

The Bradford salaried non-principal scheme: addressing the problems of GP recruitment and retention in the inner city – it's not just the money but the support

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In the context of widespread discussion about a crisis in GP recruitment and retention we review available evidence and comment on underlying policy dynamics. There have been a number of attempts to improve recruitment and retention, and examples of salaried schemes and personal medical service pilots are discussed. The results of a postal survey to health authorities requesting information on existing salaried schemes are reported. Forty health authorities responded to the survey, of which 30 had developed a scheme. These schemes had been established to address recruitment and retention issues, provide higher professional training for GPs, provide care to specific groups of patients, to support underperforming practices, and to help practices develop their range of services and address PCG/T health priorities. We then comment, in some detail, on one particular scheme as an example – the Bradford salaried non-principal scheme. The background to the scheme is described, as is the process of selecting both scheme GPs and host practices. The impact in terms of personal and professional development of the salaried GPs is discussed. Evaluation of the scheme from the perspective of the salaried GPs (via a focus group) found that the main attractions of the scheme were the opportunity to gain experience of inner city general practice without the commitment to a partnership, opportunities for professional development, and support from the peer group of salaried GPs. A number of concerns were raised relating to the clarity of their role in the practices, in particular, the extent to which the salaried GPs were being used to absorb practice workload rather than, as proposed, to facilitate practice development.

Key words: general practice; recruitment; retention; salaried service

Introduction: problems with recruitment and retention of GPs

Although the number of GPs in the workforce has remained relatively stable over the past 10 years (Department of Health, 2000) some areas are experiencing a crisis in recruitment and retention

(Sibbald and Young, 2001; Sibbald *et al.*, 2000; Sibbald *et al.*, 2000; Young and Leese, 1999).

Sibbald *et al.* (2000) conducted a survey of 100 health authorities (73% responded) and found that the majority reported problems with GP recruitment; less than 10% reported 'no problems' and 'none expected'. They point out that 'these problems were not evenly distributed, but concentrated in deprived social areas and those which were regarded as unattractive to GPs because they lacked cultural and other amenities' (p. 2). (See also, Medical Practice Committee, 1997; Smith and Barr, 1998.)

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Inner city practices experience difficulties in recruiting new GPs for a variety of reasons. These include the relatively high and stressful workload deriving from high levels of morbidity and mortality in areas of socio-economic deprivation (Lorenzton *et al.*, 1994) and a perceived lower standard of practices (Bonsor *et al.*, 1998). When these factors are combined with perceived differences in local living and working environments (e.g., housing, schools) it is not surprising that urban deprived areas experience the greatest difficulties in filling GP vacancies (Medical Practice Committee, 1997), attracting vocational trainees (Harris *et al.*, 1996), encouraging qualifiers to remain and retaining new entrant principals (Taylor *et al.*, 1999).

Problems in recruitment and retention are exacerbated by reports of low morale throughout the profession. It is argued that the GP workload has increased because of additional administrative and clinical duties (e.g., National Service Frameworks, clinical governance, specialist intermediate care, increasing demand for consultations and rising patient expectations), which have not been accompanied by extra resources sufficient to cope with the extra work. Indeed, the Royal College of General Practitioners (RCGP) (RCGP, 2000) argues that, in order to meet existing demands and government proposals contained in the NHS Plan (Secretary of State for Health, 2000), a 30% medium- to long-term increase is needed in the general practitioner workforce. Yet studies suggest that only 20% of junior doctors are expressing an interest in a career in general practice (BMA, 1998; Goldacre, 1998). When this is coupled with demographic forecasts highlighting the imminent retirement of many overseas born and trained GPs who practice in inner city deprived areas (Taylor and Esmail, 1999) it is not surprising that the RCGP (2001) argues the need for 'short-term and medium-term strategies to increase the attraction of general practice as a career, to retain trained general practitioners in the discipline, to attract those on career breaks back into general practice and to reward those who delay retirement' (p. 9).

Although there have been disputes between the government of the day and the BMA throughout the history of the NHS, the intensity of the clashes after major restructurings have been marked. For example, after the Conservatives introduction of the purchaser/provider split and general manage-

ment via 'Working for Patients' (Department of Health, 1989) the Chairman of the BMA's council opened its 1993 conference with a speech in which he spoke of his members 'becoming exhausted with trying to make the flawed reforms work ... To many it looks as if the NHS is falling away piece by piece like some cliff on the east coast ... what will be next to slide into the sea?' Since the 1997 White Paper (Secretary of State for Health, 1997) the government had been pursuing a policy with the avowed aim of putting primary care at the heart of the health care system. They had committed year on year increases in funding to accompany the NHS Plan (Secretary of State for Health, 2000). However, the sense that the demands of the 1997 changes were not being fully met by the resources of 2000 and onwards was reflected in the chairman of the BMA general practitioners committee open letter to the UK's 36 000 family doctors, sent in March 2001 and stating that: 'General Practice in the UK is in crisis. Morale within the profession has plunged to new depths ... [The Government] has ... shovelled more and more work onto general practitioners without giving the profession the numbers needed to carry it out. Now we are saying that we have had enough' (cited in *The Guardian*, 26 February 2001). The Prime Minister, on 19 March, announced a £100 million package of incentive bonuses and promised 550 extra GP training places and 400 trainers. Earlier that same month the government offered £10 000 to GPs to stay on until they were 65, and an extra £5000 to newly qualified GPs who work in deprived areas. Government plans to appoint an additional 2000 GPs in England by 2004 were countered by the BMA who argued that an additional 10 330 were needed to provide a satisfactory service.

While it is clear that, overall in the NHS, funding did increase in real terms after the National Plan (Toynbee and Walker, 2001: p. 90) the theme of this article is that 'its not just the money...'. Glennerster (2001) has summed up the intention and the challenge in health policy thus: 'If the Blair government succeeds in introducing openly debated health service rationing and standard setting it will be a remarkable achievement ... But changes of this kind, as with much of social policy, take decades to come to fruition. Therein lies the electoral problem' (p. 402). Therein also lies the problem with particular sections of the health

workforce who might feel disadvantaged by a part of the strategy.

In all areas of the welfare state there is a palpable tension between reform of the structures of services and a shift in the focus of practice and an anxiety on the part of the professions delivering that service. A sense of satisfaction with the direction of change is not one built on objective measures like, in general practice, list size (falling during this period); out of hours commitments (reduced) or levels of funding (increasing). Rather it is the sense of discomfort with the strategy and of the short-term impact of change. Examples abound: teachers pay, following the February 2000 salary settlement, began to rise after a period of decline and the school building programme gathered momentum in the second quarter of 2001. However, the challenge of a centrally imposed 'performance' regime undermines a sense of professional self-determination and instils anxieties similar to those of the GPs.

It is also evident that the reported crisis of recruitment in general practice is not a unique phenomenon. For example, the National Plan aimed at recruiting 20 000 more nurses. To achieve this 110 000 more nurses would need to be recruited over 4 years to cover those projected to retire or leave a nursing population that was ageing fast (Toynbee and Walker, 2001: p. 86).

Some of the claims of crisis in general practice can be explained by the need for a professional group to adopt a rhetorical position in its negotiations with employers. It is a position with many precedents in the NHS. Some of the claims are closely linked with the mismatch between changing expectations and resources available and some link with anxieties about the direction of change. One thing is clear – there is not a simple explanation and it is not just the money. Furthermore, local circumstances can be crucial – both in terms of exacerbating difficulties and offering a site for imaginative solutions.

Strategies to improve recruitment and retention: salaried GP schemes

Various strategies have been developed to address problems in recruitment and retention of GPs. In the survey conducted by Sibbald *et al.* (2000) health authorities produced a number of initiatives

to assist with recruitment of GPs; for example, 67% of those surveyed had a database or register of GPs looking for work and 44% provided assistance with advertising and recruitment campaigns. Initiatives designed to retain GPs included schemes to release GPs for other activities (53% of those surveyed), posts which combine general practice with research or teaching (45%), and enhanced training opportunities for registrars or new entrants as a means of encouraging them to remain in the area after qualification (34%).

Young and Leese (1999) suggest that programmes are most likely to succeed if they are tailored to meet the needs of the workforce and the specific problems of different localities. The solution, they suggest, is to provide more flexible working arrangements to make general practice more attractive. One way of achieving this is to extend the range of employment opportunities available to GPs and, in particular, to develop salaried non-principal schemes.

There has been a recent proliferation of salaried schemes reported throughout the country, for example, in Sunderland (Jones, 1997), Newcastle (Nelson, 1997), Durham (Harrison and Redpath, 1998), South London (Salmon *et al.*, 1998), North West Region (Munson, 1994; Woodward *et al.*, 1998). These schemes, with varying emphases, address the following objectives: 1) to attract additional GPs into the local area to address recruitment and retention concerns; 2) to provide the salaried GPs with experience of General Practice and to gain further professional education, thus providing a pool of high quality GPs who may succeed to practice vacancies; 3) to enable the host practices to address quality issues in the practice through time released from clinical duties.

Salmon *et al.* (1998) report that the majority of registrars in their study were unwilling to make an immediate commitment to partnerships. Some were not ready for managerial responsibilities and felt that they lacked the necessary clinical skills. Others were fearful about the perceived challenges of inner city practice. Some became locums or assistants in order to improve their clinical skills, while avoiding the managerial, financial and emotional commitments of a partnership. A salaried scheme thus catered for the perceived need for an extra structured year of professional development in general practice.

Initial evaluation of the established schemes

suggests positive outcomes regarding each of the three primary objectives listed above. Thus, for the salaried GPs the posts provide good experience of General Practice, leading to greater clinical confidence (Harrison and Redpath, 1998). They provide the salaried GP with the opportunity to see if they are suited to general practice. As one salaried GP noted:

Personally it has been an excellent year that has bridged the gap between finishing the [scheme] and feeling ready to start as a partner ... It was good to have a structure and a supportive group and to be in two practices for the year ... getting a clear picture of the kind of practice I want to be part of.
(Salmon *et al.*, 1998: p. 83)

Salmon *et al.* (1998) report that of the 25 salaried GPs who entered the London Vocationally Trained Associate scheme (four cohorts), only three were working or intending to work outside London.

In the North West scheme, initially reported by Munson (1994), particular emphasis was placed on improving the quality of primary medical services in practices struggling to cope with high patient demand, health targets and health promotion. Woodward *et al.* (1998) later reported that seven out of 16 practices achieved sustainable benefits, e.g., increased range of services provided, targets for immunizations and cervical cytology achieved, higher rates of generic prescribing, improvements in chronic disease management, and increased level of audit activity.

A number of other issues arose from the schemes. From the perspective of the host practices there was concern about their lack of control over the salaried GP and, where the scheme placed emphasis on personal and professional development of the salaried GP, the amount of time for study leave. There was also some concern about the quality of doctors who apply for schemes, i.e., were they unable to obtain a partnership? (Harrison and Redpath, 1998; Woodward *et al.*, 1998). Some were suspicious of their relationship with the health authority (Woodward *et al.*, 1998). On a more positive note, host GPs welcomed the extra help, often learnt from the salaried GP, found that they gained more empathy with new doctors, and were positive about the need to accommodate ways that young GPs wanted to work (Salmon *et al.*, 1998).

An important point raised in the scheme reported by Woodward *et al.* (1998) was that those practices that had clearly defined areas of service development benefited most. Those practices which used the salaried GP as an 'extra pair of hands' (mainly single-handed practices with high workloads) suffered at the end of the scheme by raising expectations that would not be met in the long term.

An additional approach to recruitment and retention is reported by Bellman and Morley (2001). Fourteen doctors participated in the first PCG GP Assistant/Research Associate scheme in south east London between October 1999 and June 2000. Managed by the Department of General Practice and Primary Care at Guy's, King's and St Thomas's School of Medicine the scheme sought to provide continuing professional development for both the new GPs and for the established GPs with whom they were placed. Early evaluation has been positive with the scheme appearing to be relevant regarding recruitment and retention in the inner city. The role of the University in managing the scheme has made possible academic assistance in the transition from young doctor to fully fledged practitioner and has helped in winning the support of established doctors, in part through providing a mechanism for their own professional development.

The introduction of Personal Medical Services (PMS) pilots, created by the 1997 NHS (Primary Care) Act has significantly extended the scope for salaried practice. In contrast to the 1990 General Medical Services (GMS) contract, which was based upon independent contractor status and nationally negotiated terms and conditions, PMS pilots operate under a locally agreed contract with extensive opportunities for the employment of salaried GPs. The impetus for the promotion of PMS pilots was to address the needs of local populations (particularly in deprived urban areas) by encouraging innovative new services and flexible ways of working, for example, experimenting with skill mix and the organization of the primary care team.

The opportunity for salaried practice could also address the needs of GPs who would like to opt out of the GMS contract and independent contractor status (with the option to return) as well as other non-principals who prefer a salaried contract. This could help address recruitment and retention problems, particularly in deprived urban areas which

have difficulty attracting GPs and partners, and may help in the retention of GPs who are demoralized by the bureaucratic responsibilities of partnership and the workload of inner city practices. (Further details about PMS pilots can be found in Lewis and Gillam, 1999; National Primary Care Research and Development Centre, 2001.)

The 'first wave' of PMS pilots, consisting of 100 sites, was introduced in April 1998. The 'second wave', consisting of 203 sites, was introduced from October 1999 to April 2000. Evaluation of salaried contracts within PMS pilots is being conducted by the National Primary Care Research and Development Centre, University of Manchester (PMS National Evaluation Team, 2000; Sibbald *et al.*, 2000).

Sibbald and Young (2001) report some preliminary findings in terms of the pros and cons of salaried service. Salaried GPs were more satisfied than GP principals about their level of income and hours of work, and were less stressed by problems with arranging locum cover, dealing with patient complaints, managing changes initiated by HAs, and coping with 24 hour on-call responsibility. These differences, they comment, 'are consistent with the increased clinical content and reduced administrative and out-of-hours responsibilities of salaried posts' (p. 15). Salaried GPs were more likely to report problems with poor working conditions, professional isolation and lack of support from colleagues. In terms of overall recruitment, however, Sibbald and Young, report that 'early findings suggest that the impact of salaried PMS contracts on recruitment in under-served areas was not markedly better than that achieved by inner city practices generally' (p. 15). See Gosden *et al.* (1999) for a discussion of the issues involved in the setting up and operation of salaried GP posts in two PMS sites.

A survey of salaried schemes

In order to obtain a current overview of schemes throughout the country a questionnaire was sent to each health authority asking if they had established salaried GP scheme posts to address recruitment and retention concerns. Ninety-nine health authorities in England were sent a questionnaire, of which 41 responded. Thirty of these had developed a scheme and 11 saw no need as

yet to do so. Twenty of the schemes were administered by health authorities, five by primary care groups/trusts (PCGs and PCTs) and five by other agencies including community health trusts. The contract of employment was held by the health authority or PCG/T in eight cases and by a GP practice in the other 22.

The schemes surveyed have been established to address a variety of needs, including:

- 1) recruitment and retention of GPs;
- 2) to provide higher professional training beyond established GP vocational training schemes (VTS);
- 3) to provide care to specific groups of patients, for example, those in nursing homes, services specifically for women, ethnic minorities, homeless people, and to address medical problems arising from substance abuse including drug addiction;
- 4) to support under performing practices;
- 5) to help practices develop their range of services and address PCG/PCT identified health priorities.

The practices were selected for extra help mainly by identifying health authority and PCG/T priorities such as a large ethnic group of patients, the absence of a female partner in the practice, single-handed practices needing help, and to help meet identified needs to improve access to patients.

Funding came from several sources, most commonly primary care development funds provided by the health authority. Other areas of funding included section 52 of the Red Book (NHS General Medical Services, 1998), Personal Medical Service Pilots, top slicing of General Medical Services (GMS) budgets, GMS discretionary budgets and direct funding from the Department of Health.

The number of GPs on the salaried schemes ranged widely, from one to 11 with an average of three GPs per scheme. The length of time spent on the schemes varied from a minimum of 12 months to an indefinite period, but the most common time spent on the scheme was 2 years. The teaching component of the schemes also varied, from none at all (four schemes) to three sessions per week, with the average being one session of protected learning time each week (a session is a half-day). Two schemes provided educational sessions at the basic postgraduate educational allowance level of 10 sessions per year.

The Bradford salaried non-principal scheme

Bradford inner city has a high proportion of GPs from a south Asian background (51%). This proportion approximates with a patient population of whom 55% have a south Asian origin (Bradford City Primary Care Group, 1999). Many of the south Asian GPs came to Bradford in the 1960s, and currently, approximately 50% are aged over 50 years and could therefore be expected to retire in the next 10–15 years. The health authority was concerned that this age profile, together with the more general difficulties of recruitment identified above, would mean that Bradford might experience a crisis in recruitment and retention of general practitioners in the future.

In order to address a potential crisis, the Health Authority obtained Health Action Zone (HAZ) Innovation funding to establish the Bradford salaried GP scheme. Overall the scheme's budget is £250 000 per year for 3 years with a start date of 1 September 2000. The scheme has the following aims:

- 1) To provide a pool of experienced and well-trained doctors who may be available to take up salaried posts generated by the move from general medical services to personal medical services or who might consider traditional partnerships.
- 2) To improve potentially quality standards within host practices by providing more time for principals to develop their primary care services.
- 3) To increase the availability of primary care services in the inner city through the deployment of salaried GPs.
- 4) To provide the salaried GPs with experience of inner city practice and the opportunity to develop their professional and clinical skills.
- 5) To accelerate a move from single-handed general practice to a multi-professional delivery of primary care.

The level of funding enabled the health authority to appoint a full-time scheme co-ordinator (an experienced GP and one of the authors of this article – PD) and a cohort of five whole-time equivalent (WTE) salaried GPs on 2 year contracts.

Each salaried GP was contracted to provide seven clinical sessions, allowing for two self-

development 'protected learning' sessions (a negotiated educational curriculum and an audit project) and one specialist GP work session. It was felt that this educational component would make the scheme attractive to recently qualified doctors or those who wished to return to general practice (cf., Young and Leese, 1999). Bradford Health Authority has been innovative in encouraging the development of specialist GP work in such areas as diabetes, dermatology, women's health and ophthalmology. In order to facilitate further career development it was felt exposure to some of this work could be a useful adjunct to the learning component of the scheme.

The posts were advertised nationally and 41 registers of interest were taken. This converted to 16 formal applications for the five posts. Fourteen of these applicants were interviewed and eight selected (7.5 WTE); the City PCG met the balance of funding for the additional 2.5 posts over those originally planned. The criteria for selection included extra language skills, commitment to inner city practice and potential to adapt to a changing environment.

All practices within the Bradford Health Authority area were invited to apply to be host practices for the salaried GPs. Forty-two practices responded, 22 of which were in the inner city area. As the project was HAZ funded, it was decided to concentrate the resources, as far as possible, in the inner city area. Each of the practices was visited by the scheme co-ordinator and an assessment made of their suitability to be a host practice using criteria developed in association with the Local Medical Committee, the Health Authority and the Primary Care Group. Sixteen practices were considered suitable for the first cohort, selected according to the measure of deprivation in the practice population, anticipated development of the practice in providing general medical services and identification of practices where there was a reasonable expectation of a recruitment crisis. Other relevant criteria included the possibility of 'freeing up' GPs in the practice to undertake PCT activity and aiding the professional development of the principal by utilizing the time available to them for their professional learning by the presence of the scheme GP.

The process of recruiting salaried GPs and host practices to the scheme was conducted in parallel. The Bradford scheme is essentially a PCT project

in that GPs were recruited to the Trust rather than to specific practices. As such the scheme underlines the corporate nature of primary care in PCTs. The PCT's agenda was both remedial – seeking to ameliorate the adverse impact of the general practice workforce characteristics in the city, and developmental in its pursuit of quality improvement. The scheme would also represent a model for both recruitment and retention for other groups in the primary care team and for ways of supporting medical students within City practices. In this way it was integral to the emergence of the Bradford City PCT as a first wave 'Teaching Trust' in 2001.

Each salaried GP was assigned to two practices: a single-handed practice (four sessions a week) and a group practice (three sessions a week). This arrangement would provide the salaried GP with a variety of experiences.

The scheme in operation: first cohort

There were some initial problems shortly after the salaried GPs entered their practice placements. One host practitioner resigned from the medical list shortly after the scheme started to allow a career change, thus necessitating redeployment of the salaried GP. In one practice there was a clash of personalities and the scheme GP became very unsettled. It was decided to move that GP from the practice concerned and place them in another single-handed practice.

Several of the host practices questioned why scheme members were privileged to have protected learning time when they, as hosts, were not. They felt that they, and not the scheme GPs, were carrying the responsibility. These sorts of dynamics within the scheme, essentially around issues of envy, proved difficult to reconcile. It is interesting to note, in this respect, that concerns were raised about the amount of time allocated for study leave in the studies reported by Harrison and Redpath (1998) and Woodward *et al.* (1998).

A major concern raised was what happens when the scheme GPs move on – perhaps they will have set up services that cannot be sustained? This was particularly obvious in the single-handed male practices where the issues of women's health have been difficult to address in the past. This reflects concerns expressed in Woodward *et al.* (1998).

Personal and professional development

Salaried GPs

The educational curriculum for personal development was negotiated with the salaried GPs. Particular areas of need relating to further education and general practice medicine were identified and were related to the perceived needs of the patient population (cf., Eve, 2000). The result was a decision to focus on diabetes, substance abuse management and high antibiotic prescribing. There was also a decision to consider practice organization and trends in general practice for the future. Some of these areas were addressed through the knowledge, skills and resources of GPs within the group; other areas required sessions with external specialists in both primary and secondary care.

It was interesting to observe the evolution of the group's identification of their needs. Initially, they felt a formal curriculum should be followed for several months ahead. However, as the scheme evolved new issues arose that required educational time to address. This necessitated timetabling 'free time' to address issues arising from their placements. The decision to move to this less structured format proved to be extremely valuable, enabling sensitive areas such as host practice management and prescribing policies to be discussed and action plans drawn up to address specific problems. Sharing of ideas by the group also helped to resolve potential conflicts in approaches to problems.

This time was also used for critical analysis, using case histories and events that had occurred in the practices as a focus for group learning and discussion. In the process of doing this, the group developed an identity that allowed them to share ideas and common experiences – both positive and negative. Critical event analysis has become an essential component of the educational sessions and specific problems identified in this have led to further educational input from specialists.

In line with current ideas on lifelong learning and re-validation (Calman, 1999), each member of the group has started a personal learning portfolio and it is hoped that this will be continued through their professional career. It may provide an element of a possible reaccreditation requirement in the future.

For the protected session designated to conducting an audit project, each salaried GP chose a specific topic. The areas included looking at

psychological care in the homeless, implementing a cardiovascular National Service Framework in a practice, the management of asthma and detection of low vitamin D levels in the Asian population. The nature of these projects was identified early on and the work is ongoing in conjunction with outside resources such as the University of Bradford Department of Community and Primary Care, the University of Leeds and resources within the Health Authority.

Specialist GP work sessions proved to be difficult to organize. Some of the specialist GP work in Bradford is conducted in normal surgery time making it difficult for the scheme GPs to attend. However, an individual programme was drawn up to try and accommodate the wishes of the GPs and this is currently taking shape.

Host practices

Each practice wishing to be a host practice needed to identify areas in which they would use the time given by the scheme GP. These areas could be:

- 1) personal development in an area of general practice medicine;
- 2) development of the practice in the provision of care to its population;
- 3) to allow a GP in the practice to devote time to the PCT.

The examples from outside Bradford, discussed above, showed that some health authorities had formalized service agreements for the host practices. In retrospect, this was an approach that would have been useful to follow in Bradford. Evidence is, however, accumulating of changes, particularly in the provision of primary care services such as minor surgery, child and women's health and in referral rates. A separate prescribing number has been allocated to the salaried GPs in each practice and this will permit the analysis of their prescribing data using information from the Prescription Pricing Authority collected on a quarterly basis.

Evaluation of the scheme

The scheme is being formally evaluated by the Department of Community and Primary Care, University of Bradford. This evaluation encompasses

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interviewing the salaried GPs and host GPs to obtain their views about the scheme, and analysing quarterly data relating to the quality and the range of primary care services in the host practices (including prescribing of hormone replacement therapy, antibiotics and hypnotic usage, immunization targets, cervical screening targets and contraceptive claims). Although the first cohort of salaried GPs have not yet completed their first year, some initial findings can be discussed.

Host GP expectations of the scheme

Prior to the salaried GPs entering their placements, the host practices were asked to write down their expectations of the scheme. While some of the host GPs expected the scheme to benefit the salaried GPs in terms of the experience and skills gained in inner city general practice, their primary focus was on the benefits to the host practice. This included using the time released from clinical sessions to develop their own clinical skills through training, implementing planned services (e.g., diabetes care, dermatology, women's health) and increasing audit activities. There would be an immediate impact on patient care in terms of extra appointments and, for female patients, the addition of a female salaried GP might enable the practice more appropriately to respond to their health needs.

Some host GPs commented on the possible extra demands placed upon themselves and the primary care team, for example, time required to provide advice and support for the salaried GP. There might also be particular training needs, e.g., computing systems. The provision of additional appointments could also place extra demands upon reception staff and there might also be increased use of the other members of the primary care team such as the practice nurse.

Views of the salaried GPs

A focus group was conducted with the eight salaried GPs on the scheme after they had been in their practice placements for 6 months. Discussions were centred on the following topic areas: What attracted you to the scheme? Is the scheme meeting your expectations – hopes and fears? Are there any problems that could be addressed or improvements made for future cohorts? The focus group was conducted by one of the authors (PG) who taped, transcribed and coded the results according to the topic areas and emerging themes. Participants were

informed that any views expressed would be reported anonymously.

The salaried GPs were attracted to the scheme for a variety of reasons:

- 1) The opportunity to experience general practice without the financial and managerial commitment of a partnership. The scheme might thus function as a 'stepping stone' between GP registrar and partnership, enabling them to gain experience and develop skills. The scheme would serve a similar function for those returning to general practice after a number of years in a different post. Bonsor *et al.* (1998) refer to the transition from registrar to principal as 'less of a step and more of a quantum leap' (p. 915).
- 2) The level of support provided from the scheme and from peers in the group was particularly valued. This was contrasted to their perception and/or experience of the relatively isolated position of other salaried posts or of locum posts.
- 3) The opportunities for professional development were also highly valued, compared with other salaried posts.
- 4) This scheme provided experience of inner city general practice, which some people valued when compared with other schemes based in rural areas.

It was interesting to note that the salaried GPs compared the scheme with other salaried posts or locum posts, rather than partnerships. That is, it was not a choice between joining the scheme or entering a partnership, rather a choice between the support and opportunities provided in the Bradford scheme or other salaried options without this support. Indeed, some of the participants were not considering a partnership in the near future. While this partially reflected personal preferences, it also reflected anxieties about future developments in the organization of general practice, e.g., personal medical service contracts and other salaried options.

The salaried GPs had four main fears prior to starting the scheme:

- 1) that they would be exploited, e.g., used as a locum;
- 2) that the quality of care provided in the practices might be substandard ('worried if we'd uncover anything');

- 3) that there would be personal conflicts with the host GPs relating to ways of working;
- 4) that the host GP would not fully accept them into the practice, being suspicious of their close relationship with the health authority (cf, Woodward *et al.*, 1998).

Current fears related to the development plans of some host practices. These did not appear to be well formulated and were therefore difficult to monitor. The salaried GPs perceived themselves as agents of change, and there was some frustration where advances did not appear to be being made. This was particularly related to single-handed practices, where some felt that they were merely being absorbed into the practice as an extra doctor. Woodward *et al.* (1998) also raised this concern (noted above).

There was concern about raising patient expectations. The salaried GPs felt that they were educating patients about the type of care that they could expect and that this might cause problems in the future once they left the practice. Again, this was an issue noted in the study by Woodward *et al.* (1998). A particular concern in our study related to the introduction of female doctors into single-handed male practices and their absence at the end of the scheme.

There was also concern about the types of problems that patients were presenting with to some host practices. It was commented that '50% of surgeries are full of minor things' and that patients should be educated about their demands, e.g., prescriptions, returning for antibiotics. It was, however, admitted that this may reflect an economically deprived inner city population who are presenting to get free prescriptions. Denying prescriptions was a potential source of conflict between the host and salaried GP. It was noted that some patients returned the same day and managed to obtain the prescription denied by the salaried GP.

The appointments system was a major cause for concern and conflict: in one case where the salaried GP attempted to maintain what they perceived to be sufficient time to see patients, practice staff tried to shorten appointment times to those of the host GP. This was subsequently resisted by the salaried GP. It was admitted that this problem might reflect pressure to see a high volume of patients due to the list size and high patient demand.

Support from the scheme organizer was considered excellent in so far as he dealt with problems raised promptly. Support from the host practices was 'mixed'. Salaried GPs considered measures of good support to include being allowed to assimilate at one's own pace (e.g., regarding appointment times), to be accepted as a team member (e.g., involvement in practice meetings) and having feedback about patients. It was noted that some practice staff needed to get used to other approaches to working and were wary of change. Areas where this was observed included attitudes to appointment times, the role of the practice nurse, prescribing conflicts, referral letters. Others, however, saw the salaried GP as an ally for change.

When the salaried GPs were asked what issues might be addressed or improvements made for future cohorts, the following five issues were noted:

- 1) guidance about appointments and the role of the salaried GP – so that this is consistent across practices;
- 2) a written contract specifying the developmental programme of the host practice;
- 3) greater clarity about the role of the salaried GPs in what issues they should be addressing and how they should be proceeding. This would include giving feedback to the practice about issues raised;
- 4) more information in the induction period about the health authority, hospitals, and where and how to refer patients;
- 5) periodic re-evaluation of training needs.

Conclusions

The Government has stated that a salaried service is the best way forward to solve the GP recruitment crisis (Brown and Kay, 1997). In the recent past this was not accepted by a majority of principals (Leese and Bosanquet, 1996). In seeking to reconcile the policy intention and the resistance to it several models of providing salaried services are emerging. Many of these have evolved in such a way as to meet local requirements in both service need and the personal development of the practitioners.

Of particular significance is the impact of PMS. This expands the scope of salaried practice and acts

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in concert with the introduction of the primary care trust as the organization that will be responsible for delivering primary care. The primary care trust offers the opportunity to develop a joint strategy to promote health within its geographic boundaries and to contribute to the quality of care offered via the governance of the activities of the staff. The PMS scheme is entirely consistent with this evolving corporatism.

The Bradford scheme, in many ways, fits with the overall concept of PMS salaried GP schemes. Like them it attempts to balance the need to recruit to difficult areas of practice with the personal and professional needs of the salaried GPs. This paper gives an initial view of the Bradford scheme and further formal evaluation will follow. Specifically, we will not be able to comment on retention issues for some time. Furthermore, identifying the overall impact of the scheme on the practice of primary care and on the health of the PCT's population is both a formidable task and one that needs a longer term perspective. However, early indications are that the scheme has been successful in recruiting new GPs to this deprived inner city area. This is in contrast to Sibbald and Young's (2001) early findings. We suggest that the difference, and perhaps the reasons for the more positive early indications of the Bradford scheme, lies in the structure of support that has been given to the newly recruited salaried GPs. As such the approach discussed here may prove to be useful in looking at the development of schemes in other areas.

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