Debate & Analysis

GP workload:

time for a rethink of the generalist model of care to promote retention

Much has been written in recent months about the 'crisis' in general practice; a crisis that has been linked to difficulties in recruiting to and retaining the workforce, changing working patterns, increasing care demands, and bureaucracy in the system of care. The debate has rippled through the press,[1,2] been the subject of discussion at conferences and in the pages of journals,[3] as well as prompting a number of reviews.[4–6] While rarely out of the headlines or journals, it would seem that there is more 'heat than light' in identifying a way forward.

SURVEY OF WESSEX GPs

This lack of clarity prompted us to seek the experiences of GPs and their views of working in general practice today, and to ask them to look ahead to the future. This article is based on an analysis of data gathered in Wessex by a survey of GPs (n = 1445) and interview of a purposive 'key informant' sample of seven,[7] reflecting different ages, career stages, and role types. The latter were recruited by invitation through local GP and practice networks, and those participating consented to undertake semi-structured telephone interviews. Both datasets were thematically analysed, and a fuller description of this work can be found elsewhere.[8]

A recent article in *BJGP* by Abbt and Alderson[3] argues *'It's not workload'*, however the views expressed by our informants would challenge this. They described today's general practice working environment as being very different to that of some 20 or 30 years ago. The lack of a well-defined career structure, alongside other influences, was seen as being a significant factor in GPs no longer seeking to be partners, especially those in the early stages of a career. This seems to have arisen as a result of the extended responsibilities that come with the role (such as employing staff and working with clinical commissioning groups CCGs), the imminent end of a reward for seniority and an inflexible workforce structure that does not allow senior GPs to move into roles which capitalise on their skills and experience:

'[T]here is no change in … workload from the first day they start until they leave.'

Our responders reported having formed management or 'exit' strategies to ameliorate their individual situations: younger GPs were planning to reduce sessions or move abroad; mid-career GPs too were looking to reducing sessions and/or move into salaried posts; 'twilight career' GPs and partners reported reducing sessions, planning to retire earlier, or move into alternative roles; salaried GPs reported considering leaving general practice or reducing clinical sessions; and locums reported considering leaving the profession, emigrating, or moving into alternative, portfolio roles.[8] All these strategies have the potential to impact negatively on the workforce, and the current exodus of senior GPs from the profession through early retirement may be seen as the start of these strategies being put into practice.[9]

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Our informants spoke of the workload not only increasing, but being 'unboundaried:'

'I work very long hours, very intense work, not much in the way of breaks or down time. It's solid seeing patients and masses of paperwork and then outside of work I have to log on to catch up with paperwork.'

Informants not only described the clinical administrative work extending from face-to-face consultations, but also that arising from visits, telephone consultations, and triaging being layered on top. They described a rising tide of 'invisible' paperwork from inside and outside the NHS system, including hospital clinics, out-of-hours, NHS 111, blood tests, radiological investigation results, and insurance reports, all of which is set within a culture of target management and reporting,[10] high patient expectation, and increased risk of litigation. Thus, it is not only the workload that has become unboundaried, but also the role itself in terms of scope, which sees the GP act not only as clinician, but also gatekeeper, and manager of care, bearing responsibility for interacting with other services and structures: being 'all things to all people'.[11] As a whole, this was viewed as eroding professional autonomy, displacing the patient at the centre of care and leaving GPs feeling overwhelmed:

'We are no longer allowed the freedom to make professional decisions in the interest of the community we serve.'

Informants were asked about their views on the present structure of primary care and how they saw it evolving. They acknowledged that a 'one size fits all' or '10 minutes for all' approach was not working, and that there was a need for clinical workload differentiation to take account, not only of the differing needs of patients, but also the differing needs of GPs:

'If you have been a GP for 30 years you are able and extremely competent to deal with complicated patients' needs, who need an experienced GP to manage things.'

This reflects current literature, which argues that the approach to delivering care and the general practice business model are outdated.[12–14] Smith *et al*,[12] in their review, note 'new models of care organisation are emerging organically in some areas to meet the challenges facing primary care'. Informants were aware of pockets of innovation and development in the area, but at the same time conscious of the challenges of such change. A key

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one of these challenges was seen to be the funding for general practice; while top down funding in the UK for general practice has shown a small increase between 2009 and 2014,[15] the sustained increase in bottom up, practice-level costs and continued reduction in the share of NHS expenditure received by general practice in Great Britain (from 10.3% in 2004–2005 to 8.4% in 2011–2012 taking into account reimbursement for costs of drugs and dispensing fees) sees resourcing for general practice failing to keep up with service delivery costs.[16] Read in the context of a falling number of clinicians, increasing workload, and role complexity, it is little wonder the impact is being felt in the consulting rooms, in terms of access, quality of care, motivation to innovate, and recruitment figures.

A POSSIBLE WAY FORWARD

However, innovating through recognising different areas of care provides scope to manage each in different ways. Primary health care lends itself to being divided into four main care groups: acute and chronic conditions, which are subdivided on the basis of whether the patient is mobile (ambulatory and non-ambulatory). Each of these types of care offers the opportunity to provide services in different ways, by different groups of healthcare practitioners, depending on demand and supply in a locality; further, it allows the GP workforce to be allocated to each sector depending on experience and career preferences (Box 1).

Thus, by delegating acute care (ambulatory and non-ambulatory) to other providers, time could be freed up for complex chronic care to be managed in longer appointment times. This approach re-establishes boundaries that are dependent on the nature of the work and relieves the constant pressure of time. On stepping back from partnership responsibilities senior GPs could direct their skills and experience to more complex care such as chronic health conditions. Similarly general practice may be made more attractive for younger GPs who may not want to do '4 or 5 days of solid general practice' but rather may prefer to focus on acute care or a mix of clinical and non-clinical activities. The options outlined in Box 1 would not be narrow, limiting career silos, but ones that would allow GPs to move between care groups depending on personal choice at different times in their careers, thereby allowing them to maintain their generalist role, but 'boundarise' the workload and role into manageable sectors. Organisational change is being supported by monies from the 'Vanguard Project' (previously the Better Care Fund and Integration Transformation Fund)[17] and the 'Prime Minister's Challenge' fund,[18] both of which aim to facilitate the development of healthcare models that differ from current approaches. Many CCG areas already have groups of practices working together to oversee the governance of the allocated funds. Such networks can provide the governance and professional development structures for the groups of health professionals needed, and oversee the mentoring necessary of early years GPs by those with more experience.

Informants thought that for a career in general practice to become attractive again there should be an emphasis on developing portfolio roles and interests (such as education/training, mentoring, special interest, appraising, and research) to sit alongside clinical work. Portfolio roles are particularly attractive to 'twilight' GPs as they allow flexibility to reduce workload in specific areas, and to open up roles in others, for instance experienced GPs providing ambulatory or non-ambulatory chronic care could be mentors to newly-qualified GPs in their practice of acute care.

This re-envisioned model of care provides a way forward to both promote the retention of experienced GPs to the workforce and improve care provision. It would encompass a broader clinical team, make general practice more appealing with a clearer career structure and support the development of alternative roles to complement clinical practice. Ultimately, patient care benefits from the skills and experience of established GPs, as well as offering an attractive option for those at the beginning of their career whose enthusiasm and vision may be directed towards acute care. It also offers re-entry points for those looking to make a return to work or even a move into general practice.

Box 1. Re-modelled primary care

	Ambulatory	Non-ambulatory
Acute	Acute care centre staffed by local GPs in rotation	Community doctor (which may suit newly-qualified GPs), out of hours, paramedic
Chronic	The life-force of general practice (minus acute and home visits) allowing for extended appointment times	Patients (house-bound or in residential homes) cared for by experienced community GPs, currently a health group which is poorly managed

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