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GPs' perceptions of workload in England:

a qualitative interview study

Abstract

Background
GPs report the lowest levels of morale among doctors, job satisfaction is low, and the GP workforce is diminishing. Workload is frequently cited as negatively impacting on commitment to a career in general practice, and many GPs report that their workload is unmanageable.

Aim
To gather an in-depth understanding of GPs' perceptions and attitudes towards workload.

Design and setting
All GPs working within NHS England were eligible. Advertisements were circulated via regional GP e-mail lists and national social media networks in June 2015. Of those GPs who responded, a maximum-variation sample was selected until data saturation was reached.

Method
Semi-structured, qualitative interviews were conducted. Data were analysed thematically.

Results
In total, 171 GPs responded, and 34 were included in this study. GPs described an increase in workload over recent years, with current working days being long and intense, raising concerns over the wellbeing of GPs and patients. Full-time partnership was generally not considered to be possible, and many participants felt workload was unsustainable, particularly given the diminishing workforce. Four major themes emerged to explain increased workload: increased patient needs and expectations; a changing relationship between primary and secondary care; bureaucracy and resources; and the balance of workload within a practice. Continuity of care was perceived as being eroded by changes in contracts and working patterns to deal with workload.

Conclusion
This study highlights the urgent need to address perceived lack of investment and clinical capacity in general practice, and suggests that managing patient expectations around what primary care can deliver, and reducing bureaucracy, have become key issues, at least until capacity issues are resolved.

Keywords
general practice; general practitioners; patient expectations; patients' needs; primary health care; qualitative research; workload.

INTRODUCTION

General practice has a pivotal role within the UK NHS, delivering holistic and comprehensive care to all, including urgent care, diagnosis, monitoring, health promotion and prevention, and managing access to secondary care. It is reported that 90% of NHS activity takes place in primary care.[1] However, GPs report the lowest levels of morale among doctors,[2] and recent surveys have highlighted that job satisfaction is at its lowest since 2001.[3] This discontent is compounded by concerns over a diminishing workforce: the proportion of GPs retiring or intending to leave direct patient care is increasing,[4] and recruitment to GP training schemes has been low in recent years.[5] Workload is cited most frequently as the factor negatively impacting on commitment to a career in general practice,[4] with two-thirds of GPs reporting an 'unmanageable' or 'unsustainable' workload.[2] In addition, 93% of GPs reported that workload has negatively impacted on the quality of patient care, and 68% that they experience significant work-related stress.[4] Several policy documents have recently been published, aiming to address the diminishing workforce and to plan sustainable models of care.[6–8]

Previous UK qualitative studies have identified paperwork, structural changes, changes in patient expectations, and consultation rates as influencing GP workload,[9–11] with impact on morale and inequity in workload identified as concerns.[12,13] However, in the decade since these publications there have been significant changes in UK general practice. These include:

- increasing consultation rates;[14]
- changes to contracts and funding arrangements, including the introduction of the Quality and Outcomes Framework (QOF);[15]
- a service reorganisation that includes the creation of clinical commissioning groups (CCGs);[16]
- changes in modes of patient access, for example, telephone consultations;[4] and
- changes in the nature of consultations due to demographic and disease characteristics.[1]

Therefore an up-to-date, evidence-based, in-depth understanding of GPs' perceptions and attitudes towards workload is lacking. This qualitative interview study of GPs in England aimed to understand factors that influence workload, and how it has changed over time.

METHOD

All qualified GPs working within NHS England were eligible for this semi-structured interview study. Advertisements were circulated via regional GP e-mail lists and national social media networks in June 2015, and those GPs who responded

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How this fits in

Previous research indicates burgeoning workloads in primary care, with GPs struggling to cope. This in-depth qualitative interview study of GPs provides evidence that GPs perceive workload to have increased in recent years, and this may be having adverse consequences for both patients and doctors. Reasons for this increased workload are analysed in this study, providing potential targets for future strategies to try to reduce GP workload.

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). Interviews continued until data saturation was reached. GPs were 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. Interviews were conducted using a flexible topic guide (Box 1). The topic guide was based on existing literature and discussion among practising GPs in the wider research team and pilot tested by an academic GP before the study started, and amended accordingly. It was also continuously amended during the course of the study. Interviews were reviewed throughout the study to identify data saturation.

Interviews lasted 30–70 minutes and were audiorecorded, transcribed verbatim, and anonymised. Thematic analysis was carried out, a coding scheme produced, and the data coded with the assistance of NVivo (version 10). Throughout the 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.

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?

RESULTS

In total, 171 GPs responded to advertisements, of whom 34 were selected to participate in the study. A maximum-variation sample was achieved (Table 1), including GPs from across England. First, participants' description of current workload is discussed, followed by factors contributing to workload. Data on GP strategies for dealing with workload are published in a separate, accompanying article.[17]

Participants' descriptions of workload

Most participants described long, intense days spent in general practice. Typical working days ranged from 10–14 hours, often with little or no time for breaks. GP partners tended to describe longer days than salaried or locum GPs. Many GPs reported the need to do administrative work during evenings, weekends, or days off. Although GPs described mostly feeling *'a bit resentful'* (GP21, female partner, seven sessions per week, 11–15 years' experience, medium-sized, suburban practice) about this, some commented that it was preferable to being on call or working weekends. GPs mostly felt that workload has increased in recent years, and sustainability was a concern for some. GPs were also concerned about the current intensity of workload:

'It's not just that you're working long hours. The thing which [sic] *massively changed is the intensity of when I'm here. What you can't explain is the fact that, within every moment of every day, you know, is that the numbers of tasks, and your multitasking capabilities, have had to increase.'* (GP29, male partner, 10 sessions per week, 11–15 years' experience, medium-sized semi-rural practice)

'I have a flask in my room and a little fridge to ensure I keep hydrated, otherwise I wouldn't get a drink because it's just so, I can't pop out. I probably have one wee a day! You forget to wee unfortunately, 'cos you're so busy, and it's the non-stop, it's the non-stop sort of the job I think that's the hardest.' (GP28, female partner, seven 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.

A full-time career as a GP partner was felt by nearly all participants to be unsustainable. This led to concerns about a diminishing workforce. Many participants were planning early retirement, or had experience of colleagues leaving the profession early, coupled with difficulty recruiting GPs — particularly to partnership positions, which they attributed to the difficult nature of the job.

Participants were concerned about the impacts of increasing workload, both for GPs (physical and mental wellbeing, work–life balance, morale, job satisfaction) and for the safety and care of their patients:

'Stress in the profession, I think, is pretty significant I would say. You know, you do hear regularly of sort of GPs, sort of, you know, committing suicide and stuff like that. We need to make sure that we sustain our health and our energy. Surely we should have probably half an hour downtime to have some food where nobody disturbs us, and we can, and you know, we need to have time when we get home that we don't feel completely shattered and too tired to go and do some exercise, and stuff like that, and keep ourselves fit.' (GP13, male partner, nine sessions per week, 16–20 years' experience, medium-sized suburban practice)

'The workload in the last sort of 5 years is just sort of seeming to go up year on year, and I know that I'm rushing a) patients, and b) decisions, so I don't feel I'm as safe as I was 5 years ago. I'm working harder and rushing, so I don't have time to think about things quite so much.' (GP6, male partner, six sessions per week, 16–20 years' experience, medium-sized rural practice)

'And other things have gone, you know. Things that, you know, just doing a postnatal visit on somebody who's just come back from hospital having their baby, now I haven't done one of those in years. You know, I would always visit in the past relatives after a bereavement, I don't, I certainly don't always manage it now, often it's unfortunately just a phone call.' (GP8, female partner, five sessions per week, 16–20 years' experience, medium-sized suburban practice)

There were some exceptions to the overall feeling of negativity regarding workload:

'There are positives with this workload crisis. It could be the making of general practice, I think. What we're thinking is working more cleverly really.' (GP5, male partner, eight sessions per week, 11–15 years' experience, medium-sized urban practice)

However, none of the responders felt that workload was not an issue in general practice at all. Although some participants were not dissatisfied with their own working life, all acknowledged that workload has

become more intense, or that workload is an issue for colleagues. Some salaried and locum GPs felt less negatively about workload than partner GPs. GPs with good team support and particular consultation styles also felt less negatively.

Factors impacting GP workload

The major themes that emerged to explain the perceived increase in workload were patient needs and expectations, relationship between primary care and secondary care, bureaucracy and resources, and balance of workload within a practice (Box 2).

Patients' needs and expectations

GPs felt that patient needs have increased due to medical and socioeconomic factors that, combined with increasing levels of expectation, led to concerns about the confines of a 10-minute consultation.

Medical factors. Increasing complexity due to an ageing population, chronic disease, mental illness, dementia, multimorbidity, and polypharmacy were perceived to have led to more complex and longer consultations. Participants with a large proportion of older patients felt their workload was greater than those with a smaller proportion, both within and between practices. A number of participants described workload increasing during the winter due to influenza and influenza vaccinations, and reducing during the summer due to less acute illness.

Box 2. Factors impacting GP workload

Major theme	Subthemes
Patient needs and expectations	• Medical factors — Medical complexity — Time of year • Socioeconomic factors — Social and economic deprivation — Rurality — Cultural factors — Communication • Patient expectations — Self-management and tolerance to illness — Tolerance of mistakes • 10-minute consultations — Patient lists • Accessibility
Relationship between primary and secondary care	• Shift in tasks from secondary to primary care • Communication with secondary care • Availability of other local health services
Bureaucracy and resources	• Increase in bureaucracy • Meeting targets • Funding
Balance of workload within a practice	• Practice size • Individual GP characteristics • GP role and hours • GPs as part of a team • Continuity of care

Socioeconomic factors. Many participants discussed workload in relation to social and economic deprivation. Patients in more deprived areas were less well educated about health, and requested more consultations for minor illness, and patients in more affluent areas had higher expectations, and perhaps higher levels of anxiety, also increasing demand for consultations:

'Quite a large cohort of homeless people, street-workers, and drug substance abuse that actually take a long time to obviously sort out and the constraints of the 10 minutes, it's pretty much impossible to sort of sort that out. Whereas my rural practice ... the patients around here are a lot more affluent and there's a lot of worried well, so a lot of consultations where perhaps not as much health care has happened that I'd expected to, and the sort of demands are sometimes unreasonable.' (GP27, male locum, eight sessions per week, 1–5 years' experience, regularly works at one inner-city and one rural practice)

Some participants felt that workload varied with level of practice rurality, mainly due to greater social and economic deprivation in inner-city areas. This was also due to patient attitudes and level of health education, as well as the time taken for home visits:

'I've worked in different practices, and in more rural places I think patients are a lot more resilient, you know, and will hang on [before consulting a GP].*'* (GP14, male partner, nine sessions per week, 16–20 years' experience, large suburban practice)

In areas with a significant ethnic minority population, the time needed to organise and utilise translation services, and explain the pathways through and constraints of the NHS, considerably added to workload.

Patient expectations. Some GPs strongly felt that patient demand for consultations has increased because of a growing lack of self-management and reduced tolerance for illness, resulting in patients presenting more frequently for more minor illness, or earlier in the course of an illness:

'Patients are coming in more frequently. Their ability to self-manage appears to be, in my view, zero. Someone rang me up this morning. He said, "I've got a pain in my foot." I said, "Have you taken some pain relief?" He went, "No." I said, "Well,

when you have, ring me back." You know, why do they ring for this stuff? Why, why has the public confidence in its own ability to self-manage itself fallen to zero?' (GP12, female partner, eight sessions per week, >20 years' experience, small rural practice)

The reasons for diminishing self-management and tolerance for illness were threefold:

- Breakdown in society, resulting in patients having less medical and social support from other sources, hence turning to their GP more commonly:

'Because of the breakdown in society, I think because, you know, people don't know their neighbours or their family and there's no wise person down the road that they can go to if their baby vomits, I feel like GPs are in a sense propping up society. We are just, we're taking that role of the wise old granny down the road.' (GP5, male partner, eight sessions per week, 11–15 years' experience, medium-sized urban practice)

'I think we are the first port of call when somebody's relationship goes wrong or somebody loses their job, or whatever it is, and that takes time because often there isn't anything medically wrong with them ... just people who've had something bad happen. There just isn't the social support in the community, and so we are the port of call for that, and that probably has had some increase.' (GP7, female partner, six sessions per week, 6–10 years' experience, medium-sized suburban practice)

- Increasing public access to information about health and illness, particularly from the internet, public health campaigns, and the media, resulting in increased consultations (without the additional resources to manage them):

'I've got patients who've googled their symptoms, and they've come with reams of internet printouts. And, probably, some of the internet sites they go onto are quite scary because they're not medically vetted. So yes, then they'll be alarmed and then they'll come down.' (GP23, male partner, eight sessions per week, >20 years' experience, medium-sized suburban practice)

'The media campaigns, you know: 'Go and see your doctor if you've had a cough for 3 weeks,' that kind of thing ... all of a sudden everybody with a cough for 3 weeks during 'flu season comes in. So yes, so health campaigns affect workload, local health scares.' (GP7, female partner, six sessions per week, 6–10 years' experience, medium-sized suburban practice)

- Inflation of patient expectations, which some participants believed was partially politically and media driven:

'This is stoked up to some extent by the politicians because they, particularly around elections, will say that, you know, the NHS will encompass everything. Every problem you should go and see your doctor, we'll make it possible for you to see your doctor within so much time. What they do is they stoke up expectations, instead of seeing that, the mismatch between supply and demand.' (GP10, male partner, four sessions per week, >20 years' experience, medium-sized semi-rural practice)

Related to patient demand, some GPs felt that society has become less tolerant of mistakes, and feared complaints and litigation, which impacted their workload:

'Now I, we, work in, I think, in [sic] *increasingly, not only litigious, but complaining environment, and that really for me is the reason why I just visit everybody that asks me to. I don't question any of it any more, and again I think, I think that probably fear is probably pushing workload up.'* (GP15, female partner, eight sessions per week, 1–5 years' experience, medium-sized rural practice)

Dealing with complaints was a major source of workload for those involved.

Ten-minute consultations. Participants agreed that patients commonly come to consultations with lists of multiple issues to discuss, although not all participants viewed this as a new phenomenon. Multiple issues, combined with patient complexity and comorbidities, as well as items on the doctor's agenda, such as the QOF, meant that GPs in this study generally believed that 10-minute consultations are insufficient. Inadequate resources to enable longer consultations were a strong cause of concern for a number of participants.

Accessibility. Many GPs' practices had responded to increasing patient demand by offering alternative means of contact, particularly telephone encounters. Although some found this effective, many felt the increase in telephone contact

had contributed to the rise in workload, particularly because extra time was not always allocated towards this:

'Patients think it's much easier to, obviously to reach us now, so perhaps before they would say: "Oh you know, I'll wait a day or so." But now: "Oh, I'll just ring the doctor, they can give advice." So I actually think, funny [sic] *enough, it has actually increased our workload.'* (GP18, female partner, nine sessions per week, 6–10 years' experience, medium-sized suburban practice)

Relationship between primary and secondary care

Participants described a shift in tasks from secondary to primary care, much of which was felt to be appropriate, but which was not accompanied by sufficient resources. For example, GPs now manage conditions previously managed by secondary care, such as palliative care and chronic disease, and patients are discharged to their GP more quickly. Many GPs expressed frustration at hospital doctors for increasingly requesting tasks of them that they felt were inappropriate, such as arranging further investigations:

'There are whole disease areas which we've taken on, quite rightly actually, I think, but often which aren't funded. You know, very straightforward and simple sort of chronic disease management things, like chronic kidney disease, and diabetes, and things like that which, you know, should be managed closer to home in a more reactive responsive place. But we need the funding for it, so I don't really think that's come our way.' (GP5, male partner, eight sessions per week, 11–15 years' experience, medium-sized urban practice)

'When patients are seen at the hospital or discharged from the hospital, every single letter we now read is asking the GP to do something. Now it's: "We're discharging this patient and in 3 months' time, could you do these blood tests and then just check their this, that, and the other, and if necessary do X, Y, and Z?" So, basically they're being kind of discharged to us, which obviously is just more appointments, obviously more. And every time I read a letter, I have got to action something.' (GP3, female partner, five sessions per week, 16–20 years' experience, medium-sized semi-rural practice)

GPs described arranging referrals and follow-up as difficult and time consuming, and inefficient communication increased workload, for example, GPs not receiving discharge information. Some GPs, particularly those who were more experienced, felt that personal communication with colleagues has been eroded by electronic systems. Availability, waiting times, and communication with other local health services impacted GP workload; for example, lack of community nurse capacity, insufficient mental health services, and lack of an A&E or minor injuries unit nearby all led to patients being managed more, and for longer, in primary care.

Bureaucracy and resources

There was agreement among GPs that bureaucracy has increased dramatically in recent years, particularly with the introduction of the QOF, enhanced services, Care Quality Commission (CQC) inspections, and care planning.

Some participants, particularly partners, felt very strongly that the requirement to meet targets has increased workload exponentially, while not always being evidence based or benefiting patient care:

'We have to do these care planning for [sic] *elderly, which I think's counterproductive, just increases the workload, and actually doesn't address what they want anyway. You have to do so many tick boxes that, after an hour, you are so exhausted you actually never discussed with the patient what they actually came for.'* (GP18, female partner, nine sessions per week, 6–10 years' experience, medium-sized suburban practice)

'I mean the bureaucracy is mind-boggling, unbelievable. I can't even begin to tell you the amount of unbelievable bureaucracy that gets dumped upon us, and it's all you ever do. 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)

For many partners, running the practice was a major contributor to workload, and funding structures and the processes of remuneration contributed to the perceived workload crisis. This is due to the lack of money to employ more staff to deal with the increasing workload, as well as the requirement to spend longer and longer meeting targets in order to be funded.

Balance of workload within a practice

GPs frequently discussed their role within

the practice team and how this impacted on their workload. Integral to this was an aim to maintain continuity of care.

Practice size. Patient list size (which for some participants had increased rapidly) was reported to impact workload due to the number of consultations and more difficulty in establishing continuity. A few GPs described smaller teams as being more affected by increases in workload.

Individual GP characteristics. Participants' beliefs about how evenly workload was distributed among GPs in their practice were variable. One female GP believed that having a disproportionately large number of gynaecological consultations increased her workload due to the increased time required. Age or levels of experience were thought to affect workload in different ways: workload could be greater for more experienced GPs due to having older patients with more complex health needs or lesser, due to quicker recognition of disease with greater experience. Consultation style could impact workload. This was commented on by GPs who perceived their style to both lengthen and reduce consultations:

'I'm a pretty efficient consulter, so I don't find time management a problem. I think there's a fine line between being flexible and, in inverted commas, going the extra mile for patients and making yourself too available. I think if you maintain a professional distance, that puts a certain brake on your workload.' (GP9, male partner, nine sessions per week, 6–10 years' experience, medium-sized urban practice)

'If you're the type of consulter who attracts people, if you're a more sympathetic listener type of consulter, you'll attract people who take longer and who need more support and more continuity, which makes you less accessible to [sic] *than other people, so that increases workload.'* (GP7, female partner, six sessions per week, 6–10 years' experience, medium-sized suburban practice)

GP role and hours. Both partners and salaried/locum GPs generally felt that partners had greater workload, due to practice management, other administrative tasks, and responsibility.

Two GPs had left partnerships due to unmanageable workload, and described reduced stress levels as a result, and sessional GPs were widely seen as having an improved work–life balance, although one salaried GP still aspired to become a partner. Partners felt that employing locums did not necessarily help in reducing workload:

'I'm never a big fan of locums, because I think it does not decrease your workload. Yes, they see the patient in that minute, but the patient hasn't been sorted out. So, I think, for coughs and colds, yeah it's fine, but if it's sort of more complex patients, that's very difficult and it doesn't sort the patient out.' (GP18, female partner, nine sessions per week, 6–10 years' experience, medium-sized suburban practice)

GPs as part of a team. The importance of a good team was frequently cited as a positive influence on workload and job satisfaction. Some experienced GPs felt communication among their practice team had diminished due to increased workload intensity, which negatively impacted support:

'I've been a partner now since beginning [sic] *of 1999, and there definitely used to be a slack in the day when you could sort of, you know, have a breather, just sit and chat to your colleagues, and that's gone.'* (GP8, female partner, five sessions per week, 16–20 years' experience, medium-sized suburban practice)

Other members of the practice team (nursing and administrative staff, practice manager) were acknowledged as important to many GPs, with some staff members seen as invaluable to managing workload, and staff absences being very problematic.

Continuity of care. Having an ongoing relationship with patients was generally felt to improve workload and enhance patient care, particularly for chronic conditions, because patients would not have to explain their condition to multiple GPs. Continuity was felt by some participants to be disappearing, due to part-time working and employing locums (often as a strategy for dealing with workload), and this had a negative impact on patient care. Paradoxically, a GP also reported that continuity of care could increase workload:

'If you've known somebody and you know that they've had breast cancer 2 years ago, or their husband died 3 years ago, you tend to ask that, whereas if you were new to them, and just dealing with their complaint, it would be easier.' (GP6, male partner, six sessions per week, 16–20 years' experience, medium-sized rural practice)

DISCUSSION

Summary

GPs described their workload increasing over recent years, with long and intense working days. Participants were concerned about the impact on GPs and patients. Full-time partnership was not possible for most, and many GPs felt the current workload situation to be unsustainable, particularly given the diminishing workforce.

Four major themes emerged to explain the increase in workload: increasing patient needs and expectations, the changing relationship between primary and secondary care, bureaucracy and resources, and the balance of workload within practices. Continuity of care was seen as integral to general practice, but potentially being eroded by changes in contracts and working patterns to deal with workload.

Strengths and limitations

This qualitative study provides a more in-depth assessment of GPs' perceptions and concerns regarding workload compared with quantitative methods. The authors had a relatively large number of responders from whom to select a maximum variation sample. The independent research team comprised clinical and non-clinical researchers, and, because the interviews were conducted by a non-GP, participants may have felt able to speak more freely about feelings on workload.

Limitations include those associated with qualitative research, such as the small, diverse sample, which is not necessarily representative of GPs in England. It is possible that there was natural self-selection, resulting in over-reporting of workload problems. The study took place in the summer, and responses may have been different during busier winter months.

Comparison with existing literature

The findings of this study corroborate GP surveys[2–4] and quantitative assessment of consultation rates[14] reporting increased workload over time, and decreased morale and job satisfaction, as well as older qualitative studies.[9,12,13,18,19] A recently published quantitative study using the Clinical Practice Research Datalink (CPRD) found a 12% rise in GP consultation rates between 2007–2008 and 2013–2014, and an increase in the duration of consultations, contributing to an overall workload increase of 16%.[20] A British Medical Association focus group identified similar issues to those highlighted here, including a shift in care provision from secondary to primary care, increasing patient expectations and demands (with some GPs practising defensively), too much bureaucracy, and partnership being unattractive due to high workload and responsibility.[16]

An online GP survey reported that 82% of participants intended to leave general practice, take a career break, and/or reduce clinical hours in the next 5 years, primarily due to workload intensity. This reason is followed by workload volume, time spent on unimportant tasks, concerns about the introduction of a 7-day working week, and job satisfaction. Similar themes to those in the present study arose, including increased patient expectations, recruitment and retention difficulties, burgeoning administration and bureaucracy, transfer of work from secondary care, and the introduction of 7-day working.[21] The latter concern was raised by some GPs in the present study, perhaps because the '7-day NHS' formed part of the government's election campaign shortly before the interviews were conducted.[22] A recent mixed methods study exploring why so many GPs in England leave practice before the age of 50 also found that increased workload — due in part to increased bureaucracy, the shift of work from secondary care to primary care, a change in patient demands, and time pressures — is a major contributor.[23]

Implications for practice

These are disturbing findings, raising important concerns about the unsustainability of GP workload, and the potential impacts on patient safety and care, and GP wellbeing. High workload and job stress are associated with lower practice performance and more negative patient experiences.[19] This is a significant problem, with the potential to cause harm to patients and GPs.

General practice has changed over the decade since the introduction of the 2004 contract. Major changes have taken place for day-to-day working, as well as to funding and commissioning structures. Particularly, there has been decreasing investment in primary care compared with hospitals, despite increasing expectations of the work that should be done in primary care,[8] and in combination with reducing numbers of GPs and increasing role complexity, GPs are struggling with workload.[24]

Some strategies have been introduced at a practice level to try to address increased workload, such as telephone triage.[25] However, recent evidence suggests this is not effective.[26] In 2015, a Primary Care Workforce Commission was established

to identify models of primary care to meet the needs of the future as part of a 'New deal for general practice' and a '10-point plan' for recruitment and retention of GPs.[6] The report in July 2015 laid out recommendations, including restructuring of primary care services.[8] There is controversy over whether the current partnership model is the best model to be going forward with.[27] What is clear from this study is that continuity of care is important for many GPs.

These findings indicate that general practice in England may be at a crossroads regarding a sustainable model of care. GPs in devolved nations, and other countries, may be facing similar pressures. Many of the workload pressures identified in earlier surveys (such as societal dislocation, greater public expectations, increasing bureaucracy, tension of workload equity) are still reported, but additional stressors have appeared that are eroding the ability of GPs to adapt (for example, no extra time in the day, hospital-driven tasks) or are prompting maladaption (for example, feeling the need to practise defensive medicine, having to offer less holistic care, prioritising external targets and inspections above patient care). Although these are understandable responses to external demands, they are worrying trends that may undermine GP job satisfaction. Difficulty recruiting doctors, lack of a solution provided by locums, and the financial pressures on practices further indicate that coping strategies are presently limited (the authors' accompanying article on GPs' suggestions for strategies to cope with increasing workload is published alongside this article).[17] The unattractiveness of partnership is particularly worrying because these positions are mainly occupied by the most experienced GPs who are in the best position to be able to retire.

Above all, this study highlights an urgent need to address perceived lack of investment and clinical capacity, already acknowledged by the NHS, and which the *General Practice Forward View*,[28] published in April 2016, may go some way to addressing. It also suggests that influencing, or rather reducing, patient expectations of what primary care can deliver, and reducing bureaucracy, have become key issues, at least until the capacity issues are resolved.

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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

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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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