**Perspectives of GPs working in or alongside Emergency Departments in England: Qualitative findings from the General Practitioners and Emergency Departments [GPED] Study**

**Abstract**

Background

Around 43% of Emergency Department (ED) attendances can be managed in general practice. Strategies to address this include directing appropriate patients to GPs working in or alongside EDs (GPED). Views of GPs choosing to work in GPED may inform planning and implementation of GPED services as well as wider general practice provision.

Aim

To explore the experiences and motivations of GPs choosing to work in GPEDs in England, and to identify factors that may support or hinder GPs working in GPED.

Design and Setting

Thematic analysis of 42 semi-structured interviews of GPs working in 10 GPED case sites across England.

Method

Qualitative GP interviews from a mixed methods study of GPs in GPEDs were thematically analysed in relation to research aims.

Results

Four themes were generated: the ‘pull’ of a portfolio career; the ‘push’ of disillusionment with general practice; professional reciprocity; sustainability of GPED services and core general practice. Flexible, favourable working conditions, collaboration and professional development made GPED an attractive workplace, often as part of a portfolio career or after retiring from core general practice. Working in GPED was largely driven by disillusionment with core general practice. Both GPED and core general practice were thought to benefit from GPED GPs’ skills. There were concerns about GPED sustainability and destabilisation of core general practice.

Conclusion

GPED may extend clinical careers of experienced GPs and support recruitment and retention of more recently qualified GPs. Despite some benefits, GPED may destabilise core general practice and increase pressure on both environments.

**Keywords**

General Practitioners; Emergency Department; Qualitative Research; General Practice

**How this fits in**

* Many people attending Emergency Departments could be managed by GPs and employing GPs to work in or alongside emergency departments is a way to address increased pressure on Emergency Departments.
* This study highlights the benefits of GPs choosing to work in GPED such as professional development, sharing skills and knowledge across both contexts and retaining GPs in some capacity within the clinical workforce
* However, GPs working in GPED expressed concerns that the GPED model may not be sustainable and may also contribute to destabilisation of core general practice
* By exploring the views, motivations and experiencesof GPs choosing to work in GPED, this study may inform planning and implementation of both GPED services and core general practice.

**Introduction**

Increased Emergency Department (ED) attendance continues to place pressure on emergency healthcare systems internationally1,2,3. Up to 43% of ED attendances are suitable for management in general practice1. Strategies to redirect ED patients to General Practitioners (GPs) have been employed in different countries3. In England, policies have been developed to direct appropriate patients to GPs working in or alongside EDs (GPED)4 and this has been supported by capital funding5. In response, several models for co-locating GPs in or alongside ED have been developed and are set out in a taxonomy6. As well as freeing ED capacity for the sickest patients, such initiatives are expected to improve patient flow and reduce ED crowding, although supporting evidence is limited7.

The introduction of GPED services has been undermined by lack of availability and willingness of GPs to work in these settings, leading to gaps in GP rotas.8 Simultaneously, general practice more broadly is considered to be at crisis point, with recruitment and retention presenting significant issues both in England9,10 and internationally.11,12 The consequences of role diversification, such as GPED, on general practice more widely (what we term here as ‘core’ general practice, i.e. traditional general practice located in local communities) are unclear.

This paper explores the experiences and motivations of GPs choosing to work in GPED in England, and their views about the role of GPED in relation to core general practice. Findings are used to identify factors that may support or hinder GPs working in EDs and which may be used by policy makers/managers when planning and implementing GPED and general practice provision.

**Methods**

Design

A large, longitudinal mixed-methods study was carried out to evaluate the impact of GPED on patient care, general practice, acute hospital teams and the wider urgent care system13. In this paper we draw on semi-structured interviews with GPs working in EDs.

Sampling and Recruitment of Sites and Participants

10 case study sites were purposively selected and recruited for maximum variation, i.e. model of GPED service; deprivation index; ED volume and geographical location. Table 1 describes the different GPED models and GP remit at each case site. Models are adapted from a taxonomy described by Cooper et al6. GPED GPs either undertake their role similar to core general practice, or at some sites this is extended by ordering investigations beyond what is usually expected, or managing patients with increased acuity. At one site (Juniper) GPs could work in a hybrid role across GPED and ED managing a range of patient needs. The qualitative research team approached GPs who worked within GPED sites to participate in interviews during case site data collection. While participants were recruited opportunistically, and through snowball sampling14, the sample included a range of GPs in terms of experience (e.g. GP Leads to newly qualified GPs) and their role/employment within and outside GPED (see Supplementary Table 1). A total of 39 GPs were interviewed with 3 GPs interviewed twice during the study (42 interviews in total). Interviews took place across three time points (start/middle/end of study), and at sites where GPED services had been established for varying amounts of time, in order to attempt to capture the views of GPs who had experienced different forms of GPED over differing longitudinal periods.

<Table 1>

< Supplementary Table 1>

Data Collection

Data were collected between October 2017 and December 2019. Interviews were semi-structured and primarily conducted face-to-face at case study sites, with a small number of interviews (≈10%) conducted by telephone at the participant’s request. A topic guide wasdeveloped by the research team which was underpinned by the research literature and the wider GPED study’s research questions (Supplementary Box 1), and so was broader than is reported here. The topic guide allowed exploration of the professional background, motivations, views and experiences of GPs working in GPED reported in this paper. Participant information leaflets were provided to all participants and written consent obtained.

<Supplementary Box 1>

Data Management

Data management was compliant with the Data Protection Act (2018)15 and university data security policies. It was managed and held in accordance with General Data Protection Regulations (GDPR)16. Interview data were recorded and transported on an encrypted audio-recording device. All data were stored on the secure password protected drive of a university server.

**Analysis**

A broad coding framework was developed for the wider qualitative study by the research team to reflect the aims of the GPED study as a whole. Data were then summarised into case site pen portraits,17 compared/contrasted across sites and thematically analysed.18 For the purposes of this paper, a further, more nuanced, thematic analysis of GP interview data was conducted, on the broad theme of ‘perspectives of GPs in GPED’ – one of the overarching study aims. This involved one researcher (HA) re-analysing sub-themes relating to GPs’ motivations, views and experiences identified during our primary study analysis. Findings were then discussed amongst the qualitative team. Pseudonyms were allocated to case sites (e.g. Chestnut) and unique identifiers to individual participants.

**Findings**

GPs worked in various roles in GPED, across different GPED models. Some worked in GPED as part of broader ‘portfolio working’ which describes GPs holding multiple roles. Four themes were generated which underpin the motivations, views and experiences of GPs working in GPED. The first two are concerned with the motivations of GPs working in GPED, while the latter explore the experiences and views of GPs about the benefits and ramifications of utilising GPs in EDs for both core general practice and EDs

**Motivation to work in GPED: The ‘pull’ of a portfolio a career – being a different kind of GP**

Most GPs working in GPED enjoyed the challenge of working with more acutely unwell patients and saw it as a way of extending their scope of clinical practice, broadening their career and offering potential new avenues for future working. This was particularly for newly qualified GPs who did not always consider core general practice their first-choice specialty, with GPED offering an opportunity to avoid being pigeon-holed within a linear career trajectory. These GPs positioned themselves as different from the majority of GPs who they considered more risk averse and less confident in their abilities to work in acute settings.

*There was another GP who worked [in GPED] on Mondays, but he didn't feel confident to see some of the things they were sending us, so he doesn't come anymore…. if you had people that are ready to see anything that comes in through the door then it will work really well. But then if people are happy to do that, they wouldn't have become GPs in the first place. (Birch.GP.18)*

GPs who chose to work in GPED were moving away from traditional medical careers and forging new ways of working more centred on work-life balance and diversifying opportunities.

*Career wise, I think this job suits my work life balance at the moment. I’m only doing this for two days which is five sessions….and the other days I’m able to work what I want to do in other places, locum or out-of-hours (Juniper.GP.62)*

**Motivation to work in GPED: The ‘push’ of disillusionment with general practice**

For some participants, working in GPED was seen less as a positive career choice or a genuine interest in the work; rather they worked there for pragmatic reasons. Some expressed disillusionment with core general practice which was seen as highly pressurised and increasingly demanding compared to GPED. Some participants were reluctant to join GP partnerships which involved business, managerial and employer responsibilities as well as increasingly complex clinical demands.

*Obviously, general practice in the community is really being hit hard. There are fewer GPs and quite a few of us are leaving partnerships for various reasons, so general practices are really under the cosh. With funding for district nursing, social services and all the things, it’s getting harder and harder, and we’re seeing more and more patients with more and more complex things (Rowan.GP.3)*

In contrast to the open-ended commitments of core general practice, GPED involved one-off contacts with patients which require short term decision-making as opposed to long-term management of complex clinical issues. In particular, the pressure of time-limited consultations regularly experienced in core general practice was not encountered to the same degree in GPED.

*There is something refreshing about them not being your patients, dealing with them there and then, and then not having to deal with them thereafter. It makes it, in more challenging cases, less of a burden because, as a [core] GP, they're always coming back to you, the ones you can’t do anything for. Whereas in ED it’s 20 minutes with them, or however long it takes. And then, in the nicest possible way, they're someone else’s problem, they're their own GP’s problem, they're the ones with the responsibility for their ongoing care. (Nutmeg.GP.19)*

The flexibility of working in GPED was considered by some to be more manageable in the long term. It was credited with extending medical careers which would previously have ended in early retirement or a move away from medicine due to burn-out or ill health. GPED offered an alternative way of working and this was reflected in the way GPs thought about and planned their careers.

*I came out of my partnership because of some health issues….I was really finding long, long days an issue. For me to come in and be able to practise the medicine I really enjoy, without actually having to do as many hours again doing paperwork, that has been great, and probably meant that I didn’t need to leave medicine.*

*(Rowan.GP.3)*

**Views and experiences of GPED: Professional Reciprocity**

Some interviewees saw working in GPED as a reciprocal training opportunity. They viewed their GP expertise as a useful exchange for gaining and updating their own skills in emergency medicine, while bringing a general practice philosophy to EDs. They felt GPs initially presumed most patients were not seriously ill, but had the ability to identify sicker patients and escalate care when required. Contrastingly, ED clinicians were considered to assume all patients were seriously ill until proven otherwise.

*To a GP a sore throat is a viral sore throat until you’ve got a real reason to suspect that they might have epiglottitis whereas to an ED doctor a sore throat could be epiglottitis until they’ve proved it’s not, so it’s a really different way of looking at things (Juniper.GP.39)*

This philosophical divergence was thought to have practical consequences. ED clinicians were believed to order more investigations, admit more patients and be less likely to take a ‘wait and review’ approach. Consequently, GPs felt their approach could be shared with secondary care clinicians for the benefit of patients. In return, GPs were able to update their skills in managing acutely ill patients, which would have the onward benefit of enhancing their core general practice work. GPs considered that working in GPED enabled them to be role models for junior ED doctors and was mutually beneficial to both GPs and the wider healthcare system.

*Trying to cherry pick off the people that I know that I can see probably quite quickly and then get them moving, so either referred into the hospital or back home with GP follow up or not. I think that works well and I think what some of the nursing staff quite often do [is send them] for an awful lot of blood tests that are not really necessary and actually, if they do come back abnormal, just confuse the picture and we end up hanging onto people who’re actually not really necessary. (Juniper.GP.24)*

GPs also valued the collaborative working of ED culture which was contrasted with feelings of isolation that sometimes occurred in core general practice. Participants recognised the learning opportunities and informal support gained from other GPs working in GPED and the wider ED. Working with other professional groups enabled GPs to enhance their skills which benefited their core General Practice.

*You feel like part of a team, and there's that camaraderie which is quite nice. It's nice to have the group of GPs and get their perspective on general practice in a setting like this. We're working alongside experienced nurse practitioners, asking them for advice on things like musculoskeletal things and that will actually go to aiding me when I'm in the community (Teak.GP.6)*

GPs working in GPED also felt they could facilitate collegiality between primary and secondary care. Their experience of core general practice allowed them to challenge flaws in systems for the benefit of patients and in support of core general practice.

*our other role I think is to improve things for primary care so that actually we don’t get inappropriate things being asked of primary care from secondary care. One of the things that I've done is introduced sick note certifications…we should not be sending them back to general practice just to get a sick note…So, I think GPs have a role of being here and standing up for general practice (Juniper.GP.24)*

**Views and experiences of GPs: Sustainability of GPED services and core general practice**

Participants identified several challenges to the sustainability of GPED. It was perceived that some doctors were attracted to general practice to avoid working shifts, weekends and evenings. In this way, these GPs saw themselves as different to the norm. Consequently, there was concern that the unsocial hours of GPED would reduce the pool of GPs interested in this type of work. Lack of GPs with the desire or requisite skills to work in GPED meant services were not always fully staffed, reducing the perceived impact of GPED services.

*I'm not sure we're going to suddenly stumble across a large cohort of GPs who are particularly well trained in minor injuries, number one. And the other thing we haven't really discussed is often part of their reason for becoming GPs is a decent lifestyle and decent hours. Coming to now spend Friday night, Saturday night dealing with drunks who've punched each other is not such an attractive prospect (Chestnut.GP.24)*

Remuneration was important in choosing to work in GPED. However, views and experiences differed. Some found working in GPED was competitively rewarded while others were better remunerated elsewhere. Competition for GPs’ skills and expertise between services, such as GP Out-of-Hours services and Urgent Care Centres, led in some places to a deficit of suitably qualified GPs willing to work in GPED, which caused pay inflation. However, where GPED services could not afford competitive pay, they either lost out and were under-resourced, or different strategies for attracting GPs were developed.

*there needs to be a real incentive and either it needs to be we’re offering something exciting and different and interesting, so you can be part of a new exciting team…or we’re offering a financial incentive and even though we’re offering a consultant level salary scale that still is difficult to compete with GP out- of-hours…one of our applicants does…out-of-hours and we can’t compete with it. So, he’s pulled out. (Juniper.GP.39)*

Despite these concerns, by enabling GPs to develop skills and broaden their scope of practice, GPED was considered to have the potential to retain GPs in some form of general practice for at least some of the time. Development of novel and portfolio roles were thought to reduce burnout from working in one speciality, whether ED or general practice. In addition, exposing junior doctors to GPs’ work in ED and portfolio working was considered to encourage them to consider various forms of general practice as attractive career options, which may consequently boost the number of future GPs. However, it was anticipated that to be sustainable, initiatives to develop novel general practice roles require support from the broader medical training system and relevant Royal Colleges.

*The combination [of ED and GP] I think actually it's not for everyone but it's a really attractive career option, so I think it may improve recruitment into both subjects, ED and GP, and it’d be nice to see the College back that up, maybe try and develop something like [an] interface medicine diploma or more qualifications. (Juniper.GP.24)*

GPs are a finite resource and competing services recruiting from the same pool of GPs was a concern to participants. They felt that instead of GPED reducing pressure on general practice, it added burden by diverting qualified staff from an already under-resourced and pressurised core general practice service. Increasing workload pressures and limited funding within core general practice, along with favourable GPED conditions and pay, meant GPED was seen as a more attractive workplace. These pressures had the potential to be cyclically exacerbated as fewer GPs working in core general practice would potentially lead to fewer general practice appointments, increasing burden on wider general practice and the volume of patients attending ED with primary care problems.

*I think it is getting harder to recruit GPs into general practice. I think there are four or five competing services. There are only ever going to be a finite number of GPs (Rowan.GP.10)*

Despite working in or alongside EDs, some participants thought GPs should not contribute to the ongoing depletion of core general practice but focus instead on where GP resources are needed most. Several GPs felt ambivalent about, or did not agree with, GPED as a policy and considered it contributed to further system complexity and duplication. Ultimately, some GPs felt GPED and similar initiatives destabilised core general practice and proposed a whole system approach to address restructuring and funding, rather than piecemeal initiatives that were considered to have limited effects.

*The way our model has been set up, I think what will be best for the patient is going to, potentially, be destabilising for the general practice community….Really, we need to look at the whole system in terms of that. I think without that, the thing is just going to fall apart, isn't it? You're taking out a matrix and just leaving the rungs. (Teak.GP.26)*

**Discussion**

Summary

Our study provides insight into the views, motivations and experiences of GPs working in GPED services across England to inform the planning and implementation of these services alongside wider general practice provision. GPs in our study worked within a variety of GPED models, and because the models were so diverse, it was not possible to draw specific conclusions about how this may have affected the perceptions and views of GPs. It does, however, highlight the complexity involved in delivering GP services in ED, as well as indicating the variety of different experiences of GPs working in GPED.

Established GPs in our study used GPED to maintain a medical career when they perceived core general practice to be unmanageable. For less experienced GPs, GPED provided a means of engaging with medicine in ways that fit more closely with career and life aspirations. As such, GPED can be argued to offer an important way of keeping the skills and knowledge of experienced GPs, while ‘growing’ future GPs. Lessons learned from GPED could potentially be used in similar initiatives elsewhere.

As well as perceived support for new, flexible ways of working, GPED was considered to facilitate an environment in which GPs were in demand with subsequent remuneration and wider benefits. GPED promoted general practice to the hospital workforce and provided GPs with enhanced skills transferable to their core general practice work. However, a number of unintended consequences of GPED were identified, including the possible destabilisation of core general practice though shifts in funding and ‘poaching’ of an already depleted GP workforce. The sustainability of GPED itself was questioned as services competed for finite GP resource. While GPED was considered a positive career opportunity for this self-selecting group of clinicians, there was scepticism as to whether this was applicable to the wider GP population whose work choices and requirements may differ.

Strengths and limitations

This paper reports findings from an opportunistic sample of GPs working in or alongside EDs at 10 case sites across England. The GPs interviewed had chosen to work in GPED and the ways in which GPED services functioned between case study sites varied significantly. Consequently, findings cannot necessarily be considered representative of GPs as a professional group or across different models of GPED, and in particular will not capture the views of GPs who might have considered working in GPED under different circumstances. Similarly, in such a rapidly changing environment, studies such as this one provide a cross-sectional snapshot of current issues which may change over time and, as such, should be viewed within this context. However, there are commonalities and consistencies across contexts, and findings align with and extend national and international literature.8,11,12,19 The study highlights issues that may resonate with primary care clinicians more broadly, as well as indicating a range of issues relating to both GPED and wider general practice that require further consideration and exploration.

Comparison with existing literature

GPs were attracted to GPED as it offered flexible ways of organising work and enabled them to develop portfolio careers. Portfolio working is increasingly popular among medical practitioners, particularly those who are younger and more recently qualified19. GPs with portfolio careers are less likely to consider leaving practice than those who work exclusively in core General Practice9. However, lack of formal professional support for hybrid and portfolio roles was identified in our study and is reflected elsewhere in the literature19.

In our study, GPs valued the collaborative working of GPED. The value of shared learning between GPs and ED clinicians has been highlighted elsewhere8. Job satisfaction improves when workload is shared within a team,20 and integration between primary and secondary care has been found to improve patient care21. Consequently, team working as exemplified in GPED may improve the experiences of both clinicians and patients.

Pressures of core general practice are leading GPs to consider alternative career options.9,20,22 In our study, less experienced GPs lacked interested in traditional general practice partnerships and did not plan their career at an early stage, which is consistent with previous findings12,22. We found disillusionment with core general practice provided significant impetus to drive GPs towards GPED, and our study extends previous findings by highlighting that by providing room for GPs to focus on discrete episodes of clinical work, and workforce flexibility, GPED may provide a suitable alternative or adjunct to core general practice for at least a sub-set of GPs.

However, there was scepticism amongst participants that a critical mass of GPs would be willing to staff GPED services since working patterns and conditions were considered inconsistent with what most GPs want. A recent study of GPED services identified difficulties in filling rota gaps and unsocial shift patterns8, although the reasons for this were unclear. Previous studies have identified that medical practitioners choose to work in core general practice as they perceive it to lack unsocial hours while providing work-life balance and continuity of care.11,12 This may be a limiting factor for GPs choosing to work in GPED. In our study, there were contradictions between competing assertions that GPs were attracted to GPED because it offered work-life balance in terms of limited commitment and defined, time-limited shifts, and that most GPs did not want to work unsocial hours. It is likely that different GPs have a variety of requirements. Participants in our study credited GPED with supporting core general practice by retaining GPs in some form of general practice, for at least some of the time, and promoting general practice to junior doctors. New approaches to GP careers are required in order to retain GPs22 and our findings suggest GPED may offer one of a range of approaches to address this.

Of significance is that participants in this study considered that system-wide change was necessary to address pressures on both core general practice and EDs, rather than adopting a single-initiative approach. This resonates with views of GPs working in core primary care who argue that a multifactorial approach is required to achieve effective and sustained solutions to workforce issues among GPs.22

Implications for research and/or practice

This study has a number of implications for practice. Table 2 outlines considerations which may enable GPED to develop to support both GPED services and core general practice. This may be used when planning and implementing GPED policy and services to work effectively alongside wider general practice provision.

<Table2>

**Conclusion**

GPs in our study found working in GPED to be personally and professionally beneficial. It suited their interests and allowed working and lifestyle flexibility not usually afforded in core general practice. However, the attraction of GPED was to a large extent driven by disillusionment with core general practice. This means that unless underlying issues are addressed, GPED has the potential to further destabilise general practice, with the negative consequence of creating increased pressure in both core general practice and the ED.

Our study provides a number of considerations for both the development of future GPED services and for core general practice, such as the positive effects of professional reciprocity, collaboration and personal development. GPED may offer an opportunity to support and extend clinical practice for more experienced GPs, while providing mechanisms for recruiting and retaining younger and more recently qualified GPs. However, while such initiatives are developed in an ad hoc way and without supporting system-wide changes, the potential of GPED may be limited and further depletion of the core general practice workforce a continuing area of concern.

**Funding:**

This work was supported by the National Institute for Health Research (NIHR) Health Services & Delivery Research (HS&DR) Programme, project number 15/145/06.

**Ethics committee approval:**

Ethics committee approvals were gained from East Midlands – Leicester South Research Ethics Committee (ref:17/EM/0312) and the University of Newcastle Ethics Committee (Ref: 14348/2016). HRA Approval was secured (IRAS: 230848 and 218038). Trial registration: [ISRCTN51780222](https://bmjopen.bmj.com/external-ref?link_type=ISRCTN&access_num=ISRCTN51780222)

[**Competing interests**](http://bjgp.org/authors/bjgp-ethical-guidelines)**:**

One author is seconded part-time to the post of Chief Medical Officer, NHS Digital. All other authors declare no conflict of interest.

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**Table 1: GPED Model by Case Site**

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| --- | --- | --- |
| Site | GPED Model | General Practitioner role |
| Birch | Inside ED: Parallel | GP in ED (including investigations) |
| Chestnut | Inside ED: Parallel  Outside ED: Off-site | GP in ED (usual primary care) |
| Hawthorn | Inside ED: Parallel (OOHs only) | GP in ED (usual primary care) |
| Juniper | Outside ED: 0n-site (OOHs only)  Inside ED: Integrated | GPs either work in usual primary care role or adapt a dual role where they become involved in managing patients with ED health issues |
| Linden | Outside ED: hospital site + off-site | GP in ED (UCC) (usual primary care) |
| Nutmeg | Inside ED: Parallel | GP in ED (UCC) (usual primary care) |
| Poplar | Outside ED: on-site | GP in ED (including investigations) |
| Redwood | Inside ED: Parallel | GP in ED (including investigations) |
| Rowan | Inside Emergency: Parallel | GP in ED (usual primary care ) |
| Teak | Inside ED: Parallel  Outside ED: Off-site | GP in ED (including investigations, increased acuity) |

Inside models = GPs co-located within ED. Can be: integrated = GPs work within the ED team managing a range of patients, or parallel = patients assessed as suitable for GP care ‘streamed’ to GP within the department.

Outside models = patients assessed in ED then sent to GP outside ED, either within hospital grounds (on-site) or off hospital grounds (Off-site).

UCC=Urgent Care Centre. OOH= GP Out-Of-Hours Service

**Table 2: Suggestions for Future Practice**

|  |  |  |
| --- | --- | --- |
| Sustainability of GPED | Sustainability of core General Practice | Sustainability of both GPED and core General Practice |
| Offer flexibility in work patterns, e.g. shift patterns, locum and part time work balanced with need for effective service planning and provision | Systemic change required to make general practice sustainable e.g. flexible working, collaborative working environment | Support for portfolio careers such as working in GPED may allow some GPs to extend their working life, reduce early retirement and attrition and prevent burnout |
| Support GPs to broaden clinical opportunities when working in GPED to enhance the core GP role | Support flexibility of workload organisation, e.g. consultation duration | Portfolio working and novel GPED roles require structured education and support from training systems and medical Royal Colleges |
| Support for GPs to adapt to different ways of working in GPED according to their career plan and aspirations | Use GPED to promote general practice to junior doctors and other health care professionals working in ED | Consideration of strategies to prevent/limit  competition for finite GP resource |
| Development of strategies to reduce competition for GP resource | Potential for core general practice to ‘borrow’ learning from the positive benefits GPs experience in GPED | Develop strategies that value shared learning and support for collaborative working |
| Provide ‘incentives’ to work in GPED such as support and supervision, career planning | Supporting GPs to work part-time in GPED or other portfolio working, as well as working part time in core general practice, may support retention of GPs | Develop GPED role to include input into system changes, e.g. streamlining primary/secondary care referral processes |
| Utilise GPs as a resource to share learning and primary care philosophies with ED colleagues | GPED can be used as a ‘stepping-stone’ for those GPs yet to make longer term career decisions | Professional reciprocity and broadening clinical opportunities enhances both primary and secondary care |

**Table S1: Participant Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ID | Site | Role/Employment in GPED | Working in ‘Core’ GP | Time | | Additional Information |
| B.16 | Birch | Locum | No data | T1 |  | |
| B.18 | Birch | 5 days per week | No | T1 |  | |
| C.3 | Chestnut | Lead GP on shift  2 shifts/month | Yes | T1 |  | |
| C.9 | Chestnut | Lead GP for UCC | No | T3 |  | |
| H.1 | Hawthorn | Managerial responsibilities  1 shift/week | Yes | T1 | Core GP partner | |
| H.20 | Hawthorn | Locum | Yes | T1 |  | |
| H.4 | Hawthorn | Salaried plus bank shifts  Employed by Trust | No | T3 | Near retirement | |
| J.24 | Juniper | Locum | No data | T1, T3 |  | |
| J.40 | Juniper | Locum 2 shifts/week | Yes | T2 |  | |
| J.39 | Juniper | GP Lead  Hybrid GP/ED role  Employed by Trust | No | T1,T3 |  | |
| J.44 | Juniper | Employed by Trust | No data | T3 |  | |
| J.46 | Juniper | Employed by Trust | Yes  1 session/week | T3 |  | |
| J.49 | Juniper | Employed by Trust | No | T3 |  | |
| J.62 | Juniper | Employed by Trust  2 days/week | No | T3 | Portfolio: GPED/locum/  OOH | |
| L.11 | Linden | Locum | No data | T1 |  | |
| L.19 | Linden | Locum  1 week/month | No | T1 | Works abroad | |
| N.19 | Nutmeg | Lead GPED GP | Yes | T1 |  | |
| N.24 | Nutmeg | No data | No | T3 | Left core GP partnership recently | |
| N.31 | Nutmeg | 1 shift/week | Yes | T3 | Portfolio: GPED/core GP/OOH | |
| P.9 | Poplar | Locum  Maximum 2 shifts/week | No | T1,T2 |  | |
| P.25 | Poplar | Employed by Trust | No | T2 |  | |
| P.24 | Poplar | Employed by Trust  3 shifts/week | No | T2 |  | |
| P.26 | Poplar | Bank/locum | No | T3 |  | |
| P.30 | Poplar | Bank/locum | No | T3 |  | |
| RD.1 | Redwood | No data | No data | T1 |  | |
| RD.7 | Redwood | Sessional work 2x shifts week | No | T1 | Retired core GP partner | |
| RD.20 | Redwood | Sessional work | No | T3 | Retired from core GP | |
| RN.10 | Rowan | 2-3 shifts/week | Yes | T1 | Portfolio: GPED/Core GP/OOH | |
| RN.3 | Rowan | Locum  10-12 sessions/month | No | T1 | Portfolio:  GPED/clinical lead/research | |
| RN.11 | Rowan | Sessional/locum | No | T1 |  | |
| RN.29 | Rowan | Salaried GP  150 hours/year | Yes | T1 | Core GP partner: 6 sessions/week | |
| RN.40 | Rowan | 4 sessions/week | Yes | T2 | Core GP partner | |
| RN.57 | Rowan | 2 shifts/month | Yes | T3 | Portfolio: GPED/core GP partner/OOH | |
| RN.58 | Rowan | 1-2 shifts/month | Yes | T3 | Portfolio: GPED/core GP/OOH/walk-in clinic | |
| T.6 | Teak | Bank – employed by Trust  1 shift/week | Yes | T1 |  | |
| T.4 | Teak | Employed by Trust | No | T1 |  | |
| T.5 | Teak | Bank – employed by Trust  1 session/week | Yes | T1 |  | |
| T.26 | Teak | Employed by Trust  1 shift/week | No | T1 | Portfolio | |
| T.40 | Teak | Employed by Trust | No data | T3 |  | |

OOH=GP Out-Of-Hours Service

**Box S1: GPED Topic Guide**

|  |
| --- |
| **Topic guide for GPs in ED: Before introduction of GPED** |
| **Personal:** |
| What is your current role in the GPED?  What was your previous (or concurrent) role in primary care?  Did you have a role in relation to the introduction of GPED/how did you become aware of the new service model?  Explore decision around taking the role as GP in ED context  Discussion around who is employer, professional indemnity, clinical supervision/support around clinical decision making in role as GP in ED |
| **GPED model:** |
| Tell us what you understand about the GPED model that is being implemented?  Are you aware of the background to the decision to introduce GPED:   * What it is hoped that GPED will achieve * How the service came about * Consultation process with CCG/other primary care forums   What are your thoughts on the decision to fund these models of service delivery?   * Does the idea of GPs in ED make sense in general * Aware of other types of GPED models being implemented elsewhere   Do staff (from GP component of service) have a shared understanding of the purpose of the proposed model of GPED?   * Do staff feel they have had sufficient buy in? * What are your concerns (if any) regarding implementation ? * Do you think there are any potential safety issues? * How supported do you feel by management going into the change? |
| **Expected impact:** |
| What are your expectations of the impact of the new service on your own everyday working?   * Clinically (type of patients/presenting conditions) * Working relationships with other staff (e.g. staff selecting patients to be seen by the GP, the ED staff) * Administratively/organizationally * For the service provided to patients   What you think the impact will be to your ED department on:   * Performance (4 hours, hospital admission rate) * Resources * How patients use the ED   What do you think will be the key barriers/facilitators to the introduction of GPED?  What do you think would be deemed to be successful outcomes?  How do you think patients will respond to the new service (satisfaction, ability to feedback, change in behaviour)?  Any other comments to add about GPED |
| **Topic Guide for all staff in ED: After introduction of GPED** |
| **Personal:**  What is your current role in the GPED?  What has been your role in the implementation of GPED? |
| **GPED model:** |
| Tell us about GPED as it is currently running (any differences from original plan/reasons for any changes).  Describe the process of implementation   * Key staff involved * Structural/organisational changes * Any training * Communication with staff/patients * Feedback from staff/patients * Timetable   What was expected to be achieved by the change?  What were the key barriers/facilitators?  What were the key issues for staff?  What was the attitude/approach to change from management? |
| **Impact:** |
| How do you think the GPED model is working?   * Process of selecting patients to be seen by the GP/getting the ‘right’ patients/transfer of patients * Any safety concerns * Key advantages/disadvantages   How has it impacted on overall workings of the ED?   * Has there been any impact on performance (e.g. 4 hours, hospital admission rate) * Resources   Have you been able to feedback experiences of GPED (changes in response to feedback)?  Do you think any improvements could be made to the GPED model (aware of different service configurations in other places)?  What feedback have you had from patients about the GPED model?  Do you think the availability of this GPED model is likely to change the way the public make decisions about how, when and where to seek care?  Any other comments to add about GPED |
| *For emergency care staff:* |
| How has GPED impacted on your own everyday working?   * Clinically (type of patients/presenting conditions) * Working relationships with other staff (e.g. the staff selecting patients to be seen by the GP, the GP staff) * Service provided to patients * Administratively/organizationally * Any surprises |
| *For general practice staff in GPED:* |
| How is care organised within GP component of GPED?  How does practice within GPED compare to other services (GP practice, walk-in centres):   * Clinically (types of patients/presenting conditions) * Patient ‘outcomes’ (e.g. referrals, requests for testing, transfer back to ED) * Interaction with other professional groups within GP component/ED staff * Workload * Any surprises   Discussion around who is employer, professional indemnity, clinical supervision/support around clinical decision making in role as GP in ED  Do you feel you act differently as a practitioner following time in ED (probe – both back in primary care and over time within ED)  Satisfaction with role of GP in ED   * Met with expectations * Plan to continue in role * Career plans   How do you think patients have responded to the service?   * Why they came to AE rather than GP practice   Satisfaction with GPED? |