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GPs' understanding of the wider workforce in primary care

The workforce crisis within general practice has been well documented. One response to this by NHS England has been national funding for a wider multidisciplinary team with a forecast of 26 000 additional staff by 2024. However, the impact of a wider workforce on patient care and satisfaction is not clear. Gibson *et al* (2022) showed that having more GPs in the team was associated with an increase in patient satisfaction, but this was not true for increasing staff in other clinical roles.¹

A wider workforce has so much to offer — but GPs cannot promote the roles of other colleagues if we do not understand their skill sets and the success of diversifying the

primary care workforce depends on good leadership.

We explored GPs' understanding of the wider workforce. 21 newly qualified GPs on a fellowship programme were asked to rate their understanding of 16 roles and summarise their views on the key responsibilities for GPs. All had been working in primary care for at least 18 months. GPs' understanding of other roles was highly variable with reasonable understanding of some (for example, advanced nurse practitioners, first contact physiotherapists) but poor for others (for example, physician associates, pharmacy technicians, health and wellbeing coaches, care coordinators).

GPs perceived their key responsibilities to be leadership, giving advice, coordinating patient care, holistic management, and managing complexity. The GPs valued listening to short talks from colleagues with other roles and, following an afternoon workshop, felt more equipped to work in wide multidisciplinary teams.

GPs were enthusiastic about diversification of the workforce but they cannot successfully lead teams they do not understand. Patient care and satisfaction will remain overly dependent on GPs until leaders are appropriately utilising the skill mix within their teams.² Further education is urgently needed to upskill the workforce so that they understand each others roles, and patients are directed to the right practitioner, at the right time.

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Verschlimmbesserung

I agree with David Zigmond that government has been 'trying to fix things but making them worse'. From the 1990s government promoted a consumer model. However, when patients took on the role of consumers, their expectations and demands could be impossible to fulfil, because of GPs' lack of time and funds. I found that the consequent anger of patients could be demoralising. Also, in those years, continuity of care became fragmented so that many patients did not know the GP and so had not formed a relationship of mutual understanding and trust. I felt that relationships with patients had changed from a solid growth in trust over time to something more fragile, ephemeral, and transactional, which was worse for both patients and GPs. If the government could stop making promises about what can never be, and educate and encourage patients to be realistic in their expectations, maybe GPs could lead happier lives and want to stay being GPs.

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Correction

In the Clinical Practice article: Nicholas R Jones and Thomas Round, Venous thromboembolism management and the new NICE guidance: what the busy GP needs to know. *Br J Gen Pract* 2021; DOI: <https://doi.org/10.3399/bjgp21X716765>. The duration of treatment had been incorrectly cited and should read: 'NICE recommend a minimum of 3 months of anticoagulation for a confirmed VTE, whether provoked or not. An unprovoked VTE may require 6 months of anticoagulation or longer, depending on the risks of recurrence.' The online version has been corrected.

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Editorial note

In the April 2022 print Issue the DOIs were incorrect in the Life & Times articles on pages 169–179; the correct DOIs appear in the online version and in the electronic flipbook.

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