BMJ Open

GP Partnership and Business - The Learning Needs of First Five General Practitioners in NHS Scotland: A Qualitative Study

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2021-056188
Article Type:	Original research
Date Submitted by the Author:	11-Oct-2021
Complete List of Authors:	Lindemann, Roberta; NHS Education for Scotland, Medicine Directorate Robson, Gordon; NHS Education for Scotland, Medicine Directorate Cunningham, David; National Health Service Education for Scotland Knowledge Network, Medicine Directorate
Keywords:	MEDICAL EDUCATION & TRAINING, QUALITATIVE RESEARCH, PRIMARY CARE

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

GP Partnership and Business - The Learning Needs of First Five General Practitioners in NHS Scotland: A Qualitative Study

Authors: Dr Roberta F. Lindemann MBChB MRCGP

Dr Gordon Robson MBChB MRCGP

Dr David E. Cunningham BA MBChB MPhil PhD FRCGP (corresponding author) david.cunningham@nhs.scot

Medicine Directorate, NHS Education for Scotland, 2 Central Quay, 89 Hydepark Street, Glasgow G3 8BW

Abstract (294 words):

Introduction

After completing general practice specialist training (GPST), general practitioners (GPs) in the United Kingdom can work independently, and enter into a variety of employment models within the National Health Service (NHS). Fewer recently-qualified (within five years) GPs in NHS Scotland are entering into GP partnership than in the past. This may be related to a lack of learning about the business of general practice and partnership.

Study aims

This study aimed to identify the learning needs of recently-qualified GPs in NHS Scotland concerning GP partnership and the business of general practice. It aimed to identify learning opportunities during GPST and the first five years of work, and to explore their suggestions of additional resources that would improve their sense of preparedness for partnership. A secondary aim was to explore what influenced their current choice of employment model and place of work.

Design and Setting

A qualitative research approach was used and recruitment was stratified to include participants from a range of NHS boards in Scotland including remote and rural areas. Participants were interviewed individually or in small focus groups. Interviews were audio-recorded and transcribed. Transcriptions were coded and codes developed into themes. Data saturation was achieved and verified by the researchers.

Results

27 recently-qualified GPs participated in the study. Three main themes were constructed: preparedness for partnership from experiential learning in GPST; perceived business learning needs and preferred learning styles (with learning needs

arranged into five topic areas); considerations that inform decision-making about choice of employment model and of practice. Factors that influenced the decision to enter into specific employment models were identified.

Conclusion

Lengthening the time spent in GPST may help GP trainees gain more knowledge about the business of general practice and of GP partnership.

Strengths and limitations

- Participants were drawn from 11 of the 14 NHS boards in Scotland, and they had experience of working in a range of practices and employment models.
- Participants had experience of working in areas of deprivation and remote and rural areas.
- Social networks were used to recruit participants including those who attended a large NES conference aimed at First5 GPs - this may have biased their responses in interviews.
- The study involved participants working in NHS Scotland only: the other three countries of the UK were not included in the study and it is known that employment opportunities in general practice differ amongst the four nations.

Keywords: Learning, Family Practice, Commerce

Introduction (769 words)

In the United Kingdom (UK), after completing General Practice Specialist Training (GPST), general practitioners (GPs) qualify for the Certificate of Completion of Training (CCT) in general practice, issued by the General Medical Council (GMC). Their names are added to the GMC's GP register and they are able to work independently in general practice. Newly-qualified GPs are free to choose from a range of clinical career paths and contractual employment models. The most common options for GPs wishing to continue in clinical practice in the UK are: to become a partner, to accept a salaried post, to work as a locum, or work in the Out-Of-Hours Service (1). GP partners are self-employed doctors who run their own business with other partners, holding a contract with an NHS board and providing General Medical Services to patients. Salaried GPs are directly employed by practices or NHS boards. Locum GPs are self-employed, usually offering short-term work to practices. Out-Of-Hours GPs have a contractual arrangement with an NHS board to work evenings and weekends. GPs may choose a combination of these roles, and some have non-clinical roles such as in medical education, management or university work (2). GPs within the first five years of CCT have been termed First5 GPs by the Royal College of General Practitioners (RCGP). The RCGP has called for investment and support for this group of GPs (3) (4).

Partnership has been the predominant GP employment model in the UK for the last 100 years (5). In the last ten years, there has been a persistent decline in the number of GP partners in NHS Scotland, falling from 3,779 in 2010 to 3,328 in 2020, with a corresponding increase in the number of salaried GPs from 483 to 1,144 (6). This is partly due to the growing trend of newly-qualified GPs choosing salaried and locum work after completing training (7) (8) although interest in partnership has been shown

to increase later in their careers. While only 4% of GP trainees anticipated joining a partnership in the first six months after completing training, this increased to 33.9% some five years into their career (9) with 45% of all salaried or locum GPs considering partnership for the future (10).

Reports are published regularly on the numbers of GPs in each employment model in Scotland (1). However, little is known about the factors that influence the career choices of First5 GPs. Surveys of GP trainees, salaried GPs and locum GPs have identified the negative portrayal of general practice in the media (9). This, coupled with experiences derived from their time spent in training practices, and their perceptions of the work-life balance of partners and practice morale, were significant influencers on whether to pursue partnership (9). Personal factors such as being geographically unsettled, (11) or plans to have children, were identified as reasons to postpone becoming a GP partner (12). Further deterrents to partnership included lack of training in business matters (7) (8), unease regarding the associated financial risks (10), concerns that workload may exceed capacity, and perceptions that the partnership employment model lacked flexibility. In a recent study, First5 GPs in NHS Scotland identified their perceptions of gaps in GP training that became apparent with their move into independent practice (13). The business of general practice was considered an area in which they felt they had gaps in their learning. For those First5 GPs considering partnership, perceived benefits of the model included freedom to innovate, a greater degree of influence within the practice and an expectation of a higher income (12).

While the role of a GP partner includes running a business, there is no clear definition of what business skills are needed for this role. The RCGP curriculum for GPST

includes: “developing the financial and business skills relevant for your role” (14) but does not elaborate further on what this may entail. GPST learning in this area is assessed through various components of the membership examination (MRCGP): the Applied Knowledge Test (AKT), a leadership activity, quality improvement projects and workplace-based assessments (14). However, it is not known how prepared First5 GPs considered themselves to be for the business aspects of partnership.

This study aimed to identify the learning needs of First5 GPs in NHS Scotland relating to GP partnership and the business aspects of general practice. It aimed to identify the learning opportunities during their GP specialist training and in the first five years of post-CCT work, and to explore their suggestions of additional resources that would improve their sense of preparedness for partnership. A secondary aim was to explore what influenced their current choice of employment model and place of work.

Method (537 excluding box, 675 including box)

A qualitative research approach using grounded theory methods was used to explore the perceptions and experiences of First5s in relation to their learning needs of GP partnership and the business of general practice (15). A qualitative approach using semi-structured interviews was considered appropriate as it allows researchers to question participants and identify the underlying reasons for their perceptions and experiences. This would not be possible using data collection instruments such as questionnaires. The study design consisted of a recruitment stage, data collection and data analysis, undertaken by three researchers. The first and second authors had some experience of qualitative research and were First5 GPs in clinical practice. The third author is an experienced qualitative researcher and an experienced GP.

Recruitment

First5 GPs, who were working in NHS Scotland and had completed GP training in the UK within sixty months of the beginning of the research period, were included in the study. A purposive sampling strategy was used to maximise diversity of perceptions and experiences. A sampling grid was constructed that included remote and rural GPs, those working in areas of deprivation, and the 14 territorial boards in NHS Scotland. The sampling grid included different employment models such as salaried GPs, partners, locum GPs and Out-Of-Hours practitioners. First5s were contacted by email by one researcher and invited to take part in a focus group or one-to-one interview. Further recruitment took place at a conference for First5 GPs organised by NHS Education for Scotland (NES).

Participants were sent a study information sheet giving details of its aims. They signed a consent form giving permission for their discussion to be audio-recorded and

transcribed. An assurance was given that discussions would be confidential and transcripts anonymised. A professional fee of £75 was offered to participants to compensate for loss of earnings in recognition that some were working as self-employed locums or working in Out-Of-Hours Services.

Data collection

A question topic guide (See box 1) for the semi-structured interviews was constructed by the researchers, based on the current literature, and after discussions among the research team.

Box 1: Question topic guide

1. What are your thoughts about GP training preparing you for the business and managerial aspects of being a GP partner?
2. How do you think GP training could be improved to better prepare trainees for the business and managerial aspects of being a partner?
3. What are your impressions of what it's like to be a GP partner?
4. What are some of the advantages and disadvantages of being a GP partner?
5. What are your thoughts on being a GP partner?
6. What would make you feel better prepared for partnership?
7. How would you like to learn about being a GP partner?
8. Who would you want to learn from?
9. When is the best time to start learning about partnership?
10. How much would you be willing to pay to access your preferred course?

Individual interviews and focus groups were held in mutually agreeable settings or by telephone or using video-conferencing technology. Interviews were held several weeks apart allowing researchers time to listen to audio-recordings, examine transcripts and make adaptations to questions posed to subsequent participants, thus adopting an iterative approach. Transcripts were prepared by NES clerical staff. Recruitment ended when data saturation was achieved. This was judged by the research team when no new perceptions and experiences were found from participants as the interviews and analysis progressed and confirmed by undertaking two further interviews to be sure of this.

Data analysis

Transcripts were checked against the audio-recordings and corrections made by researchers. Transcripts were read and re-read independently by researchers who undertook initial analysis of the interviews they had undertaken. Data analysis followed the method described by Charmaz: codes were constructed and brought together into themes using the Constant Comparative Method (14). Coding was undertaken separately by the researchers who met at regular intervals to discuss and agree emergent themes. Any themes causing disagreement were discussed and talked through until the research team reached agreement. Analytical memos were written and shared by the researchers.

Results (2067 including boxes, figures and raw data quotes, excluding tables)

Twenty-seven First5 GPs participated in the study and were interviewed between August 2019 and November 2019. Seven participated in one-to-one interviews, and 20 in three focus groups of six or seven participants, each lasting up to one hour. There were 18 female and nine male participants who worked between four and ten sessions per week (one session equates to approximately four hours of work (16)). Participants were drawn from 11 of the 14 territorial boards in NHS Scotland. Two participants were working in remote and rural areas as defined by The Scottish Government (17). Participants worked across a range of different employment models, with 15 working in more than one model (See table 1).

Table 1: Number of participants in each employment model

Employment Model	Number of Participants
Locum	7
Out-Of-Hours	8
Partner	9
Salaried	12
Other (advisory roles, specialist interests, clinical management, medical education, fellowships, military work)	8

Three themes were constructed and are presented in Box 2.

Box 2: Identified themes

- Preparedness for partnership from experiential learning in GP Specialty Training (GPST)
- Perceived business learning needs and preferred learning styles (with learning needs arranged into five topic areas)
- Considerations that inform decision-making about choice of employment model and choice of practice

Preparedness for partnership from experiential learning in GP Specialty Training

Some participants were attracted to general practice because it gave opportunities to develop business skills, but others did not see this as part of their role in the future. To some extent, this was influenced by First5s' experiences during GPST. Most participants felt the focus of GPST was the development of a minimum level of clinical competence required to be a safe and independent clinician as reflected in the RCGP training curriculum and the MRCGP examination.

> *"You spend your three years just trying to get through the AKT* [Applied Knowledge Test] *and CSA* [Clinical Skills Assessment] *and ideally you don't want to kill anybody when you become a GP."* (Participant 26)

During GPST, participants were introduced to the non-clinical roles of a partner to widely contrasting extents. Some had no involvement in the business of general practice which contrasted with others who were regular attenders at practice business meetings. The quality of experience was dependent on the initiative of the trainee, the attitude and inclusivity of the trainer, and the business transparency of the practice.

Participants who were included in business discussions when trainees, perceived a greater level of trust and belonging within the practice team, and were less intimidated by the future role of the GP partner. In contrast, others described being excluded from business discussions, perceiving these topics to be out-of-bounds for them as GP trainees. They described the complexity, risks and uncertainty surrounding the concept of partnership, and on completion of training lacking confidence in their ability to fulfill that role.

"When I was a GP trainee, whenever they had their business meetings, I often got asked to leave the room. So, there's always this taboo as to what actually do you do in your tax meetings?" (Participant 11)

When asked how they would like to learn about the business of general practice, participants had a preference for gradual exposure throughout training, grounded on real-life experiences, with more targeted learning nearing the point of transition to partnership.

"I think if you had something that gave you an idea about what the kind of roles and responsibilities were, maybe even a couple of case examples, then that would be a good basis for which to build on that experience." (Participant 20)

Discussions using anonymised or fictitious business information were perceived as an alternative to disclosing sensitive business and financial information to GP trainees. Participants expressed reservations about tackling this topic in single stand-alone sessions. Day-release sessions, when GP trainees from an area attended for formal teaching, were seen as opportunities to gain insight into the differences between local practices. Other suggestions included increasing the time spent in general practice during the training programme and clearer guidance in the training curriculum on how this topic could be learned.

Perceived business learning needs and preferred learning styles

Participants preferred to learn about the business of general practice from supportive and experienced partners in their training practice.

"I do feel that it's on the job training that's going to allow you to do it." (Participant 15)

External educational resources were viewed as complementary to learning from the training practice: offering learning on how to mitigate against possible "worst-case scenarios", opportunities to ask questions to subject experts, and to learn from peers at a similar career stage. Preferred learning methods and resources included face-to-face courses, interactive small group online learning or teaching sessions that were scheduled during the working week.

> *"It needs to be kind of smaller numbers of people to properly get their heads round it and ask questions."* (Participant 12)

There was a preference for speakers to be GPs, practice managers or relevant professionals such as lawyers and accountants, and for presentations to be delivered without commercial attachments and contextualised to primary care.

> *"I think I would definitely want a GP as one of them, and possibly a non-GP, someone that knows more about the business side or how other companies are run."* (Participant 5)

Most were not opposed to paying up to £200 for a full day learning event.

The learning needs of the business of general practice identified from participants were grouped into five topic areas and structured by the research team into specific learning objectives as shown in Figure 1.

Enter Figure 1 about here

Considerations that inform decision-making about employment model and choice of practice

Each of the employment models shown in figure 1 were perceived to have its own advantages and disadvantages and these are listed in figure 2. Despite many participants expressing views on their preferred model at the time of completing training, as participants gained experience over time, they gradually changed their personal priorities

> *"I came out of GP training saying I was never going to be a partner. Famous last words!"* (Participant 14)

The decision-making process about each employment model was a complex one, taking into consideration their perceptions of what each role had to offer, their preparedness to settle in a geographical area, its compatibility with their personal life goals, and whether an opening was available in their preferred practice. Partners were commonly perceived as having ultimate responsibility for the practice and the role was associated with a degree of permanence. Positive remarks about partnership included having a greater degree of autonomy over their working environment, setting the strategic direction of the practice and experimenting with new ways of working. Continuity of patient care and with the practice team were valued.

> *"We can actually make change and then I can see that come out."* (Participant 23)

Some described a sense of natural progression into the role of a GP partner with many considering partnership for the first time during their First5 years. Negative perceptions of partnership included a feeling that partners were overwhelmed and overworked. Being responsible for keeping a practice running in an environment where recruitment

was challenging, and the unclear consequences of the New GP Contract in Scotland, were seen as risky.

> *"I think of people* [partners] *being under a lot of pressure and just bursting at the seams with roles and responsibilities and low on time and resources."* (Participant 22)

The perceived advantages of salaried GP roles included having employment rights, such as maternity leave, and of having income stability. Salaried GPs were considered to have a greater sense of parity among members of the healthcare team particularly in NHS Board-managed practices. The main disadvantage of this role was thought to be a sense of frustration with their lack of influence in decision-making within the practice.

> *"I've come to realise, I want to be part of that inner circle."* (Participant 20)

The greatest attractions to working as a locum GP and in the Out-Of-Hours service were the desire to work in a range of different environments, and to create time after the intensity of training. This allowed time to consider professional options and personal life choices.

> *"We are in a culture now as GPs where we're very flexible, very sought after, very well paid as locums."* (Participant 7)

Figure 2 is a summary of the push and pull factors that affected the choice of different employment models

Insert Figure 2 around here.

Participants were selective about the practice they considered for permanence and chose a practice they were familiar with: usually having spent time there as a trainee, or as a salaried or locum GP. This allowed for a period of observation when they

assessed whether the practice had the desired characteristics they were looking for. These included having partners who demonstrated a good work-life balance, were receptive to innovation, and were perceived as being supportive to new partners. An inclusive and experienced practice team in a desirable location was valued.

> *"A practice I used to locum at has asked me to be salaried with a view to partnership next year. The reason I'm taking it on is because they're a great team. They've got a good working culture. They've got up to date admin protocols and they seem to have a good work/life balance."* (Participant 21)

Factors that made partnership feel less risky included partnerships with stable finances, with no capital investment needed from new partners, and where most partners were not approaching retirement.

Discussion (745 words)

Main findings

This study identified three main themes from interviews with First5 GPs in NHS Scotland. First5 GPs had variable experiences of learning about the business of general practice during GPST. Learning opportunities varied considerably for GP trainees and some felt excluded from business meetings during training. We identified five main themes relating to the learning needs of the business of general practice. We identified the 'push' and 'pull' factors of a range of employment models and identified how these influenced First5 GPs in decision-making regarding their employment model and place of work.

Preparedness for partnership and perception of risk associated with partnership were heavily influenced by trainees' learning experiences during training. These were varied and unstructured and largely dependent on the initiative of trainees, trainers and the transparency of practice. First5 GPs would like to have gradual exposure to the business of general practice throughout GPST with targeted learning at the time when they were considering partnership. For most participants this was after CCT.

First5 GPs preferred to learn from supportive colleagues and valued access to complementary educational resources contextualised to their work experience. They wanted to learn from experienced GPs, First5 peers and subject-area experts through mentorship or small group work. First 5s were interested in having an overview of topic areas identified rather than in-depth knowledge, with sign-posting to resources they could return to, as their learning needs evolved.

Strengths and limitations

This study identified a number of influential factors that determined the employment model chosen by First5 GPs and adds usefully to the scant literature of this area. Participants were drawn from 11 of the 14 NHS boards in Scotland, and they had experience of working in a range of practices and employment models. Participants had experience of working in areas of deprivation and remote and rural areas. Data saturation was achieved and confirmed. The research team combined current First 5s GPs in NHS Scotland with an experienced GP researcher: bringing complementary skills and a range of viewpoints to the study. All three worked in different NHS boards in Scotland.

The study had limitations. Social networks were used to recruit participants including those who attended a large NES conference aimed at First5 GPs. This may have biased their responses in interviews. The study involved participants working in NHS Scotland only: the other three countries of the UK were not included in the study. Employment opportunities in general practice differ amongst the four nations. For example, NHS England has additional business models such as super-practices and practice federations which are not seen in NHS Scotland (5). Learning needs were assessed from the perspective of First5 GPs only: future research could consider how this perspective compared with the views of experienced GPs and trainers.

Comparison with existing literature

This study supports earlier findings that decision making on choice of employment model is complex, and is influenced by training experiences (7) (9) (11) (12). It takes into account perceptions of the advantages and disadvantages of different career options in relation to professional and personal goals. The findings complement the

quantitative study which identified that the choice of employment model is fluid during the First5 years (9). We have described how this is influenced by the accumulation of professional experiences and a weighing-up of the opportunities that arise in the context of changing personal circumstances of the First5s themselves.

Implications for further research and change in practice

In some countries in the UK, GP training schemes are set to extend the time spent in clinical general practice. It would be important to identify if this leads to greater exposure of GP trainees to the business of general practice and if there are improvements to their perceptions of readiness to enter partnership.

Some participants considered that their learning experiences of the business of general practice during GPST did not allow them to gain the necessary confidence to enter partnership. Trainees' experiences varied considerably amongst participants. Those GP trainees who were trusted with confidential information and included in business meetings were more confident about these matters. UK training authorities should be more aware of this variation and encourage practices to be open and transparent about the business of general practice. Further learning opportunities at a local or regional level would be valued by trainees and training authorities should consider how best to deliver this education. Other learning materials and resources from accountants and solicitors regarding practice financial statements and partnership agreements would be welcomed by First5 GPs.

Acknowledgments

The authors would like to thank all participants and administrative staff in NES who helped in this study. The authors thank the Scottish Government for its support of the First 5 GPs educational and research service within NES. The authors would like to thank Dr Kenneth Lee and Dr John Nicol from NES for their editorial advice.

Contributors

DC conceived the study, recruited the research team and searched the existing literature. RL and GR collected the data and analysed it with DC. RL wrote the manuscript with contributions from DC and GR. DC edited the manuscript.

Funding

The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sector.

Competing Interests

DC is an Assistant Director within NHS Education for Scotland and provides CPD resources to GPs and their teams in Scotland. GR was a medical education fellow within NES. All authors were practising GPs in NHS Scotland at the time of the research project.

Patient consent for publication Not required

Ethical Approval

Under UK 'Governance Arrangements for Research Ethics Committees', ethical research committee review is not required for service evaluation or research which, for example, seeks to elicit the views, experiences and knowledge of healthcare professionals on a given subject area. Similarly, 'service evaluation' that involves NHS staff recruited as research participants by virtue of their professional roles does not require ethical review from an established NHS research ethics committee.

Provenance and peer review Not commissioned, externally peer reviewed

Data availability statement Data are available on reasonable request. Data include transcripts of audio recordings of interviews and regarded as being confidential. Participants did not consent to this data being shared.

ORCID ID

David E Cunningham http://orcid.org/0000-0002-0415-9807

References

(1) Information Services Division *Primary Care Workforce Survey Scotland 2017* NHS National Services Scotland 2018 Available at: https://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/Workforce/national_primary_care_workforce_survey.asp (Accessed 1st August 2021)

(2) Gibson J, Sutton M, Spooner S, Checkland K. *Ninth National GP Worklife Survey 2017.* Policy Research Unit in Commissioning and the Healthcare System 2017

(3) The Royal College of General Practitioners. *First5*. Available from: www.rcgp.org.uk/first5 (Accessed 1st August 2021)

(4) Taylor C, Parsons J, Sparrow N et al The First5 Concept Br J Gen Pract 2011 61(582) 72-73

(5) Department of Health and Social Care. *GP Partnership Review: Final Report* Available from: www.gov.uk/government/publications/gp-partnership-review-final-report (Accessed 1st August 2021)

(6) Public Health Scotland *General Practice: GP workforce and practice list sizes* Available from www.isdscotland.org/health-topics/general-practice/workforce-and-practice-populations/ (Accessed 1st August 2021)

(7) Nosa-Ehima M. *Through the eyes of GP trainees: workforce of the future* Available from https://www.kingsfund.org.uk/blog/2018/08/gp-trainees-workforce-future (Accessed 1st August 2021)

(8) Hunter A. *The future of general practice: the view of GP trainees* Available from https://www.kingsfund.org.uk/blog/2019/12/future-general-practice (Accessed 1st August 2021)

(9) Dale J, Russel R, Scott E, et al. Factors influencing career intentions on completion of general practice vocational training in England: a cross-sectional study *BMJ Open* 2017;(7):e017143

(10) Wessex Local Medical Committees *GP Workforce Survey 2018* Available from https://www.wessexlmcs.com/gppartnershipreview (Accessed 1st August 2021)

(11) Evans J, Lambert T, Goldacre M. GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice *Occas Pap R Coll Gen Pract* 2002 Feb;(83):iii-vi, 1-33

(12) Bregazzi R, Harrison J. Factors influencing career choice: Experience from GP Career Start in County Durham *Educ Prim Care* 2002;13:477-489

(13) Cunningham DE, Ward C, Kyle J and Yeoman L. The Learning Needs, Preferred Learning Methods, and Learning Challenges of First Five General Practitioners in NHS Scotland: A Qualitative Study *BMJ Open* 2021;11:e044859

(14) Royal College of General Practitioners *Training* Available from www.rcgp.org.uk/training-exams/training.aspx (Accessed 1st August 2021)

(15) Charmaz K. *Constructing Grounded Theory* 2nd Edition. London: Sage; 2014

(16) British Medical Association *Job Planning for GPs* Available from https://www.bma.org.uk/pay-and-contracts/job-planning/job-planning-process/job-planning-for-gps (Accessed 1st August 2021)

(17) Scottish Government. Scottish Government Urban Rural Classification 2016. Available from https://www.gov.scot/publications/scottish-government-urban-rural-classification-2016/pages/2/ (Accessed 1st August 2021)

Figure 1

NATIONAL GP CONTRACT *"I don't really understand the structure of the NHS, HSCP* [Health and Social Care Partnership]*, and it seems to me that to get anything done, you need to know who all the people are."* (Participant 4)
• Outline NHS Scotland and Health and Social Care Partnership (HSCP) structures • Recognise how practices interface with the wider NHS organisation and how they can influence change via clusters of GP practices, Local Medical Committees, NHS Boards, HSCPs, the British Medical Association and RCGP • Identify local contacts for service planning • Explore the differences in funding structure between General Medical Services (17J), Personal Medical Services (17C) and Health Board run (2C) practices • Distinguish between core funding activities and optional additional services • Discuss implementation of the new contract
PRACTICE ACCOUNTING *"Problem solving financial questions i.e., staff pay and the implications for yourself and for the practice"* (Participant 25)
• Interpret practice accounts including income, expenses, capital accounts, drawings, taxation and pensions from real or anonymised accounts • Recognise natural variations in accounts over time • Predict how practice decisions that affect income and expenses can affect drawings • Explain the first tax bill as a partner and how to prepare for it • Have an overview of the pros and cons of different practice structures, including Partnerships, Limited Liability Partnerships and "super-practices"

Figure 1

PARTNERSHIP AGREEMENTS *"Partnership is all about working with other people and its always going to be tense when you disagree"* (Participant 1)
• Outline the structure of a partnership agreement, its legal implications, and the consequences of not having a partnership agreement • Give examples of different options for clauses i.e., maternity/shared parental leave, last man standing, partner sickness, portfolio careers • Define the business responsibilities of the partner and compare this with the responsibilities of the practice manager • Describe communication strategies to prevent and manage conflict with other partners • Outline the scenarios that may result in practice closure and explore options for practices in difficulty including returning a practice to the NHS Board and protecting partners from bankruptcy

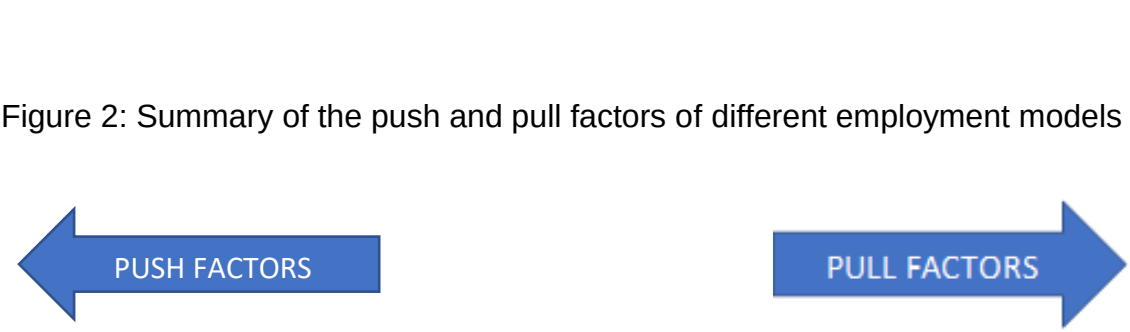
HUMAN RESOURCES *"If there is an issue with an employee you can guarantee it will be brought up at the practice meeting and you will have to make a decision on what you do with said employee."* (Participant 17)
• Recognise the responsibilities of an employer and the rights of employees • Describe what is involved in hiring new staff, conducting interviews, training staff and supporting professional development • Describe approaches for handling staff grievances, including when and how to use disciplinary processes

Figure 1

• Clarify the role of practice policies and procedures, including handling complaints
LEADERSHIP AND MANAGEMENT *"How we're going to manage these changes that are being thrust upon us or the changes that we want to do in the practice to improve our flexibility or how we work" (Participant 21)*
• Explore the characteristics of an effective partnership and a well-run practice • Describe how to create a culture that reflects the values of a practice • Discuss practical approaches for managing change with reference to real-life examples of innovation in primary care • Explore aspects of resilience and self-care as a partner including time management, boundaries and preventing burnout

Figure 2

Figure 2: Summary of the push and pull factors of different employment models



Overworked Difficult to recruit partners Difficult to leave Pressure on work-life balance More administrative work New contract uncertainty Lack of business knowledge	**Partnership**	Autonomy within practice Innovation Continuity of patients/colleagues Higher income Interest in medical education
Less influence in practice Lower income	**Salaried**	Clinical role only No business risk Guaranteed maternity leave Stable working hours Flatter hierarchy
Lack of income security Lack of continuity	**Locum or** **Out-of-Hours**	Flexibility Variety Portfolio careers

BMJ Open

The Commercial Business and Partnership Aspects of General Practice - The Learning Needs of First Five General Practitioners in NHS Scotland: A Qualitative Study

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2021-056188.R1
Article Type:	Original research
Date Submitted by the Author:	09-Jun-2022
Complete List of Authors:	Lindemann, Roberta; NHS Education for Scotland, Medicine Directorate Robson, Gordon; NHS Education for Scotland, Medicine Directorate Cunningham, David; National Health Service Education for Scotland Knowledge Network, Medicine Directorate
Primary Subject Heading:	General practice / Family practice
Secondary Subject Heading:	Medical education and training, Qualitative research
Keywords:	MEDICAL EDUCATION & TRAINING, QUALITATIVE RESEARCH, PRIMARY CARE

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

The Commercial Business and Partnership Aspects of General Practice - The Learning Needs of First Five General Practitioners in NHS Scotland: A Qualitative Study

Authors: Dr Roberta F. Lindemann MBChB MRCGP

Dr Gordon Robson MBChB MRCGP

Dr David E. Cunningham BA MBChB MSc MPhil PhD FRCGP (corresponding author) david.cunningham@nhs.scot

Medicine Directorate, NHS Education for Scotland, 2 Central Quay, 89 Hydepark Street, Glasgow G3 8BW

Abstract (277 words):

Objectives

To identify the learning needs of recently-qualified general practitioners (GPs) (First Fives) in National Health Service (NHS) Scotland concerning GP partnership and the commercial business aspects of general practice. It aimed to identify learning opportunities during GP speciality training, and the first five years of work, and to explore their suggestions of additional resources that would improve their sense of preparedness for partnership. A secondary aim was to explore what influenced their current choice of employment model and place of work.

Design

Qualitative research study using grounded theory methods. Recruitment was stratified to include First Five GPs from a range of NHS boards in Scotland including remote and rural areas. Participants were interviewed in small focus groups or individual interviews in-person, or over the telephone depending on their preference. Interviews were audio-recorded and transcribed. Transcriptions were coded and codes developed into themes using Charmazian grounded theory methods. Data saturation was achieved and verified by the researchers.

Setting

General practice in NHS Scotland. Participants GPs, within the first five years of completion of GP speciality training, who were working in NHS Scotland.

Results

Twenty-seven recently-qualified GPs participated in the study. Three main themes were constructed: preparedness for partnership from experiential learning in GP speciality training; perceived commercial business learning needs and preferred

learning styles (with learning needs arranged into five topic areas); considerations that inform decision-making about choice of employment model and of practice. Factors that influenced the decision to enter into specific employment models were identified.

Conclusion

Lengthening the time spent in speciality training may help GP trainees gain more knowledge, skills and confidence about the commercial business aspects of general practice and of GP partnership.

Strengths and limitations

- Participants were drawn from 11 of the 14 NHS boards in Scotland, and they had experience of working in a range of practices and employment models.
- Participants had experience of working in areas of deprivation and remote and rural areas.
- Social networks were used to recruit participants including those who attended a large NHS Education for Scotland conference aimed at First5 GPs - this may have biased their responses in interviews.
- The study involved participants working in NHS Scotland only: the other three countries of the UK were not included in the study and it is known that employment opportunities in general practice differ amongst the four nations.

Keywords: Learning, Family Practice, Commerce

Introduction (834 words)

In the United Kingdom (UK), after completing General Practice Specialist Training (GPST), general practitioners (GPs) qualify for the Certificate of Completion of Training (CCT) in general practice, issued by the General Medical Council (GMC). Their names are added to the GMC's GP register and they are able to work independently in general practice. Newly-qualified GPs are free to choose from a range of clinical career paths and contractual employment models. The most common options for GPs wishing to continue in clinical practice in the UK are: to become a partner, to accept a salaried post, to work as a locum, or work in the Out-Of-Hours Service (1). GP partners are self-employed doctors who run their own commercial business with other partners, holding a contract with an NHS board and providing General Medical Services to patients. Salaried GPs are directly employed by practices or NHS boards. Locum GPs are self-employed, usually offering short-term work to practices. Out-Of-Hours GPs have a contractual arrangement with an NHS board to work evenings and weekends. GPs may choose a combination of these roles, and some have non-clinical roles such as in medical education, management or university work (2). GPs within the first five years of CCT have been termed First5 GPs by the Royal College of General Practitioners (RCGP). The RCGP has called for investment and support for this group of GPs (3) (4).

Partnership has been the predominant GP employment model in the UK for the last 100 years (5). In the last ten years, there has been a persistent decline in the number of GP partners in NHS Scotland, falling from 3,779 in 2010 to 3,328 in 2020, with a corresponding increase in the number of salaried GPs from 483 to 1,144 (6). This is partly due to the growing trend of newly-qualified GPs choosing salaried and locum work after completing training (7) (8) although interest in partnership has been shown

to increase later in their careers. While only 4% of GP trainees anticipated joining a partnership in the first six months after completing training, this increased to 33.9% some five years into their career (9) with 45% of all salaried or locum GPs considering partnership for the future (10).

The Scottish Government has published its new contract for GPs in Scotland and sees the independent contractor status of GPs as important in healthcare delivery for the future (11). Another aspect valued by the Scottish Government is the concept of continuity of care, as promoted by Starfield, and the potential for long term continuity to develop effective therapeutic relationships between GPs and patients (12).

Reports are published regularly on the numbers of GPs in each employment model in Scotland (1). However, little is known about the factors that influence the career choices of First5 GPs. Surveys of GP trainees, salaried GPs and locum GPs have identified the negative portrayal of general practice in the media (9). This, coupled with experiences derived from their time spent in training practices, and their perceptions of the work-life balance of partners and practice morale, were significant influencers on whether to pursue partnership (9). Personal factors such as being geographically unsettled, (13) or plans to have children, were identified as reasons to postpone becoming a GP partner (14). Further deterrents to partnership included lack of training in business matters (7) (8), unease regarding the associated financial risks (10), concerns that workload may exceed capacity, and perceptions that the partnership employment model lacked flexibility. In a recent study, First5 GPs in NHS Scotland identified their perceptions of gaps in GP training that became apparent with their move into independent practice (15). The business of general practice was considered an area in which they felt they had gaps in their learning. For those First5 GPs

considering partnership, perceived benefits of the model included freedom to innovate, a greater degree of influence within the practice and an expectation of a higher income (14).

While the role of a GP partner includes running a business, there is no clear definition of what business skills are needed for this role. The RCGP curriculum for GPST includes: “developing the financial and business skills relevant for your role” (16) but does not elaborate further on what this may entail. GPST learning in this area is assessed through various components of the membership examination (MRCGP): the Applied Knowledge Test (AKT), a leadership activity, quality improvement projects and workplace-based assessments (16). However, it is not known how prepared First5 GPs considered themselves to be for the business aspects of partnership.

This study aimed to identify the learning needs of First5 GPs in NHS Scotland relating to GP partnership and the business aspects of general practice. It aimed to identify the learning opportunities during their GP specialist training and in the first five years of post-CCT work, and to explore their suggestions of additional resources that would improve their sense of preparedness for partnership. A secondary aim was to explore what influenced their current choice of employment model and place of work.

Method (594 excluding box 1, 732 including box 1)

A qualitative research approach using Charmazian grounded theory methods was used to explore the perceptions and experiences of First5s in relation to their learning needs of GP partnership and the business of general practice (17). A qualitative approach using semi-structured interviews was considered appropriate as it allows researchers to question participants and identify the underlying reasons for their perceptions and experiences. This would not be possible using data collection instruments such as questionnaires. The study design consisted of a recruitment stage, data collection and data analysis, undertaken by three researchers.

The researchers

The first and second authors had some experience of qualitative research and were First5 GPs in clinical practice, one being female and one male. The third author is an experienced male qualitative researcher, with a doctoral qualification in this research field, and an experienced GP.

Recruitment

First5 GPs, who were working in NHS Scotland and had completed GP training in the UK within sixty months of the beginning of the research period, were included in the study. A purposive sampling strategy was used to maximise diversity of perceptions and experiences. A sampling grid was constructed that included remote and rural GPs, those working in areas of deprivation, and the 14 territorial boards in NHS Scotland. The sampling grid included different employment models such as salaried GPs, partners, locum GPs and Out-Of-Hours practitioners. First5s were contacted by email by one researcher and invited to take part in a focus group or one-to-one interview. Focus groups allow for interactions between the individuals taking part in this type of interview, whereas in-depth interviews enable further exploration of individual's

thoughts and perceptions in a private setting. (18) Their preferences and availability for either data collection method determined whether they took part in either method. Further recruitment took place at a conference for First5 GPs organised by NHS Education for Scotland (NES).

Participants were sent a study information sheet giving details of its aims. They signed a consent form giving permission for their discussion to be audio-recorded and transcribed. An assurance was given that discussions would be confidential and transcripts anonymised. A professional fee of £75 was offered to participants to compensate for loss of earnings in recognition that some were working as self-employed locums or working in Out-Of-Hours Services.

Data collection

A question topic guide (See box 1) for the semi-structured interviews was constructed by the researchers, based on the current literature, and after discussions among the research team.

Box 1: Question topic guide

1. What are your thoughts about GP training preparing you for the business and managerial aspects of being a GP partner?
2. How do you think GP training could be improved to better prepare trainees for the business and managerial aspects of being a partner?
3. What are your impressions of what it's like to be a GP partner?
4. What are some of the advantages and disadvantages of being a GP partner?
5. What are your thoughts on being a GP partner?
6. What would make you feel better prepared for partnership?
7. How would you like to learn about being a GP partner?
8. Who would you want to learn from?
9. When is the best time to start learning about partnership?
10. How much would you be willing to pay to access your preferred course?

Individual interviews and focus groups were held in mutually agreeable settings or by telephone or using video-conferencing technology. Interviews were held several

weeks apart allowing researchers time to listen to audio-recordings, examine transcripts and make adaptations to questions posed to subsequent participants, thus adopting an iterative approach. Transcripts were prepared by NES clerical staff. Recruitment ended when data saturation was achieved. This was judged by the research team when no new perceptions and experiences were found from participants as the interviews and analysis progressed and confirmed by undertaking two further interviews to be sure of this.

Data analysis

Transcripts were checked against the audio-recordings and corrections made by researchers. Transcripts were read and re-read independently by researchers who undertook initial analysis of the interviews they had undertaken. Data analysis followed the ground theory methods described by Charmaz: codes were constructed and brought together into themes(17). Coding was undertaken separately by the researchers who met at regular intervals to discuss and agree emergent themes. Any themes causing disagreement were discussed and talked through until the research team reached agreement. Analytical memos were written and shared by the researchers.

Results (1568 including boxes, figures and raw data quotes, excluding tables)

Twenty-seven First5 GPs participated in the study and were interviewed between August 2019 and November 2019. Seven participated in one-to-one interviews which took place in their GP practice or in their home. Twenty participants took part in three focus groups of six or seven participants, each lasting up to one hour, and held at the NES CPD conference for First 5 GPs. There were no co-participants or observers. There were 18 female and nine male participants who worked between four and ten sessions per week (one session equates to approximately four hours of work (19)). Participants were drawn from 11 of the 14 territorial boards in NHS Scotland. Two participants were working in remote and rural areas as defined by The Scottish Government (20). Participants worked across a range of different employment models, with 15 working in more than one model (See table 1). A few participants were acquainted with the two First Five GP researchers but none were known to the senior researcher. This was in keeping with the researchers being drawn from the First Five GP community in NHS Scotland. Participants were aware of the research topic via the study information leaflet.

Table 1: Number of participants in each employment model

Employment Model	Number of Participants
Locum	7
Out-Of-Hours	8
Partner	9
Salaried	12
Other (advisory roles, specialist interests, clinical management, medical education, fellowships, military work)	8

Data saturation was achieved by the third focus group interview.

Three themes were constructed and are presented in Box 2.

Box 2: Identified themes

- Preparedness for partnership from experiential learning in GP Specialty Training (GPST)
- Perceived business learning needs and preferred learning styles (with learning needs arranged into five topic areas)
- Considerations that inform decision-making about choice of employment model and choice of practice

Preparedness for partnership from experiential learning in GP Specialty Training

Some participants were attracted to general practice because it gave opportunities to develop business skills, but others did not see this as part of their role in the future. To some extent, this was influenced by First5s' experiences during GPST. Most participants felt the focus of GPST was the development of a minimum level of clinical competence required to be a safe and independent clinician as reflected in the RCGP training curriculum and the MRCGP examination.

> *"You spend your three years just trying to get through the AKT* [Applied Knowledge Test] *and CSA* [Clinical Skills Assessment] *and ideally you don't want to kill anybody when you become a GP."* (Participant 26)

During GPST, participants were introduced to the non-clinical roles of a partner to widely contrasting extents. Some had no involvement in the business of general practice which contrasted with others who were regular attenders at practice business meetings. The quality of experience was dependent on the initiative of the trainee, the attitude and inclusivity of the trainer, and the business transparency of the practice.

Participants who were included in business discussions when trainees, perceived a greater level of trust and belonging within the practice team, and were less intimidated

by the future role of the GP partner. In contrast, others described being excluded from business discussions, perceiving these topics to be out-of-bounds for them as GP trainees. They described the complexity, risks and uncertainty surrounding the concept of partnership, and on completion of training lacking confidence in their ability to fulfill that role.

> *"When I was a GP trainee, whenever they had their business meetings, I often got asked to leave the room. So, there's always this taboo as to what actually do you do in your tax meetings?"* (Participant 11)

When asked how they would like to learn about the business of general practice, participants had a preference for gradual exposure throughout training, grounded on real-life experiences, with more targeted learning nearing the point of transition to partnership.

> *"I think if you had something that gave you an idea about what the kind of roles and responsibilities were, maybe even a couple of case examples, then that would be a good basis for which to build on that experience."* (Participant 20)

Discussions using anonymised or fictitious business information were perceived as an alternative to disclosing sensitive business and financial information to GP trainees. Participants expressed reservations about tackling this topic in single stand-alone sessions. Day-release sessions, when GP trainees from an area attended for formal teaching, were seen as opportunities to gain insight into the differences between local practices. Other suggestions included increasing the time spent in general practice during the training programme and clearer guidance in the training curriculum on how this topic could be learned.

Perceived business learning needs and preferred learning styles

Participants preferred to learn about the business of general practice from supportive and experienced partners in their training practice.

> *"I do feel that it's on the job training that's going to allow you to do it."* (Participant 15)

External educational resources were viewed as complementary to learning from the training practice: offering learning on how to mitigate against possible "worst-case scenarios", opportunities to ask questions to subject experts, and to learn from peers at a similar career stage. Preferred learning methods and resources included face-to-face courses, interactive small group online learning or teaching sessions that were scheduled during the working week.

> *"It needs to be kind of smaller numbers of people to properly get their heads round it and ask questions."* (Participant 12)

There was a preference for speakers to be GPs, practice managers or relevant professionals such as lawyers and accountants, and for presentations to be delivered without commercial attachments and contextualised to primary care.

> *"I think I would definitely want a GP as one of them, and possibly a non-GP, someone that knows more about the business side or how other companies are run."* (Participant 5)

Most were not opposed to paying up to £200 for a full day learning event.

The learning needs of the business of general practice identified from participants were grouped into five topic areas and structured by the research team into specific learning objectives as shown in Figure 1.

Enter Figure 1 about here

Considerations that inform decision-making about employment model and choice of practice

Each of the employment models shown in figure 1 were perceived to have its own advantages and disadvantages and these are listed in figure 2. Despite many participants expressing views on their preferred model at the time of completing training, as participants gained experience over time, they gradually changed their personal priorities

> *"I came out of GP training saying I was never going to be a partner. Famous last words!"* (Participant 14)

The decision-making process about each employment model was a complex one, taking into consideration their perceptions of what each role had to offer, their preparedness to settle in a geographical area, its compatibility with their personal life goals, and whether an opening was available in their preferred practice. Partners were commonly perceived as having ultimate responsibility for the practice and the role was associated with a degree of permanence. Positive remarks about partnership included having a greater degree of autonomy over their working environment, setting the strategic direction of the practice and experimenting with new ways of working. Continuity of patient care and with the practice team were valued.

> *"We can actually make change and then I can see that come out."* (Participant 23)

Some described a sense of natural progression into the role of a GP partner with many considering partnership for the first time during their First5 years. Negative perceptions of partnership included a feeling that partners were overwhelmed and overworked. Being responsible for keeping a practice running in an environment where recruitment was challenging, and the unclear consequences of the New GP Contract in Scotland, were seen as risky.

> *"I think of people* [partners] *being under a lot of pressure and just bursting at the seams with roles and responsibilities and low on time and resources."* (Participant 22)

The perceived advantages of salaried GP roles included having employment rights, such as maternity leave, and of having income stability. Salaried GPs were considered to have a greater sense of parity among members of the healthcare team particularly in NHS Board-managed practices. The main disadvantage of this role was thought to be a sense of frustration with their lack of influence in decision-making within the practice.

> *"I've come to realise, I want to be part of that inner circle."* (Participant 20)

The greatest attractions to working as a locum GP and in the Out-Of-Hours service were the desire to work in a range of different environments, and to create time after the intensity of training. This allowed time to consider professional options and personal life choices.

> *"We are in a culture now as GPs where we're very flexible, very sought after, very well paid as locums."* (Participant 7)

Figure 2 is a summary of the push and pull factors that affected the choice of different employment models

Insert Figure 2 around here.

Participants were selective about the practice they considered for permanence and chose a practice they were familiar with: usually having spent time there as a trainee, or as a salaried or locum GP. This allowed for a period of observation when they assessed whether the practice had the desired characteristics they were looking for. These included having partners who demonstrated a good work-life balance, were receptive to innovation, and were perceived as being supportive to new partners. An inclusive and experienced practice team in a desirable location was valued.

> *"A practice I used to locum at has asked me to be salaried with a view to partnership next year. The reason I'm taking it on is because they're a great team. They've got a good working culture. They've got up to date admin protocols and they seem to have a good work/life balance."* (Participant 21)

Factors that made partnership feel less risky included partnerships with stable finances, with no capital investment needed from new partners, and where most partners were not approaching retirement.

Discussion (745 words)

Main findings

This study identified three main themes from interviews with First5 GPs in NHS Scotland. First5 GPs had variable experiences of learning about the business of general practice during GPST. Learning opportunities varied considerably for GP trainees and some felt excluded from business meetings during training. We identified five main themes relating to the learning needs of the business of general practice. We identified the 'push' and 'pull' factors of a range of employment models and identified how these influenced First5 GPs in decision-making regarding their employment model and place of work.

Preparedness for partnership and perception of risk associated with partnership were heavily influenced by trainees' learning experiences during training. These were varied and unstructured and largely dependent on the initiative of trainees, trainers and the transparency of practice. First5 GPs would like to have gradual exposure to the business of general practice throughout GPST with targeted learning at the time when they were considering partnership. For most participants this was after CCT. First5 GPs preferred to learn from supportive colleagues and valued access to complementary educational resources contextualised to their work experience. They wanted to learn from experienced GPs, First5 peers and subject-area experts through mentorship or small group work. First 5s were interested in having an overview of topic areas identified rather than in-depth knowledge, with sign-posting to resources they could return to, as their learning needs evolved.

Strengths and limitations

This study identified a number of influential factors that determined the employment model chosen by First5 GPs and adds usefully to the scant literature of this area. Participants were drawn from 11 of the 14 NHS boards in Scotland, and they had experience of working in a range of practices and employment models. Participants had experience of working in areas of deprivation and remote and rural areas. Data saturation was achieved and confirmed. The research team combined current First 5s GPs in NHS Scotland with an experienced GP researcher: bringing complementary skills and a range of viewpoints to the study. All three worked in different NHS boards in Scotland.

The study had limitations. Social networks were used to recruit participants including those who attended a large NES conference aimed at First5 GPs. This may have biased their responses in interviews. The study involved participants working in NHS Scotland only: the other three countries of the UK were not included in the study. Employment opportunities in general practice differ amongst the four nations. For example, NHS England has additional business models such as super-practices and practice federations which are not seen in NHS Scotland (5). Learning needs were assessed from the perspective of First5 GPs only: future research could consider how this perspective compared with the views of experienced GPs and trainers.

Comparison with existing literature

This study supports earlier findings that decision making on choice of employment model is complex, and is influenced by training experiences (7) (9) (13) (14). It takes into account perceptions of the advantages and disadvantages of different career options in relation to professional and personal goals. The findings complement the

quantitative study which identified that the choice of employment model is fluid during the First5 years (9). We have described how this is influenced by the accumulation of professional experiences and a weighing-up of the opportunities that arise in the context of changing personal circumstances of the First5s themselves.

Implications for further research and change in practice

In some countries in the UK, GP training schemes are set to extend the time spent in clinical general practice. It would be important to identify if this leads to greater exposure of GP trainees to the business of general practice and if there are improvements to their perceptions of readiness to enter partnership. Some participants considered that their learning experiences of the business of general practice during GPST did not allow them to gain the necessary confidence to enter partnership. Trainees' experiences varied considerably amongst participants. Those GP trainees who were trusted with confidential information and included in business meetings were more confident about these matters. UK training authorities should be more aware of this variation and encourage practices to be open and transparent about the business of general practice. Further learning opportunities at a local or regional level would be valued by trainees and training authorities should consider how best to deliver this education. Other learning materials and resources from accountants and solicitors regarding practice financial statements and partnership agreements would be welcomed by First5 GPs.

Acknowledgments

The authors would like to thank all participants and administrative staff in NES who helped in this study. The authors thank the Scottish Government for its support of the First 5 GPs educational and research service within NES. The authors would like to thank Dr Kenneth Lee and Dr John Nicol from NES for their editorial advice.

Contributors

DC conceived the study, recruited the research team and searched the existing literature. RL and GR collected the data and analysed it with DC. RL wrote the manuscript with contributions from DC and GR. DC edited the manuscript.

Funding

The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sector.

Competing Interests

DC is an Assistant Director within NHS Education for Scotland and provides CPD resources to GPs and their teams in Scotland. GR was a medical education fellow within NES. All authors were practising GPs in NHS Scotland at the time of the research project.

Patient and public involvement

Patients and the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required

Ethical Approval

Under UK 'Governance Arrangements for Research Ethics Committees', ethical research committee review is not required for service evaluation or research which, for example, seeks to elicit the views, experiences and knowledge of healthcare

professionals on a given subject area. Similarly, 'service evaluation' that involves NHS staff recruited as research participants by virtue of their professional roles does not require ethical review from an established NHS research ethics committee.

Provenance and peer review Not commissioned, externally peer reviewed

Data availability statement Data are available on reasonable request. Data include transcripts of audio recordings of interviews and regarded as being confidential. Participants did not consent to this data being shared.

ORCID ID

David E Cunningham http://orcid.org/0000-0002-0415-9807

References

(1) Information Services Division *Primary Care Workforce Survey Scotland 2017* NHS National Services Scotland 2018 Available at: https://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/Workforce/national_primary_care_workforce_survey.asp (Accessed 5th May 2022)

(2) Gibson J, Sutton M, Spooner S, Checkland K. *Ninth National GP Worklife Survey 2017.* Policy Research Unit in Commissioning and the Healthcare System 2017

(3) The Royal College of General Practitioners. *First5*. Available from: www.rcgp.org.uk/first5 (Accessed 5th May 2022)

(4) Taylor C, Parsons J, Sparrow N et al The First5 Concept *Br J Gen Pract* 2011 61(582) 72-73

(5) Department of Health and Social Care. *GP Partnership Review: Final Report* Available from: www.gov.uk/government/publications/gp-partnership-review-final-report (Accessed 5th May 2022)

(6) Public Health Scotland *General Practice: GP workforce and practice list sizes* Available from www.isdscotland.org/health-topics/general-practice/workforce-and-practice-populations/ (Accessed 5th May 2022)

(7) Nosa-Ehima M. *Through the eyes of GP trainees: workforce of the future* Available from https://www.kingsfund.org.uk/blog/2018/08/gp-trainees-workforce-future (Accessed 5th May 2022)

(8) Hunter A. *The future of general practice: the view of GP trainees* Available from https://www.kingsfund.org.uk/blog/2019/12/future-general-practice (Accessed 5th May 2022)

(9) Dale J, Russel R, Scott E, et al. Factors influencing career intentions on completion of general practice vocational training in England: a cross-sectional study *BMJ Open* 2017;(7):e017143

(10) Wessex Local Medical Committees *GP Workforce Survey 2018* Available from https://www.wessexlmcs.com/gppartnershipreview (Accessed 5th May 2022)

(11) The Scottish Government GMS Contract Available from https://www.gov.scot/publications/gms-contract-scotland/pages/14 (Accessed 5th May 2022)

(12) Starfield B (1992) Primary Care: Concept, Evaluation and Policy. Oxford University Press, New York, USA

(13) Evans J, Lambert T, Goldacre M. GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice *Occas Pap R Coll Gen Pract* 2002 Feb;(83):iii-vi, 1-33

(14) Bregazzi R, Harrison J. Factors influencing career choice: Experience from GP Career Start in County Durham *Educ Prim Care* 2002;13:477-489

(15) Cunningham DE, Ward C, Kyle J and Yeoman L. The Learning Needs, Preferred Learning Methods, and Learning Challenges of First Five General Practitioners in NHS Scotland: A Qualitative Study *BMJ Open* 2021;11:e044859

(16) Royal College of General Practitioners *Training* Available from www.rcgp.org.uk/training-exams/training.aspx (Accessed 5th May 2022)

(17) Charmaz K. *Constructing Grounded Theory* 2nd Edition. London: Sage; 2014

(18) Barbour R Making Sense of Focus Groups Medical Education 2005;39:742-750

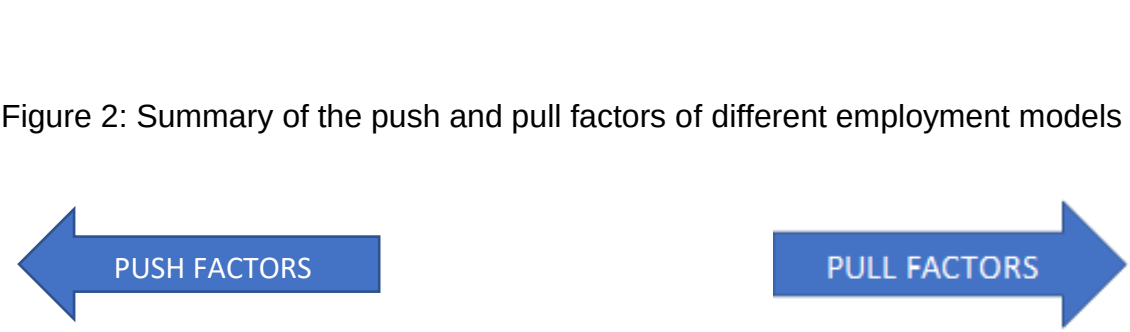
(19) British Medical Association *Job Planning for GPs* Available from https://www.bma.org.uk/pay-and-contracts/job-planning/job-planning-process/job-planning-for-gps (Accessed 5th May 2022)

(20) Scottish Government. Scottish Government Urban Rural Classification 2016. Available from https://www.gov.scot/publications/scottish-government-urban-rural-classification-2016/pages/2/ (Accessed 5th May 2022)

Figure One
NATIONAL GP CONTRACT • Describe NHS Scotland and Health and Social Care Partnership structures • Recognise practice interfaces with the NHS, and influence change via clusters of GP practices, Local Medical Committees, NHS boards, and other NHS bodies • Identify local contacts for service planning • Explore the differences in funding structure between General Medical Services (17J), Personal Medical Services (17C) and Health Board run (2C) practices • Distinguish between core funding activities and optional additional services • Discuss implementation of the new contract
PRACTICE ACCOUNTING • Interpret practice accounts: income, expenses, capital accounts, drawings, taxation and pensions • Recognise natural variations in accounts over time • Predict how practice decisions affecting income and expenses can affect drawings • Explain the first tax bill as a partner and how to prepare for it • Have an overview of different practice structures, including Partnerships, Limited Liability Partnerships and “super-practices”
PARTNERSHIP AGREEMENTS • Describe partnership agreements, their legal implications, and the consequences of not having a partnership agreement • Give examples of different options for clauses within a partnership agreement e.g. maternity and parental leave, last man standing, sickness • Define responsibilities of partners and compare with those of a practice manager • Describe communication strategies to lessen conflict between partners • Describe scenarios resulting in practice closure, explore options for practices in difficulty, including ending a NHS Contract, and protecting partners from bankruptcy
HUMAN RESOURCES • Recognise the responsibilities of an employer and the rights of employees • Describe what is involved in hiring new staff, conducting interviews, training staff and supporting their development • Describe approaches for handling staff grievances and disciplinary processes • Clarify the role of practice policies and procedures, including handling complaints
LEADERSHIP AND MANAGEMENT • Explore the characteristics of an effective partnership and a well-run practice • Describe how to create a culture that reflects the values of a practice • Discuss practical approaches for managing change and innovation in primary care • Explore aspects of resilience and self-care as a partner and preventing burnout

Figure 2

Figure 2: Summary of the push and pull factors of different employment models



Overworked Difficult to recruit partners Difficult to leave Pressure on work-life balance More administrative work New contract uncertainty Lack of business knowledge	**Partnership**	Autonomy within practice Innovation Continuity of patients/colleagues Higher income Interest in medical education
Less influence in practice Lower income	**Salaried**	Clinical role only No business risk Guaranteed maternity leave Stable working hours Flatter hierarchy
Lack of income security Lack of continuity	**Locum or Out-of-Hours**	Flexibility Variety Portfolio careers

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the inter view or focus group?	
Duration	21	What was the duration of the inter views or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	
Software	27	What software, if applicable, was used to manage the data?	
Participant checking	28	Did participants provide feedback on the findings?	
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	
Clarity of major themes	31	Were major themes clearly presented in the findings?	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.