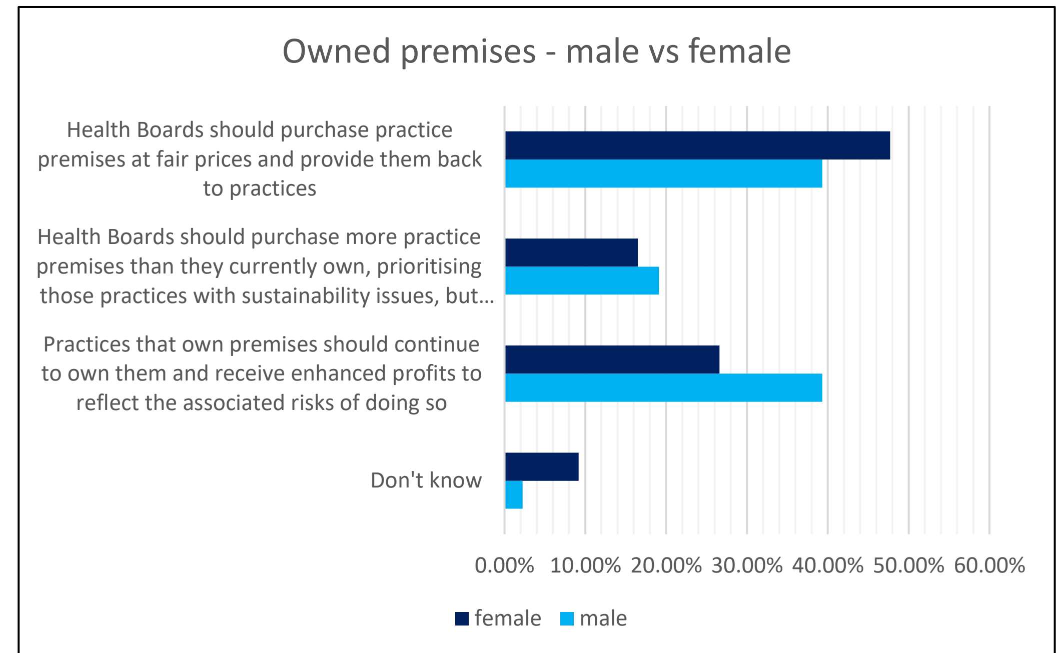


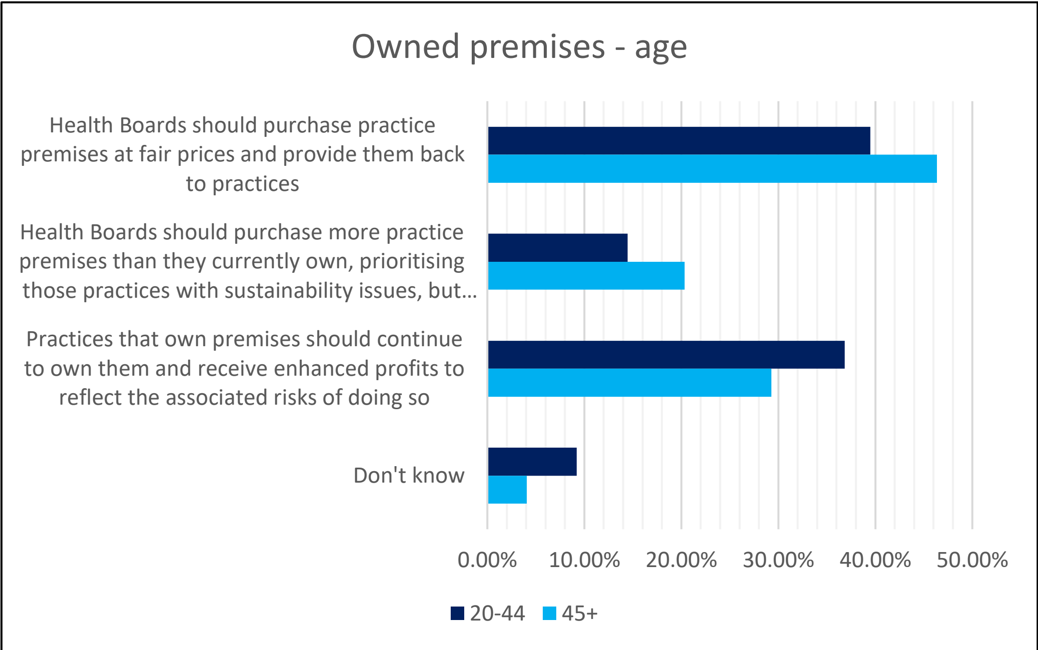
Male partners who took part in the survey were slightly more likely to be in premises that were provided by the Health Board while female GPs were slightly more likely to be in premises that were leased from a third-party. Younger GP partners were slightly more likely to be in premises that were owned by the practice or provided by the health board while older partners were more likely than younger partners to be in premises that were leased from a third party.

Partners who indicated that their premises were owned by their practice were asked about what approach to premises that are owned by practices offers the best long-term outcome for GPs. Overall, 44% of respondents said that Health Boards should purchase premises at a fair price and provide them back to practices, 18% said that Health Boards should purchase more premises than they currently own prioritising those with sustainability issues, but a sizeable number should continue to be owned by GPs, 33% said that practices should continue to own their own premises and receive enhanced profits to reflect the risks of doing so while 6% said that they did not know.

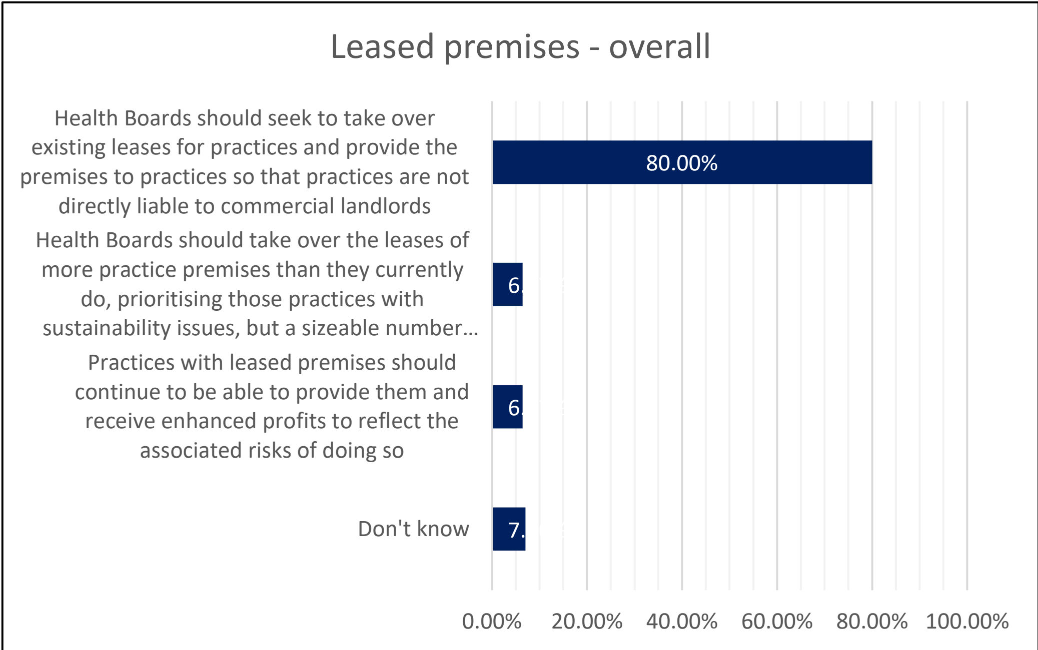
Female GP partners were more likely than male partners to say that Boards should purchase premises while male partners were more likely than females to say that practices should continue to own premises and receive enhanced profits that reflect the risk of doing so. Older GPs were more likely to be in favour of Boards purchasing premises while younger GPs were more likely than older GPs to say that practices should continue to own premises.

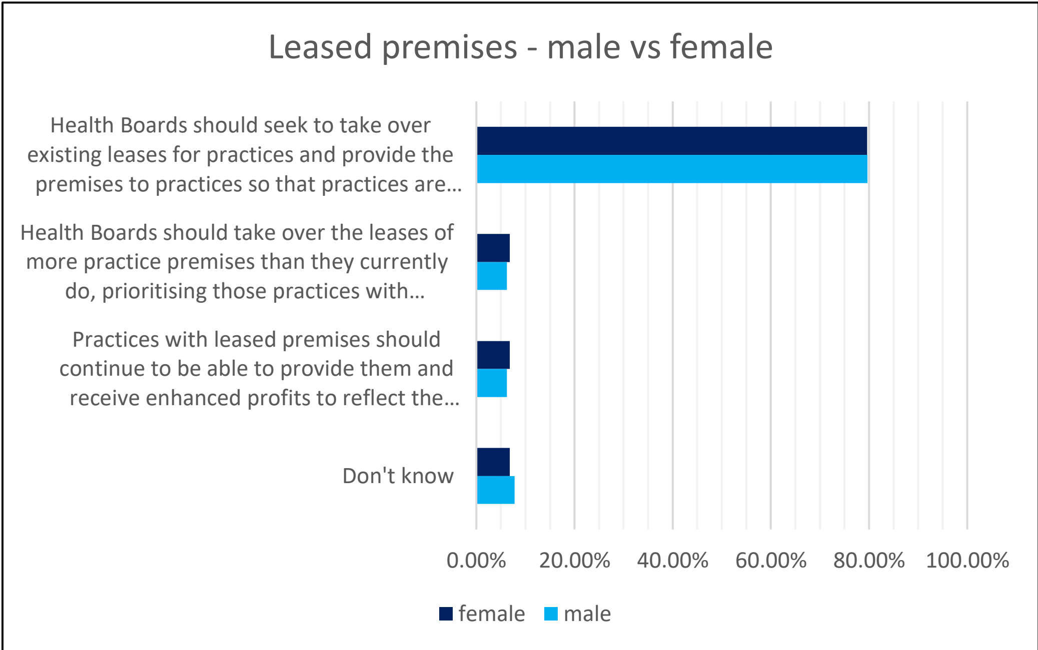


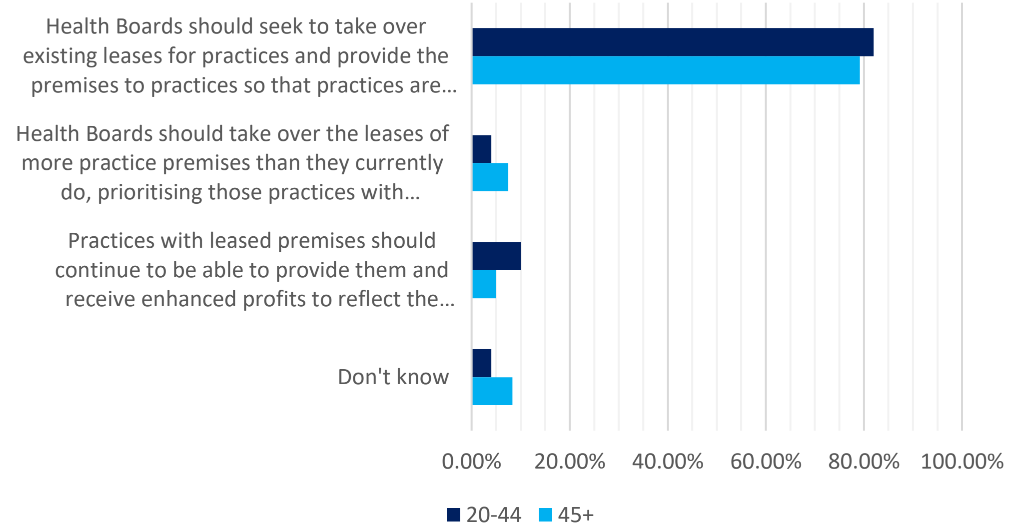




The survey also asked GP partners who are in third-party leased premises what approach they believe offers the best long term outcome for GPs. Overwhelmingly, 80% of respondents indicated that they believed Health Boards should seek to take over existing leases so that practices are not directly liable to commercial landlords. This response was broadly consistent between male and female partners and younger and older partners.







Leased premises age
Health Boards should seek to take over existing leases for practices and provide the premises to practices so that practices are...
Health Boards should take over the leases of more practice premises than they currently do, prioritising those practices with...
Practices with leased premises should continue to be able to provide them and receive enhanced profits to reflect the...
Don't know
0.00%
20.00%
40.00%
60.00%
80.00%
100.00%
20-44
45+