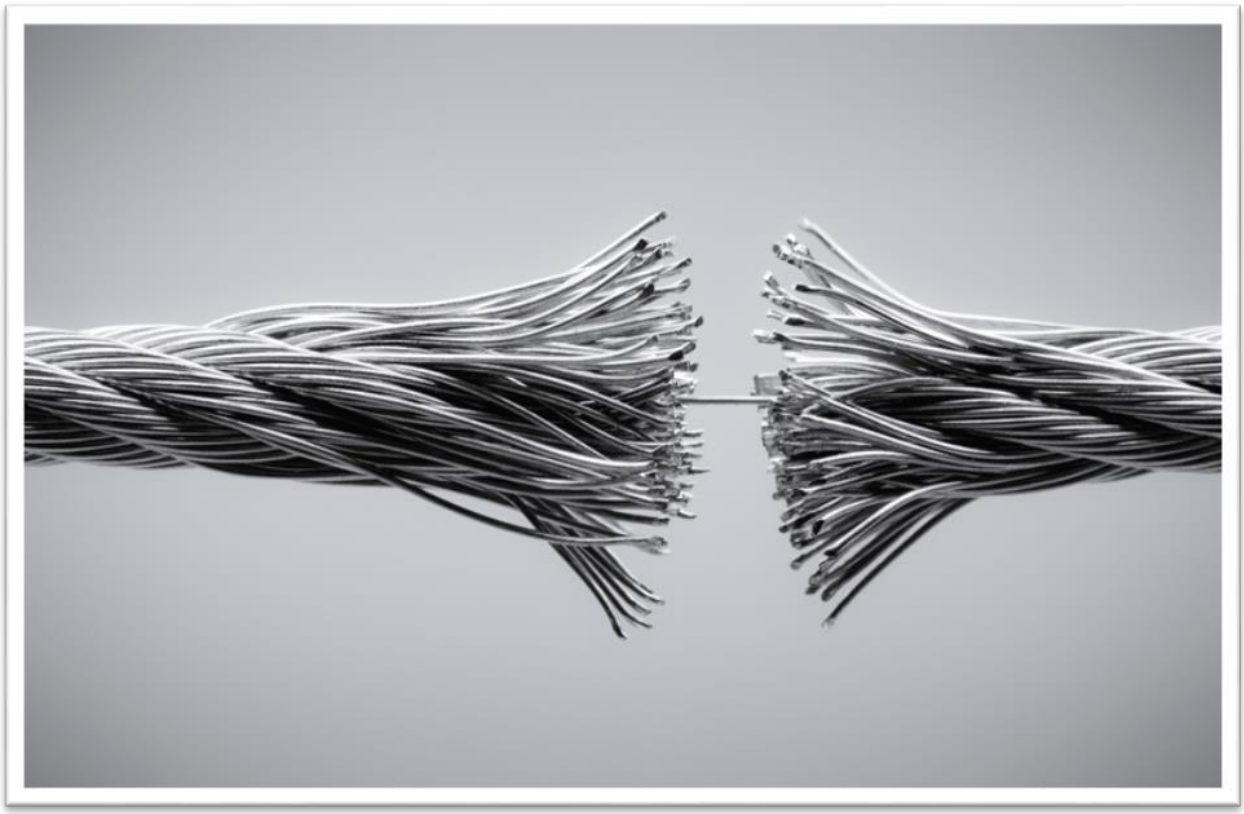
The Big GP Consultation



# Summary Report for Session 3:
## How do we most effectively recruit and retain our workforce?

Session Date: Tuesday 15th March 2022
No. of Participants: 60

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This report represents the views of the participants in the consultation and not the authors themselves

The Big GP Consultation

# Introduction

The Big GP Consultation is a platform for GP Trainees and Early Career GPs to collectively discuss their vision for the future of general practice, and how they can shape the future system that they will be working in. This programme consists of six sessions, each on a key theme relating to the future of general practice.

This programme is endorsed by Faculty of Medical Leadership and Management (FMLM). For more detail about the wider programme, please visit our website here.

# Session 3 Findings

This report details the findings of **Session 3: How do we most effectively recruit and retain our workforce?** Both the report, and the infographic, collate insights gathered from a pre-session survey (n=26), a post-session survey (n=16), and the facilitated breakout room discussions, which 60 participants took part in. Just over half of our participants who responded to our surveys are full qualified GPs, with the remainder being GP trainees.

The topics covered in the breakout rooms were as follows:

**Breakout Room 1:** How do we encourage doctors and medical students to consider General Practice?

**Breakout Room 2:** How can we improve recruitment into underserved areas?

**Breakout Room 3:** Preventing burnout in General Practice.

**Breakout Room 4:** How can we enable flexible working in general practice?

## Key Themes

The key themes of the session are summarised in the infographic below.
A high-quality copy of the infographic is available to download from our website here.

## Breakout Room 1: How do we encourage doctors and medical students to consider General Practice? #chooseGP

***General practice and primary care play a vital role in communities. Being a GP allows doctors to care for the entire family; it offers the follow-up factor and with that, the opportunity to develop relationships with patients throughout their lives rather than during isolated periods of ill health.***

Our participants discussed why they chose GP. They had taken several different routes into GP training; non-training posts, direct from foundation training, and transfer from a secondary care training programme. Our participants highlighted several key similarities that led them to their career in general practice. Many felt that they were built to be GPs and felt that it was 'in their bones.' Our participants described themselves as 'gist' people, and had less desire to know minute details. Most described enjoying all aspects of medicine during their training and struggled to pick just one area; they all enjoyed the variety that GP offers.

Despite the challenges faced in primary care, GP was viewed as a worthwhile vocation. Our participants discussed the positives of being a GP. These included job flexibility and variety of work, the ability to keep weekends free (if desired or necessary), and the opportunity to develop a portfolio career. All acknowledged that GP training allowed them to reach a more autonomous and flexible point in their career much earlier than many of their counterparts in secondary care. It was reflected that it is important that doctors become GPs because they **want** to be rather than **have** to be. Otherwise, they will likely be at the highest risk of burnout and attrition. Our participants enjoyed feeling they were part of a community, both within a practice and the wider population. In addition to this, GP still offers the opportunity to care for an entire family, and understand the wider context of a patient's presentation. Our participants preferred to be seen as specialists in family medicine as opposed to specialist generalists.

*"Training pathways need to be flexible"; in certain areas and at certain points in their career pathway, doctors should be facilitated to step into and out of different specialties.*

Our participants discussed how to facilitate movement of doctors into GP training from other specialities. It was felt that this movement, and therefore unique career paths, should be encouraged rather than discouraged, as diversity of experience breeds much more holistic GPs. The current GP training is relatively short, which was seen as a positive if doctors have built sufficient experience prior to joining the programme. However, it was felt that transitioning straight from foundation training into GP may be too short and may not allow enough time to develop both clinically and professionally. Training needs to be flexible and designed to meet the training needs of the individual, rather than a one-size-fits-all generic programme. This could be achieved with a focus on competency-based training rather than time-based.

*Medical educators must ensure that students have adequate and repeated exposure to general practice, be that through medical student placements, foundation placements, aster days, or special selective components/modules.*

Our participants discussed how to encourage medical students to choose GP. In particular, they discussed the exposure of general practice that medical students in the UK receive. It was felt that often GP placements were used as an opportunity to develop generic communication skills, and less focussed on developing the knowledge that GPs use. A key challenge that was highlighted was how to support students in seeing the positives of GP. When the profession is in such a period of rapid change, it is hard to demonstrate what GP is all about. It is also important to recognise that general practice does not suit every student. Participants felt you need to have the right mindset and personality; becoming a GP should feel like a choice and not like it is the only option.

There are now a large number of university academic departments in primary care, a rigorous membership examination, and numerous opportunities to develop specialist interests requiring additional qualifications in the form of postgraduate certificates, diplomas, and Master's degrees. Despite this GP is still not viewed as a speciality with scholarship skills and changing these attitudes would help with recruitment.

In order to improve recruitment to general practice, our participants highlighted the need for general practice and the primary care community to communicate widely across the healthcare system and society that the roles in primary care are changing.

## Breakout Room 2: How can we improve recruitment into underserved areas?

***GPs and practices in the most underserved areas need to be supported through enhanced training, and to develop and incentivise opportunities for the whole primary care multi-disciplinary team.***

The discussion group in this breakout room was a mixture of GP trainees from across England and Wales. The majority were working in underserved or deprived areas, rural practices to inner city.

*High and complex workload leads to stress, burnout and poor staff retention, which further negatively impacts recruitment.*

The participants discussed the factors that contribute to an area being underserved. Areas can be underserved for many reasons; from rural, remote areas that people have little knowledge of, to inner city socially deprived areas that have complex needs, to areas that are very expensive to live in. GPs post qualification often look to areas that they are familiar with; commonly ones that they have lived, worked, or trained in. Students from deprived or remote and rural areas are underrepresented in medical schools. There are also fewer universities in these areas, and trainees have less training experience, if any, in such areas. This means that doctors do not look to such places for their post-CCT work. There are added complexities for GPs with additional responsibilities, such as caring for children and relatives. There can be barriers to working in these areas which include fear surrounding safety and security for themselves and their family (levels of crime/antisocial behaviour and violence). and in rural areas, there can be fears about isolation, financial concerns surrounding travel costs, and availability of local amenities and services such as schools.

The groups expressed that training does not prepare doctors adequately to take on roles in these areas. In deprived areas there can be language barriers, complex needs, and a higher proportion of social impact on presentations which can make consultations more complex and potentially more challenging. Remote and rural practice creates unique challenges, such as distance to other health care services, and emergency services. Underserved areas are often very stretched with large numbers of patients to healthcare professional; this can be compounded by difficulties in recruiting staff in the wider multi-disciplinary team, further impacting the GP workload. These practices may be too busy to apply to be a training practice or create fellowship placements or retainer scheme jobs, thus reducing the pool of doctors' training and experiencing the area. These practices need support to become suitable training locations in the form of promotion of opportunities, support with administration, and enhanced support from integrated care systems to support with infrastructure and estates.

## What can we do to improve recruitment into underserved areas?

*Improving recruitment to underserved areas should start early with the promotion of healthcare roles in schools, with access to mentorship, and additional access schemes for students from less represented areas to enter healthcare training.*

The overall group consensus was that to improve recruitment into underserved areas the key is to start early by promoting healthcare roles in schools, offering mentorship, and ensuring there are schemes to improve access for students from less represented areas to enter healthcare training. It is important that all students and trainees spend time in underserved areas (rural, inner city and areas of high deprivation). Universities and training schemes need to ensure students/trainees are prepared for work in underserved areas; ensuring that students and doctors are educated on health inequalities, wider determinants of health, deprivation, rurality, health inclusion groups, motivational interviewing, working with interpreters, trauma-informed care, social issues, and the management of complex comorbidities.

For new career primary care practitioners, it was felt the creation of supported specialist posts (such as post-CCT fellowships) would pull people into underserved areas, as would providing mentorship and support to help GPs feel confident moving to areas they are less familiar with. To further enhance professional development opportunities, 'out-of-work' packs (social induction) could be offered to help support these healthcare practitioners move into the area, as well as improving the networks and opportunities to connect with healthcare workers across the area.

In addition to financial incentives like the Targeted Enhanced Recruitment Schemes, there are additional investment opportunities in the form of non-financial incentives, such as enhanced continuous professional development opportunities, additional leave, flexible working, professional networks, and sabbaticals to aid retention. Finally, in order to improve general practice recruitment to underserved areas, there is a need to consider investment in the recruitment and retention of the wider multi-disciplinary primary care team.

## Breakout Room 3: Preventing burnout in General Practice

***There are numerous reasons for the initiation and propagation of work-life imbalance within General Practice. The pandemic has heightened prevailing concerns of workforce gaps, demand and capacity mismatch and unsustainable workloads leading to a hastened path towards clinician burnout. Preventing burnout in General Practice must form a key priority for all relevant organisations if we are to recruit and retain a healthy clinical workforce and in turn, improve patient care.***

The causes and solutions for the prevention of burnout were discussed with enthusiasm by colleagues, reflecting the palpable recognition that for many it was a clear and present danger for themselves, colleagues, and by extension their patients. Many agreed that workloads had become unsustainable, mainly as a consequence of underlying GP workforce deficits, increasing demand and expectations from the public, and a shift to more complex patients (traditionally managed by secondary care) being seen by GPs. Many asserted that 10-minute appointments were no longer practical for some complex patients, and that many were seeing more in succession due to 'straight forward' cases being seen by allied healthcare professionals. This contributed to a feeling of being overstretched, with some describing feelings of moral distress by being unable to provide the care that they would want to, ultimately leading to an encroachment onto the core duties and values of a doctor.

Extending appointments to 15-minutes was debated by colleagues as a potential solution. It was discussed that it would impact upon wait times for patients to see a GP, but was identified as a key component of changing the tide of unsustainable workloads. It was clear however, that this would not be the silver bullet to save multiple generations of GPs from burnout, but rather one facet of a recovery programme for the profession. Further areas of consideration include the number of hours worked in a normal working day, the number of patients seen, the amount of hidden workload, and the complexity of the workload. An adaptable appointment system that reflects these criteria would be of benefit.

It is widely accepted that GP workforce gaps contribute to the mismatch in demand and capacity, ultimately putting clinicians on a treacherous road towards burnout. We need to aim towards an oversupply of doctors to help cope with the known mismatch, but it will take many years for GP numbers to substantially increase. In the meantime, we may need to consider greater cohesive multidisciplinary working and considering the benefits of secondary care consultants working within the community. A key component of better mutual understanding of roles between primary and secondary care clinicians, would be for all secondary care clinicians in training to undergo a compulsory General Practice placement (as all general practitioners are required to do in their training).

Isolated practice (particularly whilst undertaking burgeoning admin tasks) and a lack of peer and senior support was viewed as a key contributor to burnout within General Practice, perhaps due to a lack of sense of belonging, comradery and teamworking. Having peer

support across the different generations of GPs would help with wellbeing. Newly qualified GPs felt that experienced GPs would be able to mentor and support them through common challenges faced in practicing. Others also suggested that isolation could be reduced by enabling admin tasks to be completed in communal spaces, much like in secondary care.

A key theme highlighted through the discussion was the feeling of being devalued by the system, the media, and patients, with a lack of opportunity to set the record straight. Parity of esteem with secondary care colleagues was felt to be much needed. Colleagues felt a negative change in the doctor-patient relationship that has so long been held in such high regard. This may lead to a loss of intrinsic motivation to continue to such a complex and challenging vocation. Many felt that a stronger narrative on the pressures and challenges of providing a General Practice service were needed going forward. Others also felt that learning from other industries on motivating staff to continue to work in stressful and challenging roles was needed.

Instilling a sense of autonomy in career trajectory, the pursuit of special interests and overall working patterns was strongly supported both during training and in the First5 period. Encouraging and supporting portfolio working and special interests may help balance service needs with personal goals and interests as a suitable compromise to sustain a work-life balance.

Participants felt that appraisals and revalidation has turned into a tick box exercise that did nothing to offer peer support to fellow clinicians. It was highlighted that checking on wellbeing and external life should be undertaken informally to help identify and offer support to those who may be struggling.

Some were clear that the notion of resilience training was demoralising, incorrectly implying that the issue was within the individual's resilience temperament rather than working in a challenging, increasingly unworkable, healthcare system.

Other solutions identified to help prevent burnout were enshrining education on prevention, recognition and management of burnout within GPVTS training, and enabling protected time to attend wellbeing programmes following completion of training.

## Breakout Room 4: How can we enable flexible working in general practice?

***Supporting flexible working is a key policy that helps meet the basic needs of GPs and positively contributes to an appropriate work life balance, thus improving recruitment and retention.***

Participants agreed that the term "flexible working" encompasses two key elements: how the hours spent in work may be flexible, and the nature of the work itself may be flexible.

Participants felt one key to flexible working is supporting GPs to have a degree of control over when they are, and are not, in work. For some, this means working "less-than full-time" (LTFT). It was here that participants identified a key issue with the label of LTFT working. The reality of modern-day general practice means that those who work 9 or 10 sessions per week are working vastly in excess of what is generally accepted as full-time work – a 40-hour week. Many GPs who are then described as working LTFT, less than 9 or 10 sessions per week, are still working well in excess of 40-hour weeks. The LTFT label here is therefore misrepresentative and impacts negatively on the morale of many colleagues.

Participants also felt that using the term "sessions" is unhelpful. It is a poorly understood term that does not translate well into the time a GP actually spends working. They therefore felt a move away from this terminology is key to addressing this issue. Moving towards terms that both the public and the wider profession understand, such as "shifts," or simply describing "hours worked," would be helpful in more fairly representing the time GPs spend in work.

It was felt the public perception of GPs, specifically around the pressure that GPs are under and the time they spent in work, has fallen of late. This has been fuelled by negative media reports. Though some participants questioned the importance of the public's perception of GPs working hours, many felt that unhappy patients lead to a deterioration in the doctor-patient relationship, and in some cases, abuse of staff. Participants therefore felt that proactive steps should therefore be taken to repair and maintain a positive doctor-patient relationship.

Relaying the message to the public and profession about the true extent of the hours GPs spend in work was felt to be a key role of GP representative bodies. It was also felt that the only way to counter any negative media narrative was to maintain a united, system-wide front, that clearly describes both the pressure the system is under, and that the staff within it are doing their utmost to provide safe, high-quality care. It was noted that informative TV documentaries detailing the day-to-day working life of GPs (such as GPs: Behind Closed Doors) are also likely to be helpful in demonstrating the realities of GP life.

Though action from national organisations is vital in addressing this, participants also spoke of the power that more local actions can have, particularly at practice- or PCN-level. As clinicians, we are very good at communicating clinical management to patients, but

participants felt we are less confident with explaining how we operate as a service. This includes explaining the nature of our working patterns, and the huge amount of work GPs do outside of consultations.

*Flexible working is key to reducing burnout and maintaining a sustainable career*

Participants felt the term flexible working also covers the nature of work. For some, holding a variety of roles, including leadership, education, and working in other settings such as out-of-hours practice, the Emergency Department, or even remote care shifts from home, was key to both reducing burnout, and maintain a sustainable career. For some, LTFT working was essential due to commitments out of work, such as caring for others, which in itself is vital work.

When discussing how flexible working can be achieved alongside meeting patient need, participants agreed upon a key underlying principle: in order to meet the needs of our patients, our own basic needs must first be met. An overworked profession not only risks delivering poor care to patients, but also contributes to poor retention of staff, further exacerbating this issue. As one participant noted, “a flexible GP is better than no GP at all.” Therefore, any plans which promote meeting the basic needs of the GP workforce, such as supporting flexible working, must be a priority.

In terms of how this relates to continuity of patient care, there was a recognition that though continuity is a key element of high-quality patient care, it must be balanced with the fact that individual GPs cannot provide round-the-clock care to their patients. Participants therefore spoke positively about moving towards MDT-based continuity of care. Further work should be undertaken to outline what team-based continuity looks like in practice, understanding that no single member of the MDT is available to provide 24/7 care.

# High Impact Actions

The box below suggests areas of exploration which colleagues identified as being important in this session.

- Career flexibility:
  - Promote the benefits of career flexibility to medical students, junior doctors, and the public.
  - Policy makers and GP representatives to support flexible working.

- Education and training:
  - Increase recruitment into medical schools and GP training.
  - Ensure that medical students and doctors in training gain a broad exposure to general practice and primary care throughout their training.
  - Investment in the training and recruitment of the multi-disciplinary primary care workforce for all professionals is required to create a resilient system.

- Communications:
  - Across an integrated care system, enable communications and networking between primary and secondary care colleagues through multi-disciplinary meetings, and shared teaching opportunities.
  - Stronger public narratives are required in relation to the pressures and challenges of providing a General Practice service.

- Reduce isolation:
  - Consider designing networks that support peer-to-peer mentoring and coaching across a system.
  - Encouraging peer-based wellbeing check-ins.

- A formal evaluation of extending appointments to 15-minutes.

# Next Steps

The Big GP Consultation Team now aims to work with key stakeholders who have a responsibility for each of the areas on the previous page, to explore how these actions may be implemented.

The session outlined in this report is the third of a series of six sessions, with forthcoming sessions listed below. The Big GP Consultation Team will collate the insights shared in these future sessions and will continue to share them in the form of infographics and reports.

**Session 4: GPs in The Big Picture Part I** (Health inequalities, traditionally underserved populations, and Equality, Diversity and Inclusion)
…with guest **Dr Bola Owolabi**
*Report due May 2022*

**Session 5: GPs in The Big Picture Part II** (Primary/secondary care interface, greener practice, holistic medicine)
…with guest **Professor Martin Marshall**
*11th May 2022, 7.30pm*

**Session 6: Innovation in General Practice**
*June 2022, guests and date to be confirmed.*

More information on future sessions can be found on our website here.
Outputs from previous sessions can be found here.

If you are a GP Trainee or early career GP and would like to participate in the remainder of the programme, please do let us know via our website.