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# GP views on strategies to cope with increasing workload:

## a qualitative interview study


## Abstract

### Background
The existence of a crisis in primary care in the UK is in little doubt. GP morale and job satisfaction are low, and workload is increasing. In this challenging context, finding ways for GPs to manage that workload is imperative.

### Aim
To explore what existing or potential strategies are described by GPs for dealing with their workload, and their views on the relative merits of each.

### Design and setting
Semi-structured, qualitative interviews with GPs working within NHS England.

### Method
All GPs working within NHS England were eligible. Of those who responded to advertisements, a maximum-variation sample was selected and interviewed until data saturation was reached. Data were analysed thematically.

### Results
Responses were received from 171 GPs, and, from these, 34 were included in the study. Four main themes emerged for workload management: patient-level, GP-level, practice-level, and systems-level strategies. A need for patients to take greater responsibility for self-management was clear, but many felt that GPs should not be responsible for this education. Increased delegation of tasks was felt to be key to managing workload, with innovative use of allied healthcare professionals and extended roles for non-clinical staff suggested. Telephone triage was a commonly used tool for managing workload, although not all participants found this helpful.

### Conclusion
This in-depth qualitative study demonstrates an encouraging resilience among GPs. They are proactively trying to manage workload, often using innovative local strategies. GPs do not feel that they can do this alone, however, and called repeatedly for increased recruitment and more investment in primary care.



### Keywords
general practice; general practitioners; primary health care; qualitative research; workload.


## INTRODUCTION

General practice provides the usual first point of contact, and most preventive care and follow-up management, in the UK NHS. With 90% of NHS activity occurring in primary care,[1] a year-on-year rise in GP consultations in England since 2008[2] has been compounded by increased case complexity and comorbidity, set to rise further.[3] This expansion has not been matched by increased recruitment or funding in general practice. Between 2009 and 2014, the headcount of UK GPs grew by just 0.2%,[4] while the population grew by 6%. The Royal College of General Practitioners (RCGP) estimates that 8000 more full-time equivalent (FTE) GPs will be needed by 2020,[5] but boosting the number of GP trainees is proving difficult.[6] Meanwhile, the share of NHS expenditure allocated to general practice has fallen by almost 20%, and forecasts predict a substantial funding shortfall of £1.6 billion by 2017–2018.[2]

The growing workload crisis has become a significant issue. Two-thirds of GPs describe their workload as 'unmanageable' or 'unsustainable',[7] and 93% report that their workload has negatively impacted on the quality of patient care.[8] Early retirement is being considered by 60%.[7] Causes of increased workload include increased administrative load, target management, high patient expectation, and increased risk of litigation.[9] Most GPs (90%) believe that high levels of workload damage the quality of patient care, and that 10-minute consultations are inadequate to meet patient needs,[8] although these concerns are not new.[10,11]

Given the very real concerns about sustainability of UK general practice, change and resilience seem necessary for survival.[12] This qualitative interview study of GPs in England aimed to investigate views on workload and, for this analysis, exploring what strategies GPs reported and suggested for dealing with workload.

## METHOD

All qualified GPs working within NHS England were eligible for this semi-structured interview study, underpinned by a modified grounded-theory approach. An advertisement was circulated via regional GP e-mail lists and social media networks. Those who responded were purposively selected to obtain a maximum variation sample in terms of GP characteristics (number of sessions per week, years as a GP, additional roles, GP role) and practice characteristics (list size, geographical location, rurality, number of other staff), to represent the range of GP demographics in NHS England. GPs who responded, but were not invited to participate, were politely thanked and offered an explanation about the high response rate. Interviews continued until data saturation was reached, when those analysing the data agreed no new themes were being identified from further interviews. GPs were


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## How this fits in

Finding the best ways for GPs in the UK to manage their workload is imperative. This in-depth qualitative interview study with GPs in England uncovers the use of many approaches to workload management. Attempts are made to identify which strategies GPs think are successful and unsuccessful. The study also aimed to identify what GPs feel they need in terms of further support.

reimbursed with a £50 gift voucher.

Interviews were conducted in June and July 2015 by telephone or face-to-face, and participants provided oral or written consent, respectively. An experienced non-clinical primary care researcher conducted interviews using a flexible pilot-tested topic guide (Box 1). An academic GP reviewed the interviews throughout the study.

Interviews lasted 30–70 minutes and were audiotaped, transcribed verbatim, and anonymised. Thematic analysis was carried out by the primary care researcher and the academic GP, who independently read interviews, drafted coding schemes, and identified initial themes to reflect their content. The coding schemes were compared and found to be similar, and were merged into an agreed coding scheme. With the assistance of QSR NVivo, (version 10) data were coded by two authors independently, with discussion, and each checked the other's coding. Throughout analysis, codes and themes were added, merged, and refined. Attention was paid to the diversity of participants' experiences and attitudes, discrepant cases, and differences between GPs with varying characteristics. Interim descriptive accounts were discussed and agreed among all authors.

## Box 1. Interview topic guide

**Topic *(prompts, if necessary)***

- Can you describe your workload? (*Volume, working hours, intensity)*
- Can you describe a typical working day/week?
- How do you feel about your workload? *(Manageability, sustainability, job satisfaction)*
- What contributes to your workload? *(Patient care, other activities)*
- Do you think that your workload has changed over time? *(When, why, how)*
- What are your thoughts about the content of consultations? *(Complexity, duration, change over time, what makes consultations complex)*
- How is workload distributed across your practice?
- What factors influence your workload?
- How do you cope with your workload?
- Do you/your practice have any strategies for dealing with the workload? (*How effective do you think these strategies are?)*
- Do you have any ideas for other strategies for dealing with the workload?
- Are you expecting workload to change in the future?
- Is there anything else about GP workload that you'd like to mention?

Data on participants' perceptions of workload and factors contributing to workload are published alongside a separate, accompanying article on GP perceptions of workload in England.[13] The analysis presented here is of participants' discussions of strategies for dealing with workload.

## RESULTS

One-hundred and seventy-one GPs responded to advertisements, of whom 34 participated. A maximum-variation sample was achieved (Table 1), including GPs from across England.

Participants discussed existing strategies for dealing with workload, strategies that were previously attempted, and ideas for potential future strategies. Emerging themes were grouped into 'levels' of strategies: patient-level, GP-level, practice-level, and systems-level approaches for managing workload (Box 2).

### Patient-level strategies

Patient education was the most commonly identified patient-level strategy for managing workload. Charging for GP services was discussed but was more controversial.

*Patient education on self-management.* Lack of self-management of minor illness such as colds and sore throats was commonly identified. Many responders tried to address this by educating patients about appropriate service use, for example, via the surgery website or posters, leaflets, and PowerPoint presentations in waiting areas, although some doubted how often patients accessed such resources.

The extent to which GPs, rather than the government, should be responsible for delivering patient education was contentious. Ten-minute consultations limited the potential for educating patients about where and when to consult.

Several participants felt that delivering a consistent message throughout the practice was key to patient education, but could be challenging:

*'... if you have a stable doctor population in your surgery and you have the same six doctors and they are there long-term then the messages the patients are getting is the same, which is "if you ring up with a cold and you come in for a cold you're not gonna have any treatment for that because it's a cold".'* (GP35, female locum, six sessions per week, 6–10 years' experience, medium-sized urban practice)

**Table 1. Characteristics of participants**

| GP characteristics | | *N* = 34 |
|---|---|---|
| Sex | Male | 17 |
| | Female | 17 |
| GP role | Partner | 28 |
| | Salaried | 3 |
| | Locum | 3 |
| Number of sessions in general practice per week | 1–4 | 3 |
| | 5–6 | 13 |
| | 7–8 | 11 |
| | 9–10 | 7 |
| Years as a GP | 1–5 | 7 |
| | 6–10 | 7 |
| | 11–15 | 3 |
| | 16–20 | 9 |
| | >20 | 8 |
| Other roles[a] | GP trainer | 14 |
| | Appraiser | 6 |
| | CCG roles | 8 |
| | Out-of-hours | 7 |
| | None of the above | 13 |
| **Practice characteristics[b]** | | ***N* = 31** |
| List size | ≤5000 (small) | 4 |
| | 5001–10 000 (medium) | 10 |
| | 10 001–15 000 (medium) | 13 |
| | >15 000 (large) | 4 |
| Location | Rural | 7 |
| | Semi-rural | 7 |
| | Suburban | 9 |
| | Urban | 8 |
| Dispensing | Yes | 9 |
| | No | 22 |
| Number of other GPs[c] | 1–3 | 4 |
| | 4–6 | 7 |
| | 7–9 | 12 |
| | 10–12 | 4 |
| | 13–15 | 2 |
| | >15 | 2 |
| Number of clinical staff who are not GPs[c] | 1–3 | 6 |
| | 4–5 | 10 |
| | 6–7 | 5 |
| | 8–10 | 8 |
| | 11–20 | 2 |
| Number of non-clinical staff [c,d] | 1–10 | 6 |
| | 11–20 | 14 |
| | 21–30 | 7 |
| | >30 | 3 |

*[a]Numbers add up to greater than the number of participants because some participants had multiple other roles, so were counted multiple times in this category. [b]For partners and salaried GPs only. [c]Absolute number, not full-time equivalents. [d]Data missing for one participant. CCG = clinical commissioning group.*

Education through media and schools was commonly discussed, as was the idea that public health campaigns could focus more 'positively' on self-treating:

*'… that's what NHS England should be doing, they should be doing, you know, press campaigns, you know, "do you really need to see a doctor, couldn't you go and see your pharmacist, couldn't you speak to your nan, couldn't you just do some saltwater gargles for your sore throat, you know, but if it's worse in 2 days, fine, see your GP".'* (GP28, female partner, seven sessions per week, 6–10 years' experience, medium-sized urban practice)

*Charging for services.* A significant minority of participants raised the idea of some form of charge being levied for a primary care appointment.

This was viewed as a method of deterring patients from making *'… oh I just thought I'd check'* appointments (GP03, female partner, five sessions per week, 16–20 years' experience, medium-sized semi-rural practice)

*'People pay more and wait more and are politer to their hairdressers than they are to their GP. I mean, there has to be some identification of cost. I had suggested that when people come for their prescriptions they should have an itemised bill, they don't have to pay it but, "Today your consultation would have cost this. This drug would have cost this."'* (GP04, female partner, six sessions per week, >20 years' experience, medium-sized semi-rural practice)

*'The only way people appreciate things is if they have to put their hands in their pocket and even if it was a tiny amount it would reduce demand because it certainly does where prescriptions are concerned, people that pay for their prescriptions say "Actually I don't think I'll take that", but when they don't pay for them they go "Oh I can have three lots of medicines for my hay fever please."'* (GP12, female partner, eight sessions per week, >20 years' experience, small rural practice)

GPs strongly in favour of charging for appointments often acknowledged that their opinion is not universally shared. Others expressed concerns that the bulk of people whom they perceived to consult often (children, older people, people receiving benefits) were likely to be exempted under any charging system anyway.

### GP-level strategies

Many participants discussed their own personal approach to managing their workload and coping with stress. Annual leave was often discussed, along with strategies for managing challenging patients.

**Table 1. Strategies for managing GP workload**

| Major theme | Sub-themes |
|---|---|
| Patient-level strategies | • Patient education on self-management<br>• Charging for services |
| GP-level strategies | • Improving the efficiency of the working day<br>• Managing patients with multiple agendas<br>• Personal coping strategies<br>• Taking leave |
| Practice-level strategies | • Delegating tasks: clinical and non-clinical staff<br>• Telephone appointments<br>• Triage<br>• Staff recruitment<br>• Practice management |
| Systems-level strategies | • A need for additional funding<br>• Improving recruitment to general practice<br>• Reducing bureaucracy<br>• Redistributing workload and improving communications with secondary care<br>• Federations and hubs |

*Improving the efficiency of the working day.* A variety of strategies was suggested, including dealing with tasks as they are received and proactively ringing patients to complete a task.

Many participants used remote access to complete tasks from home, and cited this as an important factor in maintaining ability to deal with workload safely:

*'Well doing letters and results at home is a big thing now. I think, you know, I decided, well I just get too hungry and tired … that's when I'll make mistakes and that's scary.'* (GP19, female partner, six sessions per week, 16–20 years' experience, medium-sized rural practice)

*Managing patients with multiple agendas.* The challenge of managing burgeoning lists of patient issues in 10-minute appointments was often discussed, although some felt this was not a new problem. Many participants negotiated the boundaries of the consultation explicitly with patients, but often recognised that this could be stressful:

*'Patients have always tried to bring up 10 things in a 10-minute consultation, I think it's how you deal with that. I think if you try and deal with all 10, then inherently you have a long, complex consultation. I think if you put your foot down and say, "Look, this is inappropriate, I can't do a good job here" then you have a shorter one.'* (GP09, male GP partner, five sessions per week, 6–10 years' experience, large urban practice)

*Personal coping strategies.* Social support was often seen as key to coping with workload. The loneliness of consulting was commented on, with designated practice coffee times seen as important for camaraderie (although team interaction was felt as being continually eroded by an increased workload):

*'I think it's good to get it off your chest. We had a really good moan this morning round the coffee machine.'* (GP25, male partner, 10 sessions per week, >20 years' experience, large rural practice)

Almost all participants felt that full-time working was not possible, and reducing the number of sessions was often cited as a strategy for managing personal workload:

*'… the level of emotional and mental exhaustion means that if you work full-time you will burnout.'* (GP28, female partner, seven sessions per week, 6–10 years' experience, medium-sized urban practice)

*'I think if I hadn't changed, reduced my sessions, I would be, I don't know where I'd be actually, I don't think I'd have survived the winter.'* (GP05, male partner, eight sessions, per week, 11–15 years' experience, medium-sized urban practice)

Despite reducing their sessions, many GPs worked at home or on days off to manage their workload. Having a special interest or 'portfolio' career was felt by some to be an effective coping mechanism, with GP training, appraising, research, clinical commissioning group work, and General Medical Council work among the roles fulfilled by participants. A GP working in a larger, recently merged practice described the use of a 'buddy system' (being paired with another GP to share a patient list) as a mechanism for managing workflow in a mostly part-time GP workforce.

*The benefits and problems of taking leave.* Annual leave was seen as important to preserve emotional health, but could adversely affect workload for colleagues, which could be managed by restricting the number of GPs allowed leave simultaneously, or having locum sessions to cover absences.

**Practice-level strategies**

Delegation of tasks within the practice was a key theme of practice-level strategies, as was use of telephone appointments and telephone triage. The need to recruit more GPs was consistently discussed.

*Delegating tasks.* There was agreement that tasks should be delegated as far as

possible to other, less qualified, practice staff to protect GPs' time. One locum felt that delegation of work was a feature of the better-run practices in which she had worked (GP35, female locum, six sessions per week, 6–10 years' experience, medium-sized urban practice)

*Sharing work with other clinical staff.* Most participants' practices used nurses for minor illness, although insufficient nurses available to manage minor illness led to spillover to GPs. Many GPs reported that practice nurses are undertaking most routine chronic disease management, which was viewed positively:

*'... absolutely fantastic, I mean, I think she's a doctor with a nurse's, you know, hat on, really, and she's brilliant on cardiology, rheumatology, she does joint injections, she interprets, you know, she manages all our rheumatology patients, manages all our asthmatics and COPDs.'* (GP02, female partner, five sessions per week, >20 years' experience, medium-sized semi-rural practice)

Although this seemed to be universally regarded as time-saving for GPs, several participants felt that it may not actually be cost-effective if nurses required more time to complete tasks. Increasing comorbidity might also challenge the sustainability of this model:

*'... hypertension would be nursing, the only problem with hypertension we're finding is usually by the time they've got hypertension they've also got diabetes, obesity, and something else, so, and they're on a statin, so it's harder for the nurse to do comorbidity work.'* (GP03, female partner, five sessions per week, 16–20 years' experience, medium -sized semi-rural practice)

The idea of 'stepping up a grade' was a common theme:

*'... everybody's stepping up a grade if that makes sense, so effectively we are consultants, our practice nurses are doing, you know, simple minor illnesses and chronic disease management and healthcare assistants are doing what nurses used to do, etcetera.'* (GP 14, male partner, eight sessions per week, 16–20 years' experience, large suburban practice)

*Extending the roles of non-clinical staff.* The importance of a good administrative team was often cited, and most participants' practices had trained non-clinical staff to carry out tasks aimed at reducing the administrative burden on GPs, such as the 'initial triage' of incoming letters to highlight medication changes and coding.

Concerns raised about the medicolegal implications of delegating work to non-clinical staff limited the willingness of some GPs to delegate tasks.

*Use of telephone appointments.* Participants did not universally agree on the effectiveness of telephone consultation at reducing workload. Some felt that certain tasks could easily be carried out over the telephone (for example, medication dose alterations), or reduced the time needed during a subsequent face-to-face appointment. Paradoxically, some felt that telephone consultations could increase workload if they operated as an extra to existing surgeries, or become a hidden workload:

*'... what it does is actually it moves the workload out of eyesight of your staff which is not always a good thing.'* (GP07, female partner, six sessions per week, 6–10 years' experience, large suburban practice)

*Telephone triage as a tool for managing workload.* Significant variation in the ways practices used telephone triage was apparent within the study sample. Opinions about the efficiency of telephone triage for managing workload were divided, particularly whether it reduced face-to-face contacts:

*'We reckon that cuts our consultation by 50%. So we'd see 50% of them and the other 50% we would advise on the telephone.'* (GP03, female partner, five sessions per week, 16–20 years' experience, medium-sized semi-rural practice)

*'We tried it and a couple of partners found it just really stressful and essentially they found that everybody they spoke to they brought down ...'* (GP08, female partner, five sessions per week, 16–20 years' experience, medium-sized suburban practice)

*The need to recruit more GPs.* Recruitment of more GPs was consistently seen as key to managing workload, but several participants expressed concerns about how they would afford this:

*'... we haven't got the money, we'd love to employ another GP, but because there's no extra money, in fact it's being squeezed, we*

*can't afford to ...'* (GP03, female partner, five sessions per week, 16–20 years' experience, medium-sized semi-rural practice)

A significant proportion of participants discussed the possibility of employing allied health professionals such as pharmacists and emergency care practitioners to help manage workload, but only a minority said that their practice currently did this. A lack of funding was most often cited as the barrier and several raised the idea of shared employment by a local GP federation.

*Practice management.* A minority of GPs discussed the role of IT systems in managing workflow, including electronic prescribing as a particular efficiency. Organisation of the appointments system varied greatly between practices, but there was no agreement on a best structure to efficiently manage workload.

**Organisational and systems-level strategies**

The need for additional funding for primary care was consistently raised and was linked to recruitment and retention of staff.

*Need for additional funding.* Most GPs felt that an increase in funding was central to managing workload. Many referred to reductions in their income in recent years, and felt they were trying to do more with less:

*'... it's very hard not to see that the basic problem is that there's a huge budget deficit and not, and, you know, there's not enough money to go round.'* (GP15, female partner, eight sessions per week, 1–5 years' experience, medium-sized rural practice)

*Strategies to improve staff recruitment to primary care.* Most believed that increasing funding would improve recruitment, by increasing capacity to employ extra staff. Several pointed to perceived negative *'digging that goes on at general practice.'* (GP12, female partner, eight sessions per week, >20 years' experience, small rural practice) by the national media and government. Improving morale was seen as key to attracting new GPs:

*'I think one of the things is the nasty newspaper stuff is just* so *demoralising, it's just* really horrid *and when the government sort of go, "Oh well, you know, the hospitals are overrun but that's because the GPs aren't doing anything" ... It's just terrible, it makes me* so *upset.'* (GP19, female GP partner, six sessions per week, 16–20 years' experience, medium-sized rural practice)

Several GPs wanted more junior doctors to rotate through general practice, to manage workload and improve recruitment.

*Reducing bureaucracy in primary care.* Paperwork was viewed by many participants as a workload component that could be significantly reduced:

*'... seeing the patients is a piece of cake, the bureaucracy around seeing them is unbelievable.'* (GP12, female partner, eight sessions per week, >20 years' experience, small rural practice)

Care plans and the Quality and Outcomes Framework (QOF) were often described as overly bureaucratic, while adding little to the quality of care. Sick notes were singled out as not necessarily requiring GP expertise:

*'QOF has its potentials but QOF for QOF's sake is just silly, you end up calling patients in just for the sake of ticking off you've done a review and it's, not quite right I don't think ... like these care plans that we're meant to be doing at the moment are just a complete waste of time.'* (GP31, female partner, six sessions per week, 1–5 years' experience, small suburban practice)

*Redistributing workload and improving communication with secondary care.* Several GPs described workload increasing as a result of a shift in the workload from secondary to primary care. One GP described inviting hospital colleagues to spend time with them in an attempt to facilitate understanding of the role of the GPs. Others felt that GPs need to be more 'resilient' and 'fight back'.

Several GPs felt that hospital specialist e-mail advice lines provided rapid responses to queries that might otherwise have required referral.

*Using federations and hubs.* Many participants pointed to GP federations as a future mechanism for increasing efficiency and decreasing workload by sharing both work and resources between practices. Two often-discussed models were the creation of minor illness hubs to which practices could triage patients (therefore freeing up time for GPs to manage chronic disease), and shared employment of nurse practitioners, emergency care practitioners, or pharmacists.

The need to create larger practices was stated by some as undesirable yet necessary for survival, but not sufficient to reduce workload:

*'I don't think there will be very many practices of our size still around in 10 years' time actually, I think practices of our size will have to merge or die ... Because, yeah, because there is so much work outside of normal patient care that unless you've got sort of 10 GPs and a couple of practice managers to share it it becomes overwhelming.'* (GP11, male partner, eight to nine sessions per week, 1–5 years' experience, small semi-rural practice)

Several participants worked in practices where mergers had occurred, with small list size or GP retirement cited as catalysts. One recognised that a larger staff team facilitated more individual areas of expertise, but also felt that with more doctors a *'collusion of anonymity.'* (GP20, male partner, five sessions per week, >20 years' experience, medium-sized urban practice) was possible, challenging the provision of continuity and consistency of care provided to patients. These GPs were not clear that mergers had decreased their workload.

## DISCUSSION

### Summary

These data indicate that GPs are proactively attempting to manage workload, using strategies at various levels. Some strategies were positive (role delegation, better use of digital health), but some carry the potential to worsen workload in the longer term (reducing sessions, using telephone triage).[14] Delegation of work to allied health professionals or administrative staff was felt to be necessary for freeing more patient-facing GP time, with increased funding thought to be key for recruitment of GPs and other staff. Patient education was seen as vital for reducing demand on limited resources, but the responsibility for this was often placed with public health, government, or the media rather than GPs. The most common personal strategy for managing workload was reducing sessions, which in the context of increasing patient demand and a static or reducing GP workforce, combined with the potential negative impact on continuity of care, is concerning.

### Strengths and limitations

The relatively large number of responders allowed selection of a maximum variation sample of GPs from across England. Interviews were conducted by a non-clinician, which may have increased objectivity in question style and enabled GPs to speak more freely. The other authors are academic GPs and their personal experiences of workload may have influenced their contributions to the analysis, despite efforts to remain objective.

A natural limitation of this work is that the views of the small but diverse study sample are not necessarily representative of all GPs. Self-selection of participants may have resulted in over-reporting of workload problems, or a skewed perspective of the ability to provide solutions. Strategies for managing workload were nested within a longer interview exploring all dimensions of GP workload, which may have affected participants' responses to this area of questioning. Including practice managers or allied health professionals in further research would be beneficial.

### Comparison with existing literature

Previous research has described the perceived reasons for the rise in GP workload, reviewed GPs reducing their sessions, leaving, and difficulties in recruitment.[8,15,16] To the authors' knowledge, this is the first study exploring GPs' strategies for coping with workload.

Telephone triage was often discussed, although views on efficiency were notably polarised. This is reflected in a recently published trial demonstrating an overall increase in GP workload with telephone triage, but a substantial reduction in face-to-face contacts.[14] A recently published retrospective analysis showed a doubling of GP telephone consultation rates between 2007–2008 and 2013–2014 on a background of a 12% increase in overall GP consultations.[17] There is a clear need to distinguish between redistribution and reduction of GP workload.

Delegating work and employing allied health professionals such as pharmacists, echoes a call from the RCGP in 2015 to increase the number of pharmacists working as part of the general practice team.[18] The Primary Care Workforce Commission report published in 2015 also sets out a vision for the future of primary care to increase the multidisciplinary workforce, including pharmacists, physician associates, and more support staff to reduce the administrative burden on GPs, and also suggested a new model with practices forming networks or federations.[19] No participants discussed the possibility of harnessing volunteers to assist in managing workflow, although the King's Fund is currently examining this.[12]

Many participants raised patient safety implications of workload. The RCGP compared primary care with other safety-critical industries, recommending an *'urgent full-scale review in to how bureaucracy and unnecessary workload can be cut'*.[20]

The British Medical Association offers a practical guide for practices to assist workload management,[21] and the present data suggest that GPs are already using many of these strategies.

**Implications for research**

That the present participants did not have a unified view on how to improve GP workload is unsurprising: GP practices vary enormously in almost every regard, and it is perhaps this very variation that makes finding solutions to the workload crisis so challenging. A one-size-fits-all approach is unlikely to fit very many at all.

Some consistent themes emerged, however. Increased part-time working and portfolio careers are becoming increasingly common and policies for primary care need to embrace this. Without more GPs, this will further increase pressures. Effectively introducing allied health professionals requires research to ensure this strategy does not compromise patient care, and to better understand how to maximise utility of these roles.

It is perhaps funding that lies at the core of this issue. Primary care can become more efficient, but implementation of new models of care requires significant investment in infrastructure. The April 2016 publication of the *General Practice Forward View*[22] promises increased investment in general practice, a reduction in bureaucracy, and efforts to reduce inappropriate demand, but has been criticised for lacking detail.[23] The present work suggests that GPs are proactively seeking to manage workload in the face of little conclusive evidence as to how best to achieve this. A stronger evidence base is urgently required to drive policy promises into practical change.

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**Ethical approval**

The study was approved by the University of Oxford Central University Research Ethics Committee (MS-IDREC-C1–2015–092).

**Provenance**

Freely submitted; externally peer reviewed.

**Competing interests**

FD Richard Hobbs is a practising GP and Research Lead for the Modality Super-Partnership. The other authors have declared no competing interests.

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## REFERENCES


1. NHS England. *Transforming primary care in London. General practice. A call to action*. 2013. https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/Call-Action-ACCESSIBLE.pdf (accessed 2 Dec 2016).
2. Deloitte. *Under pressure: the funding of patient care in general practice*. London: Deloitte, 2014.
3. Department of Health. *Long-term conditions compendium of information: third edition*. 2012. https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition (accessed 2 Dec 2016).
4. Health and Social Care Information Centre. *General and Personal Medical Services, England — 2004–2014, as at 30 September*. 2015. http://content.digital.nhs.uk/catalogue/PUB16934 (accessed 2 Dec 2016).
5. Royal College of General Practitioners. Over 500 surgeries at risk of closure as GP workforce crisis deepens. 2014. http://www.rcgp.org.uk/news/2014/october/over-500-surgeries-at-risk-of-closure-as-gp-workforce-crisis-deepens.aspx (accessed 2 Dec 2016).
6. Centre for Workforce Intelligence. *In-depth review of the general practitioner workforce*. London: CfWI, 2014. http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce (accessed 15 Nov 2016).
7. British Medical Association Health Policy and Economic Resarch Unit. *BMA quarterly tracker survey: current views from across the medical profession. Quarter 3: July 2015*. https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/bma%20quarterly%20tracker%20july%202015%20final.pdf (accessed 2 Dec 2016).
8. British Medical Association. *National survey of GPs: the future of general practice 2015*. http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/surveys/future-of-general-practice (accessed 2 Dec 2016).
9. Lyon-Maris J, Edwards L, Scallan S, Locke R. GP workload: time for a rethink of the generalist model of care to promote retention. *Br J Gen Pract* 2015; DOI: https://doi.org/10.3399/bjgp15X687145.
10. Lester H, Campbell SM, McDonald R. The present state and future direction of primary care: a qualitative study of GPs' views. *Br J Gen Pract* 2009; **59(569):** 908–915.
11. Evans J, Lambert T, Goldacre M. GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice. *Occas Pap R Coll Gen Pract* 2002; **83:** iii–vi, 1–33.
12. Baird B, Charles A, Honeyman M, *et al. Understanding pressures in general practice*. 2016. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf (accessed 2 Dec 2016).
13. Croxson CHD, Ashdown HF, Hobbs FDR. GPs' perceptions of workload in England: a qualitative interview study. *Br J Gen Pract* 2016; DOI: https://doi.org/10.3399/bjgp17X688849.
14. Campbell JL, Fletcher E, Britten N, *et al*. Telephone triage for management of same-day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis. *Lancet* 2014; **384(9957):** 1859–1868.
15. Rimmer A. One in eight GP training posts vacant, despite unprecedented third round of recruitment. *BMJ* 2014; **349:** g6478.
16. Doran N, Fox F, Rodham K, *et al*. Lost to the NHS: a mixed methods study of why GPs leave practice early in England. *Br J Gen Pract* 2016; DOI: https://doi.org/10.3399/bjgp16X683425.
17. Hobbs FR, Bankhead C, Mukhtar T, *et al*. Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14. *Lancet* 2016; **387(10035):** 2323–2330.
18. Royal College of General Practitioners. Pharmacists set to work in GP surgeries in radical move to ease pressures on general practice and improve patient care. 2015. http://www.rcgp.org.uk/news/2015/march/pharmacists-set-to-work-in-gp-surgeries.aspx (accessed 2 Dec 2016).
19. Primary Care Workforce Commission. *The future of primary care: creating teams for tomorrow*. 2015. https://www.hee.nhs.uk/sites/default/files/documents/WES_The-future-of-primary-care.pdf (accessed 2 Dec 2016).
20. Royal College of General Practitioners. *Patient safety implications of general practice workload*. 2015. http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/2015/RCGP-Patient-safety-implications-of-general-practice-workload-July-2015.ashx (accessed 2 Dec 2016).
21. British Medical Association. *Quality first: managing workload to deliver safe patient care*. 2015. https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/urgent%20prescription%20for%20general%20practice/quality%20first%20managing%20workload%20to%20deliver%20safe%20patient%20care.pdf?la=en (accessed 2 Dec 2016).
22. NHS England. *General practice forward view*. 2016. https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf (accessed 2 Dec 2016).
23. Roberts N. GP forward view: reaction from across the profession. *GP Online* 2016; **21 Apr:** http://www.gponline.com/gp-forward-view-reaction-across-profession/article/1392144 (accessed 2 Dec 2016).