

## **Seventh National GP Worklife Survey**

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## **Executive summary**

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National surveys of GPs' working conditions and attitudes to primary care reforms were undertaken by the National Primary Care R&D Centre in 1998, 2001, 2004, 2005, 2008 and 2010. We undertook the seventh survey in this series in the autumn of 2012.

The surveys provide a consistent series over a long period on GPs' job satisfaction, stressors, hours of work and intentions to quit. Each survey has a nationally-representative, cross-sectional element and a longitudinal element. In 2012, there were 1,189 respondents in the cross-sectional element and 2,015 respondents in the longitudinal element. This report provides key findings from the survey and makes comparisons with previous surveys.

### **Clinical commissioning**

Thirteen percent of respondents had a formal role at Clinical Commissioning Group (CCG) level and a further fifteen percent stated that they were their practice's commissioning lead. The majority of respondents agreed that GPs added value to pathway/service design, needs assessment, improving relationships with providers and contract negotiations/monitoring. However, respondents were divided on whether commissioning was part of their role as a GP. Respondents expressed concerns about the impact that CCG introduction had had on their personal workloads, the time that they could spend on direct patient care and continuity of care. Respondents also reported that the introduction of CCGs had led to decreases in referrals and practice prescribing, and increased integration between primary and secondary care. Seventy-seven percent of respondents stated that their practice was a member of the most appropriate CCG. Sixty-eight percent of respondents thought that practice income should not be related at all to CCG performance.

### **Job satisfaction**

The level of overall job satisfaction reported by GPs in 2012 was lower than in all surveys undertaken since 2001. On a seven-point scale, average satisfaction had declined from 4.9 points in 2010 to 4.5 points in 2012 in both the cross-sectional and longitudinal samples. This change is robust to the changing age-sex composition of GPs, which has remained relatively stable in recent years. The largest decreases in job satisfaction between 2010 and 2012 were in the domains relating to 'hours of work' and 'remuneration'. The changes were much smaller in the other specific domains of job satisfaction.

## **Hours of work**

Respondents to the 2012 survey reported working an average of 41.7 hours per week. This is a small increase (0.3 hours) compared to the 2010 survey. The percentage of GPs who indicated that they worked at least one weekday evening session in a typical week had changed very little (58% in 2012; 57% in 2010), but the percentage who indicated that they worked at least one weekend session in a typical week had declined considerably (from 15% in 2010 to 10% in 2012). There was no change between 2010 and 2012 in the proportion of GPs reporting undertaking out-of-hours work: in 2012, 21% did so, for a median of 4 hours. Fewer GPs reported that their practice offered extended hours access at the weekend (32%) and on weekdays (76%) than in 2010. Respondents also reported devoting a similar percentage of their time to direct patient care (62%) as in 2010.

## **Stressors and job attributes**

In 2012, as in 2010, GPs reported most stress due to 'increasing workloads' and 'paperwork' and least stress due to 'finding a locum' and 'interruptions from emergency calls during surgery'. Reported levels of stress increased between 2010 and 2012 on all 14 stressors, generally by 0.2-0.4 points on a five-point scale. Reported levels of stress are now at their highest since the beginning of the National GP Worklife Survey series in 1998.

Many attributes of GPs' jobs had changed very little between 2010 and 2012. In 2012, the proportion of respondents reporting that they 'have to work very intensively' was 95% and 84% reported that they 'have to work very fast'. Fewer than 10% thought that recent changes to their job had 'led to better patient care'. However, 83% stated that their job 'provides me with a variety of interesting things'.

## **Intentions to quit**

The proportion of GPs expecting to quit direct patient care in the next five years had increased from 6.4% in 2010 to 8.9% in 2012 amongst GPs under 50 years-old and from 41.7% in 2010 to 54.1% in 2012 amongst GPs aged 50 years and over.

## **Conclusion**

The 2012 survey reveals the lowest levels of job satisfaction amongst GPs since before the introduction of the new contract, the highest levels of stress since the start of the survey series, and a substantial increase over the last two years in the proportion of GPs intending to quit direct patient care within the next five years.

## Background

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The National Primary Care Research & Development Centre undertook postal surveys of General Practitioners' working lives in 1998 (Sibbald et al., 2000), 2001 (Sibbald et al., 2003), 2004 (Whalley et al., 2005, 2006a), 2005 (Whalley et al., 2006b, 2008), 2008 (Hann et al., 2009) and 2010 (Hann et al., 2011). The seventh in this series was undertaken in the autumn of 2012.

This series of questionnaires spans over a decade and continues to provide a unique resource for tracking long-term trends, as well as identifying the key policy and environmental issues impacting on GPs' working lives.

The 2012 survey performed a number of important functions:

- to contribute to the ongoing tracking of GPs' satisfaction and pressures at work through a series of primary care reforms;
- to provide further evidence on trends in GPs' hours, activities and intentions to quit general practice; and
- to gauge GPs current involvement in, and opinions on, clinical commissioning, at the point where CCGs were being established in shadow form and prior to their role in commissioning coming into effect formally from April 2013.

## Methods

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The data were collected via a postal questionnaire survey administered to a sample of GPs between September and November 2012.

### Target sample

The target sample consisted of GP providers, salaried GPs and GP retainers practising in England. Data were obtained from:

- the annually collated General Medical Services (GMS) Statistics database maintained by *The Information Centre for health and social care*<sup>1</sup> (containing GMC number, age, gender and contract status of all GPs in contract with the NHS in England as of 1<sup>st</sup> October each year); and
- NHS Prescription Services data available from Connecting for Health (at <http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods/genmedpracs>), which records contact data for current (and historical) GP prescribers.

Following the methodology employed in previous surveys, two samples of GPs were drawn from the subset present on both the 2011 GMS Statistics database and the prescriber list:

1. A cross-sectional sample - a random sample of 3,000 GPs, excluding GP registrars, representing approximately 1/12<sup>th</sup> of the GP population;
2. A longitudinal sample of 3,280 GPs who responded to: the 2010 survey (2,350 GPs); the 2008 survey but not the 2010 survey (855 GPs); or to all three of the surveys conducted in 2001, 2004 and 2005 (75 GPs).

The random sample of 3,000 GPs was drawn first. Those GPs eligible for the longitudinal sample but not already selected as part of the random sample (2,984 GPs) were added to form the overall study sample. After removing 'duplicate records' (e.g. individual GPs holding more than one contract for whom two had been selected), the final total target sample contained 5,973 GPs.

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## Response rate

Reminders were sent at three and six weeks after the initial mailing. Each mailing included a covering letter, the survey questionnaire and a reply-paid envelope. Respondents were asked to return the questionnaire blank if they did not wish to participate and wanted to avoid receiving reminders.

The response rate in the cross-sectional survey was 40% (1,189 of 2,995: up on the 36% achieved in the 2010 survey) and in the longitudinal sample was 62% (2,015 of 3,274: also up on the 59% achieved in the 2010 survey).

Some of the questionnaires were completed by a different GP to whom the invitation was addressed. Cross-referencing the age and gender reported by the respondent with that of the intended recipient recorded on the GMS Statistics database suggested that 251 of 1,167<sup>2</sup> questionnaires in the cross-sectional sample (21.5%) were completed by a different GP than the GP to whom the letter was addressed. Proportionately, this happened more frequently in the cross-sectional element of the survey than the longitudinal element (15.2%; 301 of 1,984<sup>3</sup>).

The achieved samples in previous GP satisfaction surveys have been reasonably representative of the entire GP populations at those times. Adjustments for observed differences between the achieved samples and the populations have made little difference to key statistics. Furthermore, while previous surveys have shown an inverse relationship between average satisfaction and response rates, previous analysis has shown that this relationship does not lead to bias in the estimated changes in mean satisfaction or in the estimated effects of the determinants of satisfaction (Gravelle, Hole and Hussein, 2008).

The age, gender and contract type compositions of the entire GMS database and the cross-sectional sample of respondents are summarised in Table 1. There is good representation of all groups. However, respondents aged between 50 and 59 are over-represented compared to the entire GP population, whilst other age groups are under-represented, especially the very youngest (under 35 years) and very oldest (60 years and over) groups. Respondents are more likely to be GP providers than in the GP population.

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<sup>2</sup> 22 questionnaires had missing age and/or gender.

<sup>3</sup> 31 questionnaires had missing age and/or gender.

**Table 1: Representativeness of the cross-sectional element of the survey**

	All GPs (2011 - excl. Registrars)	2012 Worklife Survey Respondents
N	34,245	1,189
<u>Age (years)</u>		
< 35	4,026 (11.8%)	89 ( 7.7%)
35 - 39	5,253 (15.3%)	161 (13.9%)
40 - 44	5,149 (15.0%)	147 (12.7%)
45 - 49	6,130 (17.9%)	190 (16.4%)
50 - 54	6,056 (17.7%)	285 (24.7%)
55 - 59	4,191 (12.2%)	209 (18.1%)
60 +	3,440 (10.0%)	75 ( 6.5%)
<u>Gender</u>		
Male	18,621 (54.4%)	631 (54.6%)
Female	15,624 (45.6%)	525 (45.4%)
<u>Contract type</u>		
Provider	26,827 (78.3%)	996 (86.2%)
Other + Locum	7,418 (21.7%)	160 (13.8%)

Note: Information on age and/or gender and/or contract type was missing for 33 respondents.

### **Samples analysed**

Depending on the focus of the analysis, we use different samples throughout this report: (i) the cross-section sample only; (ii) the longitudinal sample only and (iii) a pooled sample, representing all respondents to the 2012 survey. The sample used for each table is indicated in the table notes. In general, where a question has been asked in previous surveys, and the primary purpose is to compare a representative sample of GPs in 2012 with a representative sample in earlier years, we include only the 1,189 respondents in the cross-sectional sample in 2012. Where possible we complement this analysis with analysis of the same individuals over time, using the 2010-2012 longitudinal sample. This serves to assess the robustness of the findings from the comparison of two repeated cross-sections and provides more detailed consideration of how the distributions of the variables have changed over time. Where a question has not been asked in previous surveys, and the primary purpose is an accurate representation of the current situation, we present figures based on all available responses from the pooled sample (e.g. in the clinical commissioning section).

### **Questionnaire content**

To permit tracking of long-term trends, many of the questions used in the 2012 survey were the same as those used in previous surveys. The questionnaire contained sub-sections covering: personal, practice, job and area characteristics; job stressors; job attributes;

intentions to quit or retire; job satisfaction; clinical commissioning; and the GPs' role in patient health, work and wellbeing. The main content is outlined below.

### ***Personal, practice, job and area characteristics***

Questions included: age; sex; contract type; estimated hours of work (during surgery hours and out-of-hours); estimated allocation of time between direct and indirect patient care and administration; and practice size (numbers of doctors, nurses and patients).

### ***Job stressors***

Respondents were asked to rate the amount of pressure they experience from each of 14 potential sources of job stress on 5-point response scales.

### ***Job attributes***

GPs were asked to indicate the extent to which they agreed or disagreed (on a 5-point scale) with 15 statements relating to their job control, workload, job design and work pressures.

### ***Intentions to quit or retire and other changes in work participation***

GPs were asked about the likelihood (rated on a 5-point scale) that they would make certain changes in their work life within five years, including: increasing work hours; reducing work hours; leaving direct patient care; and leaving medical work entirely.

### ***Job satisfaction***

Job satisfaction was measured with the reduced version of the Warr-Cook-Wall questionnaire that has been used in previous surveys. This asks about nine individual domains of job satisfaction as well as satisfaction overall. Each item in the measure is rated on a 7-point scale, ranging from 'extremely dissatisfied' (score=1) to 'extremely satisfied' (score=7).

### ***Clinical commissioning***

GPs were asked about their current involvement in clinical commissioning and any previous involvement in GP-led commissioning. They were also asked about the added value that GPs bring to commissioning and how the introduction of clinical commissioning groups had impacted on them and their patients locally.

### ***GPs' role in patient health, work and wellbeing***

This section of the questionnaire was developed for the 2010 survey in conjunction with policy customers in the Health Work and Well-being Delivery Unit, led from the Department for Work and Pensions. The 19 items selected relate to GPs' views on: the relationship of work to health; GPs' role, training and confidence in supporting patients with health problems into work; their views on the fit note; and the availability of services to support patients into work. The findings from this section of the questionnaire are available in a separate report (Hann and Sibbald, 2013).

## Clinical Commissioning

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### Current commissioning involvement

GPs were asked whether they currently had a role within the Clinical Commissioning Group (CCG) to which their practice belonged. Of 2,930 respondents, 383 (13%) reported having a formal role at CCG level (e.g. Office Holder; Committee Member; Workstream Lead). A further 441 GPs (15%) reported that they were commissioning lead for their practice (but did not have a formal role at CCG level).<sup>4</sup> These 824 GPs were asked to report how many hours per week, on average, they spent on this role: the reported median was 3 hours [IQR = (2, 8) hours; based on 598 responses].

Of those with a formal role, 114 (29.8%) were female. Of those who were their practice's commissioning lead, 136 (30.9%) were female. Overall, 34.4% of males have a CCG role versus 20.0% of females. GPs aged fifty years or over were the group most likely to have either a formal role (14.2%) or be their practices' commissioning lead (16.0%), compared to both GPs aged under 40 years (10.9% and 10.4% respectively) and GPs aged 40 to 49 years (12.1% and 15.5% respectively).

Over half of respondents (51%; N = 1,460) reported that another GP in their practice had a formal role at CCG level. GPs aged under 40 years were most likely to do so (55.2%), whilst GPs aged fifty years or over were least likely (49.4%). Only 2% (N = 58) reported that they did not know whether another GP in their practice had a formal role at CCG level.

When asked about their future involvement in clinical commissioning, less than 1 in 10 of GPs (9%; N = 252) indicated that they would like a formal role at CCG level in the future. Eight-three percent (N = 2,298) said that they did not want a formal role in the future, and 8% (n = 231) reported being undecided. GPs aged under 40 years gave the most positive response: 14.3% expressed their desire for such a role, compared with 7.4% of GPs aged 40 to 49 years and 8.7% aged fifty years or over.

### Previous commissioning involvement

GPs were asked about leadership roles that they had held in previous forms of GP-led commissioning (Table 2). Of 2,930 respondents, previous involvement with Practice Based

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<sup>4</sup> 23 GPs reported having both roles and are classified as having a formal role.

Commissioning (18.6%) and Primary Care Groups (16.0%) was most common. Only 46 GPs (1.6%) indicated that they had previously had a leadership role in Total Purchasing Pilots.

***Table 2: Leadership Role in Previous Forms of GP Commissioning***

Practice Based Commissioning	18.6%
Primary Care Groups	16.0%
Fundholding (inc. Community Fundholding)	13.9%
Primary Care Trusts	12.0%
Alternatives to Fundholding (e.g. Locality Commissioning)	7.0%
Total Purchasing Pilots	1.6%

Based on responses from the 2012 combined cross-sectional and longitudinal samples (N = 2,930).

### **Opinions on clinical commissioning**

More than two-thirds of respondents (68%) thought that practice income should not be related to CCG performance at all. Twenty percent of GPs thought that up to 5% of practice income was an appropriate figure. Only 3% of respondents thought that in excess of 10% of practice income should be related to the performance of CCGs.

More than three-quarters of GPs (77.1%) agreed that their practice was a member of the most appropriate CCG: only 3.9% disagreed, whilst 5.8% were uncertain.

GPs were 'split' as to whether commissioning was part of their role; 36.6% agreed to some extent whilst 41.0% disagreed to some extent. The percentage in agreement varied by age with GPs aged fifty years and over most likely to disagree to some extent (under 40 years = 34.3%; 40 to 49 years = 40.7%; fifty years or over = 42.6%). GPs aged under 40 years were the most likely to neither agree nor disagree. Table 3 shows respondents' views on the added value of GP involvement in clinical commissioning. The majority of respondents agreed to some extent that GPs added value to pathway and service design (86.7%), needs assessment (70.4%), improving relationships with providers (64.8%) and contract negotiation and monitoring (57.8%). Only a small minority of respondents disagreed with these statements or stated that they did not know if GPs added value.

**Table 3: Views on the added value of GP involvement in clinical commissioning**

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know
Commissioning is part of my role as a GP	15.3	25.8	21.2	28.9	7.8	1.1
GPs add value to needs assessment	2.5	5.4	18.0	53.0	17.4	3.7
GPs add value to pathway/ service design	1.5	1.7	8.3	53.8	32.9	1.8
GPs add value to contract negotiation & monitoring	4.3	12.8	21.7	39.9	17.9	3.5
GPs add value to improving relationships with providers	3.2	6.7	21.5	44.6	20.2	3.8
My practice is a member of the most appropriate CCG	1.3	2.6	13.2	42.7	34.3	5.8

Cell figures represent within-row percentages, based on responses from the 2012 combined cross-sectional and longitudinal samples. Range of N = 2,903 - 2,918.

Table 4 shows respondents' views on how the introduction of CCGs has affected aspects of their job, their patients and the local health economy. The vast majority of GPs (82.4%) indicated that their overall workload had increased to some extent following the introduction of CCGs. Only 6 respondents reported a decrease in their workload.

GPs were most likely to report that CCGs had not changed other aspects of their job, the care they provided, their patients and the local health economy. However, those who did report changes in these dimensions were likely to report a decrease rather than an increase in: the time they spent on direct patient care (35.2% decreased vs. 12.8% increased), the number of referrals they make (37.1% vs. 4.2%), practice prescribing expenditure (39.8% vs. 5.7%) and continuity of care for patients (31.8% vs. 8.8%). A greater percentage of GPs reported an increase rather than a decrease in the integration of primary and secondary care (22.2% vs. 17.6%).

**Table 4: GPs views on the introduction of Clinical Commissioning Groups**

To what extent have CCGs affected ...	decrease a lot	decrease a little	no change	increase a little	increase a lot	don't know
Your overall workload	0.1	0.1	15.1	37.7	44.7	2.3
Time spent on direct patient care	6.0	29.2	49.9	8.3	4.5	2.1
Number of referrals made	2.0	35.1	56.3	3.3	0.9	2.4
Level of practice prescribing expenditure	3.4	36.4	49.2	4.6	1.1	5.4
Integration of primary and secondary care	6.6	11.0	54.3	20.6	1.6	6.0
Continuity of care for patients	10.0	21.8	54.5	7.8	1.0	5.0
Health inequalities	2.3	8.6	68.5	8.1	4.0	8.5

Cell figures represent within-row percentages, based on responses from the 2012 combined cross-sectional and longitudinal samples. Range of N = 2,903 - 2,916.

### **Views on clinical commissioning by current CCG role**

The views of the 383 GPs with a formal role at CCG level were compared with those of the 441 practice commissioning leads and, where applicable, the 2,106 respondents who reported having neither role.

Those GPs with a formal role reported spending a median of 6 hours per week on this role [IQR = (3, 12) hours; based on N = 364], whilst practice commissioning leads reported spending a median of 2 hours per week on this role [IQR = (1, 3) hours; based on N = 234].

GPs currently in a formal role were more likely to have had leadership roles in all previous forms of GP-led commissioning (Table 5). For example, 58% had such a role in Practice-Based Commissioning, compared to 29.3% of current practice commissioning leads and just 9.2% of GPs currently with neither role.

**Table 5: Previous Leadership Roles in GP-led Commissioning by Current Role**

	Formal Role at CCG level	Practice Commissioning Lead	Neither Formal nor Practice Lead
Practice Based Commissioning	58.0%	29.3%	9.2%
Primary Care Groups	40.7%	19.7%	10.7%
Fundholding (inc. Community Fundholding)	25.6%	17.0%	11.1%
Primary Care Trusts	37.1%	14.1%	7.0%
Alternatives to Fundholding (e.g. Locality Commissioning)	19.6%	8.6%	4.4%
Total Purchasing Pilots	5.5%	0.5%	1.1%

Percentages are based on “Yes” responses from the 2012 combined cross-sectional and longitudinal samples.

Over half of the GPs currently in a formal role at CCG level (51%) expressed a desire to continue with this role in the future. However, this sentiment was not so popular amongst current commissioning leads (9% wanted a future formal role) or GPs with neither role (3% wanted a future formal role).

Table 6 shows respondents’ views on the added value of GP involvement in clinical commissioning by current CCG role. GPs with a formal role at CCG level were the most likely to agree to some extent (and, in particular, strongly so) that commissioning was part of their role as a GP; 76.3% responded in this way, compared to 50.1% of GPs who were practice commissioning leads and 26.6% of GPs who held neither position.

Respondents with a formal role were also most likely to agree to some extent and, in particular, strongly agree, that GPs added value to pathway and service design, needs assessment, improving relationships with providers and contract negotiation and monitoring. Again, practice commissioning leads were more likely to agree to some extent than GPs in neither role.

More than two-thirds of GPs with a formal role (67.2%) strongly agreed that their practice was a member of the most appropriate CCG. This figure was also considerably lower in the

other two groups (36.6% amongst practice commissioning leads; 27.9% amongst GPs with neither role).

**Table 6: GPs views on the added value of their involvement in clinical commissioning by current CCG role**

	current CCG role	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know
Commissioning is part of my role as a GP	Formal	4.7	8.4	10.2	43.1	33.2	0.5
	PCL	11.2	19.1	18.9	40.8	9.3	0.7
	Neither	18.1	30.3	23.7	23.8	2.8	1.3
GPs add value to needs assessment	Formal	1.6	1.6	8.4	42.2	44.5	1.8
	PCL	2.3	4.6	17.1	54.7	18.7	2.7
	Neither	2.7	6.3	20.0	54.6	12.2	4.2
GPs add value to pathway/ service design	Formal	1.3	0.0	2.4	26.1	68.7	1.6
	PCL	1.1	0.7	6.2	55.4	36.2	0.5
	Neither	1.7	2.2	9.8	58.6	25.6	2.2
GPs add value to contract negotiation & monitoring	Formal	1.6	6.3	13.4	38.5	38.7	1.6
	PCL	5.2	13.4	22.7	38.4	17.7	2.5
	Neither	4.6	13.8	23.0	40.4	14.1	4.1
GPs add value to improving relationships with providers	Formal	1.6	1.6	11.2	32.4	51.4	1.8
	PCL	4.8	5.7	19.8	49.3	18.4	2.1
	Neither	3.2	7.8	23.7	45.9	14.8	4.6
My practice is a member of the most appropriate CCG	Formal	1.6	1.6	5.8	21.0	67.2	2.9
	PCL	0.5	2.8	14.1	44.5	36.6	1.6
	Neither	1.4	2.8	14.4	46.3	27.9	7.2

Cell figures represent within-row percentages, based on responses from the 2012 combined cross-sectional and longitudinal samples. Range of N for Formal Role at CCG level = 381 - 383; for PCL = 434 - 440; for neither role = 2,082 - 2,095. PCL = Practice Commissioning Lead.

Table 7 shows respondents' views on how the introduction of CCGs has affected aspects of their jobs, their patients and the local health economy, by current CCG role. GPs that reported having a clinical commissioning role, regardless of this role, were more likely to indicate that their overall workload had increased to some extent than GPs reporting having neither role. The former group were also more likely to indicate, to some extent, a decrease in the time they spend on direct patient care (a considerable decrease for a significant minority with a formal role) and the number of referrals they make.

GPs with a formal role at CCG level were most likely to report a decrease in practice prescribing expenditure (51% did so) and indicate that they believed primary and

secondary care were now more integrated (47.5%). Their views on changes in continuity of care for patients and health inequalities were also more 'favourable' than practice commissioning leads and GPs with no CCG role, although these differences are much less pronounced than others.

**Table 7: GPs views on the effect of the introduction of CCGs by current CCG role**

To what extent have CCGs affected ...	current CCG role	decrease a lot	decrease a little	no change	increase a little	increase a lot	don't know
Your overall workload	Formal	0.0	0.0	7.6	31.9	60.2	0.3
	PCL	0.2	0.2	6.1	39.2	53.5	0.7
	Neither	0.1	0.1	18.3	38.4	40.0	3.1
Time spent on direct patient care	Formal	19.0	32.7	37.5	7.1	3.2	0.5
	PCL	5.2	44.8	39.6	7.1	3.0	0.5
	Neither	3.7	25.2	54.4	8.8	5.0	2.8
Number of referrals made	Formal	2.9	43.1	50.7	2.1	0.5	0.8
	PCL	1.6	40.5	53.2	3.2	0.7	0.9
	Neither	2.0	32.5	58.0	3.5	1.0	3.1
Level of practice prescribing expenditure	Formal	6.0	45.0	43.5	3.9	0.5	1.1
	PCL	3.6	36.1	53.5	3.4	1.4	2.0
	Neither	2.9	34.8	49.4	4.9	1.2	6.8
Integration of primary and secondary care	Formal	2.9	6.8	41.8	41.5	6.0	1.0
	PCL	8.6	9.8	56.7	20.6	1.1	3.2
	Neither	6.8	12.0	56.0	16.8	0.9	7.5
Continuity of care for patients	Formal	5.2	19.9	50.3	19.4	3.1	2.1
	PCL	11.4	20.5	57.1	7.7	0.9	2.5
	Neither	10.6	22.4	54.7	5.6	0.6	6.1
Health inequalities	Formal	2.1	19.6	66.3	6.3	2.1	3.7
	PCL	2.1	6.6	73.0	8.4	4.8	5.2
	Neither	2.4	7.0	68.0	8.4	4.2	10.1

Cell figures represent within-row percentages, based on responses from the 2012 combined cross-sectional and longitudinal samples. Range of N for Formal Role at CCG level = 379 - 383; for PCL = 440 - 441; for neither role = 2,084 - 2,093. PCL = Practice Commissioning Lead.

## Job Stressors, Job Attributes and Intentions to Quit

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### Job stressors

#### *Levels of job stressors in 2012*

Respondents were asked to rate 14 factors according to how much pressure they experienced from each in their job on a five-point scale from 'no pressure' (=1) to 'high pressure' (=5). Summary statistics for the cross-sectional sample are provided for each stressor in Table 8.

The stressors are ranked in descending order of the mean score. GPs reported most stress with increasing workloads, paperwork, having insufficient time to do the job justice, increased demand from patients and changes imposed by their primary care organisation. They reported least stress with interruptions by emergency calls during surgery and finding a locum. More than 8 out of 10 GPs reported experiencing considerable or high pressure from increasing workloads and paperwork. Just 3 out of 10 GPs experienced the same levels of pressure from interruptions by emergency calls and finding a locum.

The ranking of stressors by mean scores and the percentages reporting high pressure (4 or more) is very similar (particularly for the items generating the greatest stress levels) and we therefore use mean scores throughout the remainder of this section.

**Table 8: Levels of job stress in 2012**

Job Stressor	Cross-sectional sample	
	Mean rating	% reporting considerable/ high pressure
Increasing workloads	4.40	86.20
Paperwork	4.22	80.85
Having insufficient time to do the job justice	4.18	77.65
Increased demand from patients	4.05	74.81
Changes imposed from the PCO	3.98	69.91
Dealing with problem patients	3.70	58.26
Long working hours	3.68	59.19
Dealing with earlier discharges from hospital	3.62	56.06
Unrealistically high expectation of role by others	3.44	50.80
Worrying about patient complaints/ litigation	3.32	43.53
Adverse publicity by the media	3.26	44.02
Insufficient resources within the practice	3.15	37.37
Interruptions by emergency calls during surgery	2.92	29.30
Finding a locum	2.74	31.19

% considerable/high pressure = % rating 4 or 5. Range of N for cross-sectional sample = 1,151 - 1,183.

### ***Changes in job stressors from 2010***

The changes in mean stress ratings between 2010 and 2012 in the cross-sectional sample are shown in Table 9. The stressors are ranked from the largest increase in rating to the smallest increase in rating. Average stress ratings reported on the same questions in the 1998, 2001, 2004, 2005 and 2008 surveys are also shown.

On all 14 factors, average stress ratings have increased between 2010 and 2012. The greatest increases were observed in relation to increasing workloads, dealing with earlier discharges from hospital, unrealistically high expectations of the role by others, having

insufficient time to do the job justice and paperwork: an increase in excess of one-quarter of a 'point' was observed in mean stress ratings on these five factors since 2010. Very modest increases were observed in relation to finding a locum and adverse publicity from the media; other stressors increased by between 0.20 and 0.24 'points'.

On 6 of the 14 factors (workloads, dealing with earlier discharges from hospital, having insufficient time to do the job justice, paperwork, long working hours and dealing with problem patients), mean stress ratings are at their highest level since the beginning of the National Worklife Survey series. On 4 more factors (high role expectations by others, increased demand from patients, worries about patient complaints and insufficient practice resources), mean stress ratings are at their highest level since 2001.

**Table 9: Changes in mean job stressor ratings - cross-sectional samples**

Job Stressor	Mean Stress Rating							Change
	1998	2001	2004	2005	2008	2010	2012	'10 - '12
Increasing workloads	3.78	4.24	4.08	3.79	4.04	4.02	4.40	+0.38
Dealing with earlier discharges from hospital	2.93	3.21	3.25	3.14	3.23	3.27	3.62	+0.35
Unrealistically high expectation of role by others	3.17	3.53	3.20	2.70	3.14	3.11	3.44	+0.33
Having insufficient time to do the job justice	3.41	4.14	3.99	3.61	3.88	3.88	4.18	+0.30
Paperwork	3.47	4.18	4.15	3.86	3.97	3.96	4.22	+0.26
Increased demand from patients	3.77	4.09	3.74	3.62	3.70	3.81	4.05	+0.24
Changes imposed from the PCO	3.44	4.00	3.82	3.76	4.01	3.74	3.98	+0.24
Long working hours	3.13	3.60	3.43	2.90	3.41	3.44	3.68	+0.24
Worrying about patient complaints/ litigation	3.26	3.57	3.20	3.07	3.06	3.08	3.32	+0.24
Dealing with problem patients	3.50	3.42	3.28	3.13	3.37	3.48	3.70	+0.22
Insufficient resources within the practice	2.42	3.19	3.13	2.86	2.98	2.94	3.15	+0.21
Interruptions by emergency calls during surgery	2.87	2.94	3.00	2.73	2.75	2.72	2.92	+0.20
Finding a locum	2.71	3.19	3.64	3.24	2.45	2.61	2.74	+0.13
Adverse publicity by the media	2.66	3.57	3.09	2.86	3.65	3.20	3.26	+0.06

Stressors ranked from greatest positive change to least positive change between 2010 and 2012.

## **Job attributes**

Respondents were asked to indicate the extent to which they agreed or disagreed with a set of statements designed to measure the extent of job control, the nature of job design and work pressure. Responses were recorded on a five-point scale: strongly disagree, disagree, neither, agree, strongly agree.

### ***Levels of job attributes in 2012***

Table 10 shows that respondents were most likely to agree to some extent with the statements that they had to work very intensively (95%), that they had to work very fast (84.1%) and that their job provided a variety of interesting things (82.5%). In addition, approximately 7 out of 10 GPs agreed to some extent that they did not have time to carry out all their work, that they were required to do unimportant tasks, detracting from more important ones, but that they always knew what their responsibilities were. Respondents were least likely to agree with the statements that work relationships were strained (21.5%), clear feedback about their performance was received (21.4%) and that changes to the job in the last year had led to better patient care (10%). Sixty-two percent of GPs disagreed to some extent with this latter statement.

**Table 10: Job attributes in 2012**

Job Aspect	% disagree/ strongly disagree	% agree/ strongly agree
(W) Have to work very intensively	1.02	95.01
(W) Have to work very fast	3.13	84.09
(C) Job provides variety of interesting things	4.41	82.54
(P) Do not have time to carry out all work	11.67	73.37
(P) Required to do unimportant tasks, preventing completion of more important ones	11.75	71.17
(D) Always know what responsibilities are	11.82	70.19
(C) Choice in deciding how to do job	22.72	53.21
(D) Involved in deciding changes that affect work	32.46	46.32
(C) Working time can be flexible	33.08	41.71
(C) Choice in deciding what to do at work	32.83	38.66
(D) Consulted about changes that affect work	40.17	37.71
(C) I can decide on my own how to go about doing my work	31.50	37.68
(P) Relationships at work are strained	54.54	21.54
(D) I get clear feedback about how well I am doing my job	38.95	21.42
(D) Changes to job in last year have led to better patient care	61.96	9.97

(C) = Job Control, (W) = Workload, (D) = Job Design, (P) = Work Pressures. Figures are based on the 2012 cross-sectional sample. Range of N = 1,179 - 1,184.

### ***Changes in job attributes since 2010***

The percentage of respondents to the 2012 survey agreeing to some extent with each of the 15 statements are compared to previous surveys in Table 11. The percentage of respondents agreeing with statements regarding workload (fast/ intensive) and work pressures (insufficient time; unimportant tasks; relationships) has shown the greatest increase between 2010 and 2012: these are generally aspects of the job with which GPs also most frequently agree (and have done so since 2005). A greater percentage of GPs (+3.0%) in 2012, compared to 2010, also agreed to some extent that they received clear feedback about how well they were doing. All other aspects of job control and design showed a decline in the percentage of GPs in agreement in 2012. This was particularly evident in relation to being able to decide what to do and how to do the job and being involved in deciding changes that affected the job. Since 2005, GPs' responses imply that working speed and intensity have increased most (greatest positive change in agreement: +13%), but that changes to the job are not resulting in better patient care (greatest negative change in agreement: -20%).

**Table 11: Trends in Job Design and Work Pressures, Workload and Job Control**

Job Issue	% agree/ strongly agree				Change '10 - '12
	2005	2008	2010	2012	
(P) Do not have time to carry out all work	66.7	68.7	67.1	73.4	+6.3%
(W) Have to work very fast	70.7	77.1	77.9	84.1	+6.2%
(P) Required to do unimportant tasks, preventing completion of more important ones	69.7	71.7	67.2	71.2	+4.0%
(P) Relationships at work are strained	n/a	n/a	18.7	21.4	+3.7%
(W) Have to work very intensively	81.6	91.0	91.5	95.0	+3.5%
(D) I get clear feedback about how well I am doing my job	17.6	n/a	18.4	21.4	+3.0%
(C) Working time can be flexible	46.8	44.8	42.6	41.7	-0.9%
(D) Consulted about changes that affect work	34.4	34.6	39.7	37.7	-2.0%
(C) Job provides variety of interesting things	81.5	83.2	84.7	82.5	-2.2%
(D) Changes to job in last year have led to better patient care	30.1	13.6	13.2	10.0	-3.2%
(D) Always know what responsibilities are	57.8	68.3	73.5	70.2	-3.3%
(C) I can decide on my own how to go about doing my work	n/a	n/a	41.3	37.7	-3.6%
(D) Involved in deciding changes that affect work	48.7	48.8	50.5	46.3	-4.2%
(C) Choice in deciding how to do job	62.5	58.4	58.6	53.2	-5.4%
(C) Choice in deciding what to do at work	28.3	44.7	44.7	38.7	-6.0%

Notes: Job attributes are classified into four groups: (C) = Job Control, (W) = Workload, (D) = Job Design, (P) = Work Pressures. n/a indicates that these questions were not included in the survey that year. All figures are based on the respective cross-sectional samples.

## **Intentions to quit**

### ***Likelihood of leaving direct patient care***

Respondents were asked how likely they were to leave direct patient care within the next five years. This has been shown to be a valid predictor of intentions to quit and actual quitting behaviour (Hann, Reeves & Sibbald, 2011). For older GPs, intentions to leave direct patient care may be dominated by early retirement plans. Respondents were, therefore, asked at what age they planned to retire and how likely this was to happen. Using this information we can distinguish planned retirements from other reasons for leaving direct patient care.

Table 12 shows the likelihood of leaving direct patient care stratified by whether or not the GP was currently aged less than 50 years. Approximately 3 out of every 10 (31.2%) respondents indicated that there was a considerable or high likelihood that they would quit direct patient care within five years. Amongst those aged 50 years or over the corresponding figure was over half (54.1%), with the vast majority of these (241 out of 306 = 78.8%) indicating that the likelihood was high. In contrast, fewer than 1 in 10 GPs aged under 50 years indicated that there was a considerable or high likelihood of leaving direct patient care within five years (8.9%): more than half (52.8%) stated that there was no likelihood.

***Table 12: Likelihood of leaving ‘direct patient care’ within five years in 2012***

Likelihood of leaving ‘direct patient care’ within five years (2012)	All GPs (N = 1,149)		GPs aged <50 (N = 583)		GPs aged ≥50 (N = 566)	
	N	%	N	%	N	%
None	408	35.5	308	52.8	100	17.7
Slight	250	21.8	155	26.6	95	16.8
Moderate	133	11.6	68	11.7	65	11.5
Considerable	92	8.0	27	4.6	65	11.5
High	266	23.2	25	4.3	241	42.6

Figures are column percentages based on the cross-sectional sample in 2012. The GPs’ age was missing in 16 cases (where ‘likelihood of leaving’ had been expressed): these are excluded from the analysis.

Of the 566 GPs aged 50 or over (average current age = 55 years), 551 reported the age at which they planned to retire. The average reported age of planned retirement was 61 years, with a range of 52 to 76 years. When asked how likely it was that this would happen, 34.5% stated 'definite', with another 42.7% 'very likely' and 21.4% 'quite likely'. Over half (55.2%, 304 of 551) of the respondents aged 50 or over planned to retire at an age within the next five years, and 87.2% of these said that it was either definite or very likely that this would happen. Only 11 of the 509 respondents aged under 50 (2.2%) who reported the age at which they were planning to retire reported an age that was within the next five years.

Table 13 shows that 'intentions to quit' are at their highest levels compared to previous surveys. The percentage of all respondents to the 2012 survey expressing considerable or high quitting intentions is considerably greater than in 2010. This is, in the main, due to the increase in quitting intentions expressed by GPs aged 50 or over.

**Table 13: Trends in Intentions to Quit**

Considerable/high intention to leave direct patient care within five years	All GPs	GPs aged <50	GPs aged ≥50
1998	15.3%	5.6%	n/a
2001	23.8%	11.4%	n/a
2004	23.7%	13.1%	n/a
2005	19.4%	6.1%	41.2%
2008	21.9%	7.1%	43.2%
2010	21.9%	6.4%	41.7%
2012	31.2%	8.9%	54.1%

n/a indicates that these figures were not presented in the corresponding reports/articles. All figures are based on the cross-sectional samples in the respective years.

### ***Likelihood of changing working hours***

Respondents were also asked to indicate whether the likelihood that they would either increase or (separately) reduce their working hours within the next five years. Possible responses to both questions were: none; slight; moderate; considerable; and high.

Table 14 shows that the majority (63%) of all respondents stated that there was no likelihood of them increasing their working hours over the next five years. Approximately 22% reported that there was a moderate, considerable or high likelihood. As with

intentions to quit, there were notable differences between GPs aged less than fifty and GPs aged fifty and over: in the former group, 29.4% stated that there was a moderate, considerable or high likelihood of working increasing hours, whereas in the latter group this figure was 13.7%. Five percent of GPs in each age stratum indicated a high likelihood of increasing their working hours. Over half of all respondents (55.7%) reported that there would be a moderate, considerable or high likelihood that they would be reducing their working hours within five years. However, nearly as many GPs reported that there would be no likelihood of working reduced hours as a high likelihood. Again, there were differences by age: a greater likelihood of reducing working hours was more prevalent amongst GPs aged fifty and over (74.2% moderate, considerable or high) than GPs aged less than fifty (37.8%). Almost half of the former group expressed a high likelihood of so doing.

**Table 14: Likelihood of changing working hours within five years in 2012**

Likelihood of changing working hours within five years (2012)	All GPs		GPs aged <50		GPs aged ≥50	
	Increase	Reduce	Increase	Reduce	Increase	Reduce
	%	%	%	%	%	%
None	62.9	25.6	50.7	36.9	75.7	13.9
Slight	15.4	18.7	20.0	25.3	10.7	11.9
Moderate	8.4	12.5	12.3	14.5	4.3	10.3
Considerable	8.3	14.6	12.0	12.0	4.4	17.3
High	5.1	28.6	5.1	11.3	5.0	46.6

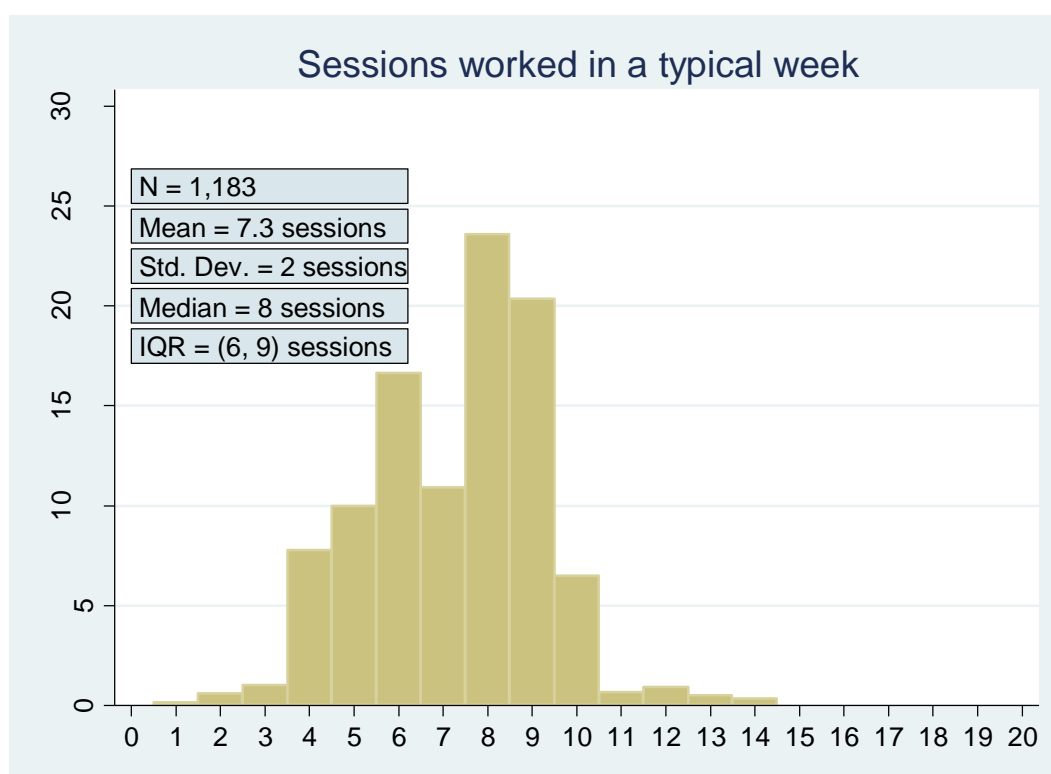
Figures are column percentages based on the cross-sectional sample in 2012. N = 1,149 for 'increase hours' (586 <50; 563 ≥50); N = 1,147 for 'reduce hours' (585 <50; 562 ≥50). GPs whose age was missing were excluded from the analysis.

## Hours of Work

### *Sessions worked per week in 2012*

We asked respondents how many sessions they worked in a typical week. Figure 1 shows that, in 2012, respondents most frequently reported working either 8 or 9 sessions per week, with a secondary peak at 6 sessions (corresponding to part-time working). The median number of sessions worked in a typical week was 8 (inter-quartile range = 6 to 9), whilst the mean number was 7.3 sessions per week (standard deviation = 2 sessions). The mean number of sessions worked in 2012 is lower than that observed in the 2010 survey (7.5 sessions; standard deviation = 2 sessions). Table 15 reveals that the reason for this is the substantial decline (approximately 6%) between 2010 and 2012 in the number of GPs working more than 8 sessions per week (in particular, 8.5 or 9 sessions per week), and the corresponding increase in the number of GPs working between 4 and 7 sessions per week (in particular, 5.5 or 6).

**Figure 1: Distribution of sessions worked in a typical week in 2012**



Data are based on the cross-sectional sample in 2012.

**Table 15: Number of Sessions Worked in 2010 and 2012**

	2010	2012
Number of sessions worked in a typical week	% of GPs	% of GPs
#sessions ≤ 4	9.5	9.6
4 < #sessions ≤ 5	9.0	9.9
5 < #sessions ≤ 6	12.9	16.7
6 < #sessions ≤ 7	9.6	11.0
7 < #sessions ≤ 8	23.7	23.4
8 < #sessions ≤ 9	25.0	20.5
9 < #sessions ≤ 10	6.8	6.4
#sessions > 10	3.6	2.6

Figures for ‘% of GPs’ are column percentages based on the respective cross-sectional sample (N = 1,061 in 2010; N = 1,183 in 2012).

We also asked GPs to indicate when they worked their sessions. This was to identify those who were working ‘anti-social hours’. Of the 1,177 GPs who reported when they worked their sessions, 684 (58.1%) indicated that they worked at least one weekday evening session in a typical week, a slight increase from 2010 (57.2%), whilst 118 (10.0%) indicated that they worked at least one weekend session in a typical week, a decrease from 2010 (15.1%).

#### **Average hours worked per week in 2012**

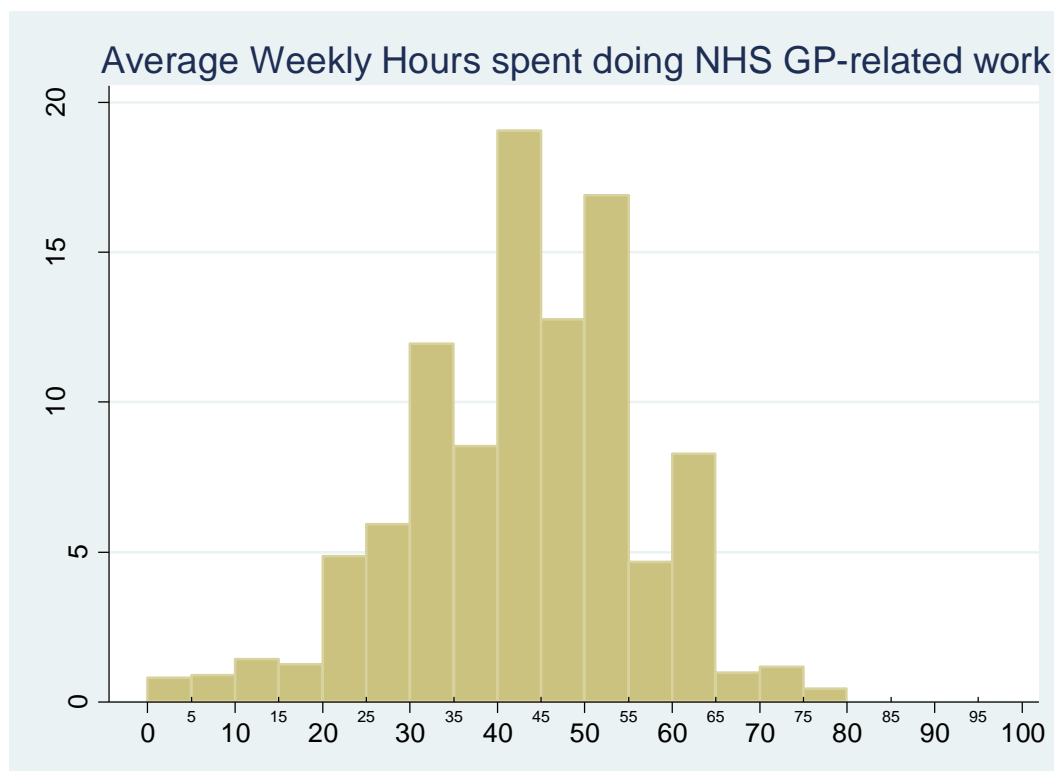
GPs were asked:

*How many hours do you spend, on average, per week, doing NHS GP-related work?  
(Please include ALL clinical and non-clinical NHS work but EXCLUDE OUT-OF-HOURS WORK)*

The mean number of weekly hours that the 1,112 respondents reported working was 41.7 (standard deviation = 13 hours) and the median number was 42 hours (Inter-Quartile Range = 32 to 50). The distribution of average weekly hours worked in 2012 is shown in Figure 2.

Nearly one-third of respondents (31.7%) reported working between 40 and 50 hours per week, whilst just over 20% reported working either 30 to 40 hours per week (20.4%) or 50 to 60 hours per week (21.6%). More than one in ten GPs (10.9%) reported that they worked 60 hours or more per week.

**Figure 2: Distribution of ‘Average Weekly Hours Worked’ in 2012**



Data are based on the cross-sectional sample in 2012.

### ***Trends in average hours worked per week***

The average number of hours worked per week increased slightly between 2010 and 2012 (Table 16), though the change is not statistically significant ( $t=0.53$ ;  $p=0.594$ ). An increase of a similar magnitude was also observed in the longitudinal sample. Average weekly hours spent on NHS GP-related work increased from 42.4 (standard deviation = 12.8 hours) in 2010 to 42.8 (standard deviation = 13.2 hours) in 2012 in this sample, though this too was not statistically significant ( $t=0.89$ ;  $p=0.374$ ).

**Table 16: Summary statistics for average weekly hours worked: 2008 - 2012**

Year	N	Average	Std. Dev.	95% C.I.
2008	634	42.1	13.0	41.1, 43.1
2010	1,054	41.4	12.9	40.6, 42.2
2012	1,112	41.7	13.0	40.9, 42.5

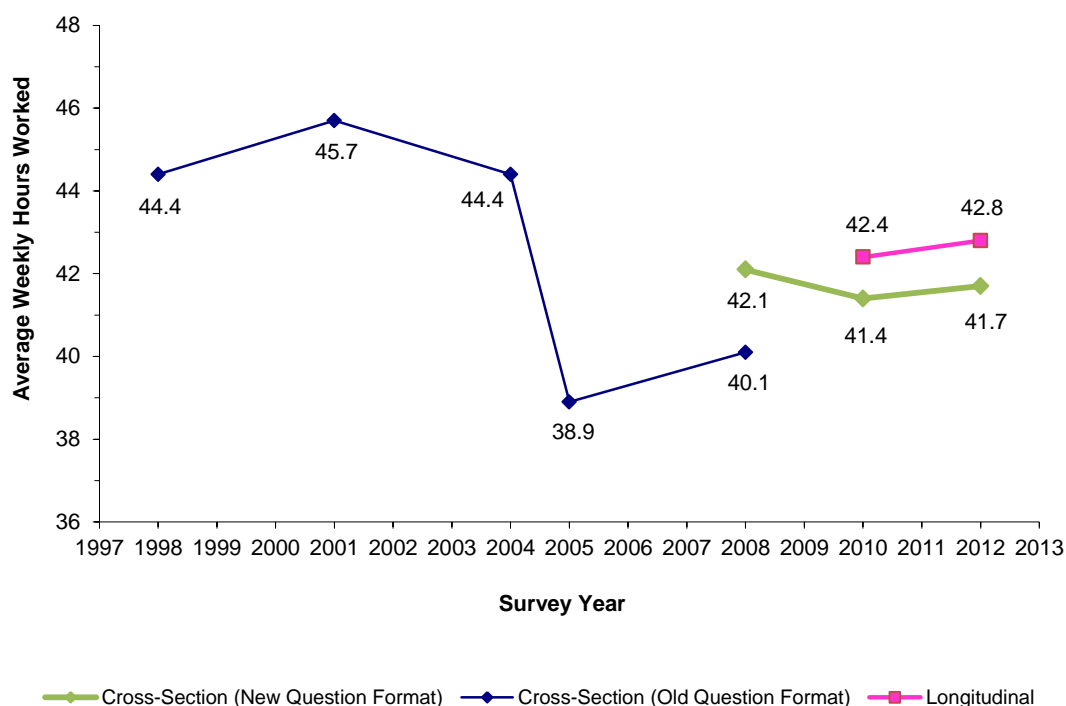
Figures are based on the cross-sectional samples in the respective years. In 2008, two different phrasings of the hours of work question were asked, with GPs randomly assigned to one or the other.

Prior to 2008, hours of work was elicited using a different phrasing of the question to that in 2010 and 2012:

*How many hours per week do you typically work as a GP?  
(Please exclude any hours on call)*

To enable comparison of the series over time, the two question formats were asked of random halves of the 2008 survey. Figure 3 illustrates these series graphically.

**Figure 3: Trends in average weekly hours worked: 1998 - 2012**



The figures for the longitudinal sample are based on data from GPs who responded in 2010 and 2012 (N = 1,498).

### ***Association of Hours Worked to Sessions Worked***

There was a substantial positive correlation between the number of sessions worked in a typical week and the number of hours spent doing NHS-related work in both years (0.65 in 2010; 0.58 in 2012). In 2012, GPs who indicated that they worked more than 8 sessions in a typical week also reported that they spent, on average, around 50 hours undertaking NHS-related work. Generally, the average number of hours worked per week was greater in 2012 than in 2010 for the corresponding number of reported sessions worked (Table 17).

**Table 17: Number of Sessions Worked and Average Hours Worked by GPs who work that number of sessions in 2010 and 2012**

Number of sessions worked in a typical week	2010		2012	
	% of GPs	Average Hours Worked	% of GPs	Average Hours Worked
#sessions ≤ 4	9.5	23.7	9.6	26.0
4 < #sessions ≤ 5	9.0	30.5	9.9	31.3
5 < #sessions ≤ 6	12.9	35.0	16.7	35.4
6 < #sessions ≤ 7	9.6	39.4	11.0	41.4
7 < #sessions ≤ 8	23.7	46.3	23.4	46.0
8 < #sessions ≤ 9	25.0	47.3	20.5	50.1
9 < #sessions ≤ 10	6.8	49.6	6.4	50.0
#sessions > 10	3.6	55.1	2.6	53.5

Figures for ‘% of GPs’ are column percentages based on the respective cross-sectional sample (N = 1,061 in 2010; N = 1,183 in 2012). Figures for ‘hours worked’ are based on the average number for GPs who also report how many sessions they work in a typical week.

### ***Out-of-Hours work***

Respondents were asked if they undertook any out-of-hours work and, if so, on average, how many hours per week. Twenty-one percent (240/1,160) of respondents in the cross-sectional sample reported undertaking some out-of-hours work. This included 198 GP providers (19.6% of all providers who responded to the survey) and 42 non-provider GPs (25.6% of all such GPs in the survey). Overall, the proportion of GPs participating in out-of-hours work is unchanged from 2010 (where 218 out of 1,053 respondents reported doing so). This figure (218) consisted of 185 GP providers (20.4% of all such survey respondents) and 33 non-providers (22.8%). Compared to 2010, the proportion of GP providers participating in out-of-hours work has decreased slightly whilst the proportion of non-provider GPs participating has increased.

Of the 240 respondents who reported undertaking out-of-hours work in 2012, 232 reported how many hours they spent on average per week. The median number of hours was 4

(inter-quartile range = 2 to 6), identical to that in 2010. The vast majority of GPs (84%) who reported working out of hours did so even though their practice had opted-out of out-of-hours working (Table 18).

**Table 18: Practice opt-outs and out-of-hours work in 2012**

Has your practice opted out of 'out-of-hours' work?	N (%) [of 1,172 GPs]	Median weekly hours spent doing out-of-hours work (N)
Yes	1,059 (90.4%)	4.0 (192)
No	113 ( 9.6%)	3.0 ( 37)

Figures are based on the cross-sectional sample. Median weekly data on hours worked are calculated only for GPs stating that they undertook some out-of-hours work.

Data from the longitudinal sample broadly mirrors that of the cross-sectional sample, with one key difference. In 2010, 346 out of 1,545 respondents (22.4%) reported working out-of-hours (for a median of 4 hours); this percentage had declined to 16.9% (259 out of 1,536 respondents) in 2012 (median number of hours worked = 4). Two-hundred and nine GPs stated that they undertook some out-of-hours work in both years.

### ***Extended opening hours***

We asked GPs whether their practice offered extended hours access. Table 19 shows that 31.9% of respondents said that their practice offered access at weekends (372 of 1,165), 75.7% on weekdays (882 of 1,165) and 23.8% on both weekdays and at the weekend (277 of 1,165). All of these figures have decreased compared to the corresponding data from 2010, in particular that for weekend access (39.8%). Only 16.1% of respondents (188 of 1,165) replied that their practice did not offer any extended hours access; this is an increase compared to the corresponding figure in 2010 (10.2%).

**Table 19: Extended Hours Access in 2010 and 2012**

Does your practice have Extended Hours Access	2010	2012
	N = 1,054	N = 1,165
On Weekdays	858 (81.4%)	882 (75.7%)
On Weekends	419 (39.8%)	372 (31.9%)
On Weekdays & Weekends	330 (31.3%)	277 (23.8%)
No Extended Hours Access	107 (10.2%)	188 (16.1%)

Data are based on 'valid' responses from the respective cross-sectional samples.

### ***Percentage of time spent on various activities***

In addition to asking GPs the number of hours worked on average per week, the questionnaire asked GPs to indicate how much time they spent on different aspects of their work, namely:

- Direct patient care (e.g. surgeries; clinics; telephone consultations; home visits)
- Indirect patient care (e.g. referral letters; arranging admissions)
- Administration (e.g. practice management; PCO meetings; etc)
- Other (e.g. continuing education/ development; research; teaching; etc)

Table 20 shows the average percentages reported by respondents in the cross-sectional samples in 2005, 2008, 2010 and 2012 and in the longitudinal sample. In 2012, 62% of a GPs' time was devoted to direct patient care, with 19% devoted to indirect patient care and 11% devoted to administration.

The respondents in the 2012 cross-sectional sample reported devoting a lower percentage of their time to direct patient care than respondents in the 2005, 2008 and 2010 cross-sectional samples. There has been a 0.7% increase in the percentage of time devoted to indirect patient care between 2010 and 2012. The changes in the longitudinal sample (in both 2010 and 2012) broadly mirror those for the cross-sectional sample. Respondents in the longitudinal sample reported small increases in the percentage of time devoted to indirect patient care and administration between 2010 and 2012, at the expense of time devoted to direct patient care.

**Table 20: Percentage of time devoted to different activities, 2005-2012**

Type of activity	Cross-sectional sample				Longitudinal sample	
	2005	2008	2010	2012	2010	2012
Direct patient care	63.3	63.0	63.1	62.3	62.5	61.4
Indirect patient care	18.2	17.5	18.6	19.3	18.4	19.0
Administration	11.3	12.0	10.7	10.9	11.2	11.9
Other	7.1	7.5	7.6	7.5	7.9	7.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

Figures are column percentages. Numbers may not sum to 100% due to rounding errors. N = 868 for the 2005 cross-sectional sample; 1,280 for the 2008 cross-sectional sample; 1,015 for the 2010 cross-sectional sample; 1,154 for the 2012 cross-sectional sample. N = 1,526 for the longitudinal sample.

## Job Satisfaction

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Questions on job satisfaction have been included in GP surveys since 1987. This section of this report provides summary statistics on these elements of the survey and analysis of recent trends. Respondents were asked to rate their satisfaction on nine specific domains and for their job 'overall' on a seven-point scale from 'extremely dissatisfied' (=1) to 'extremely satisfied' (=7).

### *Job satisfaction levels in 2012*

Summary statistics for the cross-sectional sample are provided in Table 21. Mean overall job satisfaction is 4.54 points. Just over half of the respondents (56.7%) reported being satisfied with their job overall (scores of 5 or more), whilst less than one-quarter (22.5%) reported being dissatisfied (scores of 3 or less).

The nine individual aspects of the job are ranked in descending order of the mean score in Table 21. Respondents reported most satisfaction with their colleagues and fellow workers, physical working conditions and the amount of variety in the job. These domains had both the highest mean satisfaction scores and the greatest percentage of GPs indicating 'satisfaction': at least 3 out of every 4 respondents were satisfied with these aspects of the job and dissatisfaction was rare. Respondents displayed least satisfaction with their hours of work: fewer than half were satisfied (46.2%), whilst more than one-third (36.5%) were dissatisfied.

The ranking of job domains is almost identical whether we use the mean scores or the percentages reporting dissatisfaction or satisfaction. In the remainder of this section we summarise the job satisfaction responses using the mean scores.

**Table 21: Summary statistics for job satisfaction in 2012**

Job domain	Mean	% dissatisfied	% satisfied
Colleagues and fellow workers	5.56	6.45	83.36
Physical working conditions	5.30	11.61	77.28
Amount of variety in job	5.28	9.67	77.01
Amount of responsibility given	5.16	11.56	71.68
Opportunity to use abilities	5.08	13.34	72.56
Freedom to choose own method of working	4.78	17.83	63.33
Remuneration	4.56	22.52	55.72
Recognition for good work	4.52	23.20	56.90
Hours of work	4.09	36.45	46.22
<b>Overall Satisfaction</b>	<b>4.54</b>	<b>22.48</b>	<b>56.74</b>

% dissatisfied = % rating 1, 2 or 3; % satisfied = % rating 5, 6 or 7. Figures are based on the 2012 cross-sectional sample. Range of N = 1,171 - 1,181.

### ***Changes in satisfaction ratings from 2010***

The changes in mean satisfaction ratings between 2010 and 2012 in the cross-sectional sample are shown in Table 22. The satisfaction domains are ranked from the largest change in ratings between 2010 and 2012 to the smallest change. Average satisfaction ratings for 1998, 2001, 2004, 2005 and 2008 are also shown.

The mean level of overall satisfaction of 4.54 in the cross-sectional sample in this survey is 0.33 points lower ( $t=-5.60$ ;  $p<0.001$ ) than the mean level reported in 2010 (Table 22). Mean levels of satisfaction have also decreased, to varying degrees, on seven of the nine individual domains. The most notable declines are in satisfaction with remuneration (0.31 points) and hours of work (0.30 points). Satisfaction with colleagues and fellow workers (by 0.02 points) and physical working conditions (by 0.07 points) have increased since 2010: these are the two highest ranked satisfaction domains in 2012.

Overall job satisfaction is at its lowest level since 2001. In terms of the overall series, satisfaction with particular aspects of the job such as remuneration, hours of work and amount of responsibility given are at a 'mid-point': that is, they are higher than in the surveys undertaken before the introduction of the new contract (1998, 2001 and 2004) but lower than in the surveys undertaken since. Levels of satisfaction with other aspects of the job are, in general, also higher in 2012 than in the years prior to the introduction of

the new contract. Levels of satisfaction with physical working conditions and (with the exception of 2010) variety in the job have never been so high.

A corresponding decrease of 0.38 points ( $t=-10.90$ ;  $p<0.001$ ) in overall satisfaction was observed in the longitudinal sample of 1,565 GPs who participated in both the 2010 and 2012 surveys (Table 23). Of the 1,541 respondents who reported their overall job satisfaction level in both years, 313 (20.3%) reported being more satisfied in 2012 than in 2010, 570 (37.0%) reported being equally as satisfied and 658 (42.7%) reported being less satisfied in 2012 than in 2010. Mean levels of satisfaction declined on all nine individual domains; remuneration and hours of work exhibiting the greatest changes, complementing the findings of the cross-sectional sample.

**Table 22: Average satisfaction ratings over time**

Satisfaction domain	Mean Satisfaction Rating							Change
	1998	2001	2004	2005	2008	2010	2012	'10 - '12
Remuneration	3.48	3.51	4.38	5.30	4.73	4.87	4.56	-0.31
Hours of work	3.70	3.32	3.94	4.86	4.21	4.39	4.09	-0.30
Amount of responsibility given	4.99	4.59	5.05	5.43	5.20	5.33	5.16	-0.17
Freedom to choose own method of working	4.87	4.35	4.66	5.00	4.65	4.91	4.78	-0.13
Recognition for good work	4.21	3.57	4.28	4.80	4.46	4.65	4.52	-0.13
Amount of variety in job	4.94	4.76	5.06	5.26	5.23	5.38	5.28	-0.10
Opportunity to use abilities	4.64	4.27	4.85	5.19	5.01	5.11	5.08	-0.03
Colleagues and fellow workers	5.31	5.37	5.60	5.65	5.49	5.54	5.56	+0.02
Physical working conditions	4.99	4.86	4.91	5.08	5.07	5.23	5.30	+0.07
<b>Overall Satisfaction</b>	<b>4.65</b>	<b>3.96</b>	<b>4.62</b>	<b>5.21</b>	<b>4.68</b>	<b>4.87</b>	<b>4.54</b>	<b>-0.33</b>

Domains ranked by greatest change from 2010 to least change. Figures are based on respective cross-sectional samples. Range of N for 2005 = 882 to 887; for 2008 = 1,275 to 1,289; for 2010 = 1,048 to 1,061; for 2012 = 1,171 to 1,181.

**Table 23: Change in satisfaction ratings from 2010 - longitudinal sample**

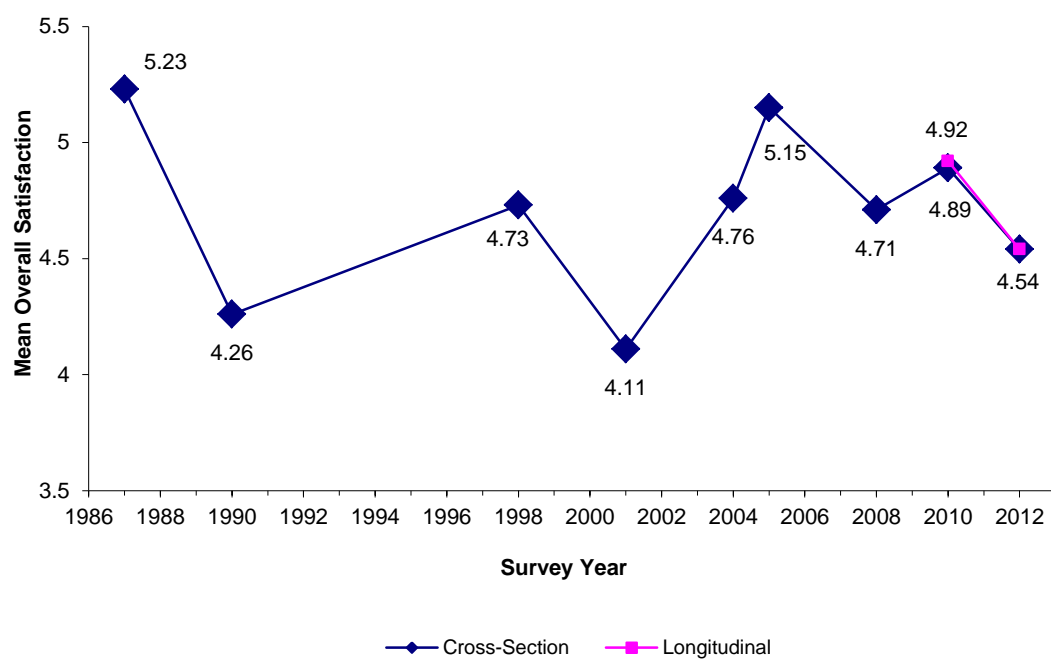
Job Aspect	Mean Satisfaction		Change '08 - '10
	2010	2012	
Remuneration	4.95	4.58	-0.37
Hours of work	4.28	3.96	-0.32
Amount of responsibility given	5.33	5.14	-0.19
Recognition for good work	4.67	4.48	-0.19
Freedom to choose own method of working	4.90	4.72	-0.18
Opportunity to use abilities	5.20	5.08	-0.12
Colleagues and fellow workers	5.61	5.54	-0.07
Amount of variety in job	5.42	5.37	-0.05
Physical working conditions	5.31	5.26	-0.05
<b>Overall Satisfaction</b>	<b>4.92</b>	<b>4.54</b>	<b>-0.38</b>

Domains ranked by greatest change from 2010 to least change. Range of N for 2010 = 1,547 to 1,553; for 2012 = 1,545 to 1,555.

### ***Long-term trends in job satisfaction: 1987 - 2010***

Changes in overall job satisfaction may, in part, reflect the changing composition of the GP workforce. In order to control for such potential changes, we directly-standardised the levels of overall job satisfaction observed in each survey to the age-sex composition of provider and salaried GPs in the 2011 GMS Statistics database. Mean levels of overall job satisfaction between 1987 and 2012 are shown in Figure 4.

**Figure 4: Trends in mean overall job satisfaction: 1987 - 2012**



Cross-sectional series has been standardised to the age-sex structure of the 2011 GMS Statistics database, with the exception of 1987 and 1990 for which the necessary figures are not available.

## Concluding remarks

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Overall job satisfaction declined between 2010 and 2012, from 4.87 points to 4.54 points in the cross-sectional sample and from 4.92 points to 4.54 points in the longitudinal sample. Overall job satisfaction is at the lowest level since 2001. Satisfaction on seven of the nine individual domains of job satisfaction also declined to varying degrees between 2010 and 2012. These reductions in satisfaction were largest with respect to hours of work and remuneration. In addition, quitting intentions were more prevalent in 2012 than in 2010, especially in GPs aged fifty years or over.

The average number of hours worked per week has increased by less than half-an-hour compared to 2010, with respondents reporting working an average of 41.7 hours per week (42.8 hours in the longitudinal sample). Levels of stress associated with increasing workloads, paperwork and having to work long hours increased from the levels observed in 2010, and reported levels of stress are now higher than in any of the previous surveys. The number of GPs who reported working out-of-hours was unchanged: just over one-in-five reported doing so. There was a small decrease in the proportion of GPs stating that their practice offered extended hours access, especially at weekends.

GPs, on the whole, agreed that their involvement added value to clinical commissioning, although they were split as to whether commissioning was part of their role as a GP. The majority of GPs thought that the introduction of Clinical Commissioning Groups had increased their workload and reduced the amount of time they spent on direct patient care; otherwise, they reported little or no change to general practice in their local area. Thirteen percent of GPs reported having a formal role at clinical commissioning group level, whilst a further fifteen percent indicated that they were the commissioning lead for their practice. GPs who had a formal role viewed commissioning differently to practice commissioning leads: they spent more hours working in this capacity and had more favourable views on the added value of GP involvement in clinical commissioning. These GPs were also more likely to have had a role in previous forms of commissioning, as well as being more likely to state that they wanted to continue in such a role in the future.

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