Analysis

Will the GP workforce crisis be solved by top-down initiatives?

INTRODUCTION

The GP-to-patient ratio is falling. This issue is increasingly political. Politicians quote impressive figures to the electorate; the Conservative party recently promised to deliver 6000 extra GPs by 2024.[1] Concentrating solely on numbers of GPs promised by politicians is damaging: it leads to short-term centralised initiatives to recruit and retain GPs.

It does not address the wicked problems facing general practice. Patient demands are changing. GPs are facing chronic excessive workload.[2] More GPs want portfolio roles and fewer want to be partners.[3] Technology is having an impact on the way patients access and receive care. New roles are being created to work alongside GPs in primary care and new models of care are being initiated.[4]

Furthermore, focusing purely on whole numbers can give a misleading picture of patients' experiences. For example, it is not clear whether the government target is for whole-time-equivalent GPs or not, and whether the number of trainees is included. Both of these factors impact on the true GP-to-patient ratio.

In the next 5 years, 8500 GPs plan to leave the health service;[5] many others are choosing to work less than full time. This is largely related to chronic excessive workload as well as other factors including pension legislation, which is forcing many GPs to retire early to avoid additional lifetime allowance tax charges.[6]

Furthermore, many GPs who remain are burning out, resulting in poor care for patients as well as damage to their own health and wellbeing. Doctors suffering from burnout have between 45% and 63% higher odds of making a major medical error in the next 3 months compared with those who are not.[7]

Sustainable retention initiatives that get to the root of issues causing GPs to leave the profession, work less than full time, and burn out should be prioritised. Furthermore, retention needs to be part of a quality improvement approach. Evidence-based initiatives should be implemented and, where more experimental approaches are used, these must be fully evaluated.

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In 2017, 100 million GBP was committed to recruit 3000 doctors from abroad by NHS England.[8] Despite the investment in international recruitment, few GPs have been recruited; there is a global shortage of healthcare workers.[9] Retention funding per doctor has been proportionally smaller than that spent on international recruitment per doctor. This must change.

AN EFFECTIVE APPROACH TO RETENTION

The majority of retention funding is allocated centrally via the update to the GP contract agreement.[10] The document *Making General Practice a Great Place to Work* states that:

'... national support is key to getting interventions off the ground quickly (e.g. by providing access to funding), but ultimately success in improving retention locally relies on local engagement and support being in place'.[11]

The establishment of primary care networks and integrated care systems provides a huge opportunity for locally designed initiatives. Previously, it was difficult for individual practices to have dedicated human resource expertise. Collaborative working at scale makes this possible. For example, in Haringey their federation, Federated4Health, created peer group support for newly qualified GPs with a mentor available by WhatsApp, who made the doctors feel valued and enabled them to start quality improvement projects in their practices.[12]

Until recently, retention money has frequently been released late in the financial year along with late publication of guidelines for how it should be spent. This has rendered it difficult to design sustainable, impactful localised initiatives. Furthermore, funding for retention currently flows from multiple sources including NHS England and Health Education England. It is not always clear who is funding what. This risks duplication and ineffective, poorly coordinated initiatives. Finally, funding can come with disproportionate assurance requirements. These should not overburden people, instead allowing them to spend time implementing effective schemes.

Having a section on retention in the contract agreement raises its profile but there are risks. The initiatives may not be flexible enough to allow localisation and so may miss the main issues facing an area. Guidelines may be produced late, making it hard to design effective initiatives. The money may not be passed down in a timely fashion. The funding may have fixed numbers for some schemes. It would be better for regions to have a pot of retention money with a pick-and-mix set of retention options so that they could localise and distribute according to need. Furthermore, some of the schemes risk reaching those who are already engaged rather than those close to burnout, for example, the 'new to partnership payment'.

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Influential bodies should emphasise that these retention schemes do not stand alone. They must be part of the Long Term Plan's move to stabilise and strengthen general practice. Part of the organisational development of general practice must involve putting workforce first. The recent General Medical Council report *Caring for Doctors, Caring for Patients* provides evidence-based

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guidance on how to promote engagement and satisfaction in the workforce. Doctors have three essential needs: autonomy, belonging, and competence.[2] Staff who show poor engagement and satisfaction offer poor quality of care to patients, are less productive and efficient, and are more likely to suffer from burnout and leave the profession.[13,14]

A primary care staff satisfaction survey (PCSSS) would support those implementing retention initiatives to understand and measure the factors that are instrumental to effective workforce retention. Secondary care clinicians have been able to express their views on their job satisfaction for about 20 years through the annual staff survey. Primary care has the Manchester Work-Life survey, whose strength is to test the temperature of the GP workforce over time but is less effective on linking reasons for job satisfaction with engagement locally. This does not enable causal analysis of satisfaction and therefore does not support measurement of retention initiatives or drive design of them. A PCSSS would also enable measurement of other staff members whose views are also key for stabilising primary care.

A survey created for primary care should be solely to support local leaders in designing initiatives to support primary care staff engagement and satisfaction rather than for performance management. Furthermore, the survey should be released as part of a resource pack, which includes a toolkit and set of UK case studies, to support leaders to improve on the results. For example, the North Cumbria Primary Care Alliance faced a 40% GP vacancy rate. Furthermore, they recognised that their young GPs did not want traditional partnerships and did not want to buy into premises. This was leaving senior GPs trapped, working excessive hours, and unable to sell their premises. Therefore, they designed an innovative not-for-profit with key stakeholders to allow their GPs to become salaried.[15] The model has strong support from patient groups.

SUMMARY

The UK has a falling GP-to-patient ratio. Influential bodies must champion and adequately fund locally implemented retention initiatives to ensure that primary care is sustainable for the future and meets the changing needs of our population. Funding needs to be coordinated, recurrent, consistent, and with realistic timelines attached.

Furthermore, these bodies must coordinate and support systematic measurement of staff engagement and satisfaction in primary care through a survey to improve design of retention initiatives, and to support the development of an evidence base of effective schemes.

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