Retaining the experienced GP workforce in direct patient care (ReGROUP)

South West Clinical Senate
1 February 2018
Taunton

NHS National Institute for Health Research

University of Bristol

University of Exeter Business School

University of Exeter Medical School

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GPs

The Observer

GP numbers tumble in England as recruitment crisis bites

family doctor training is at its lowest level since 2007, sparl

not enough GPs to cope

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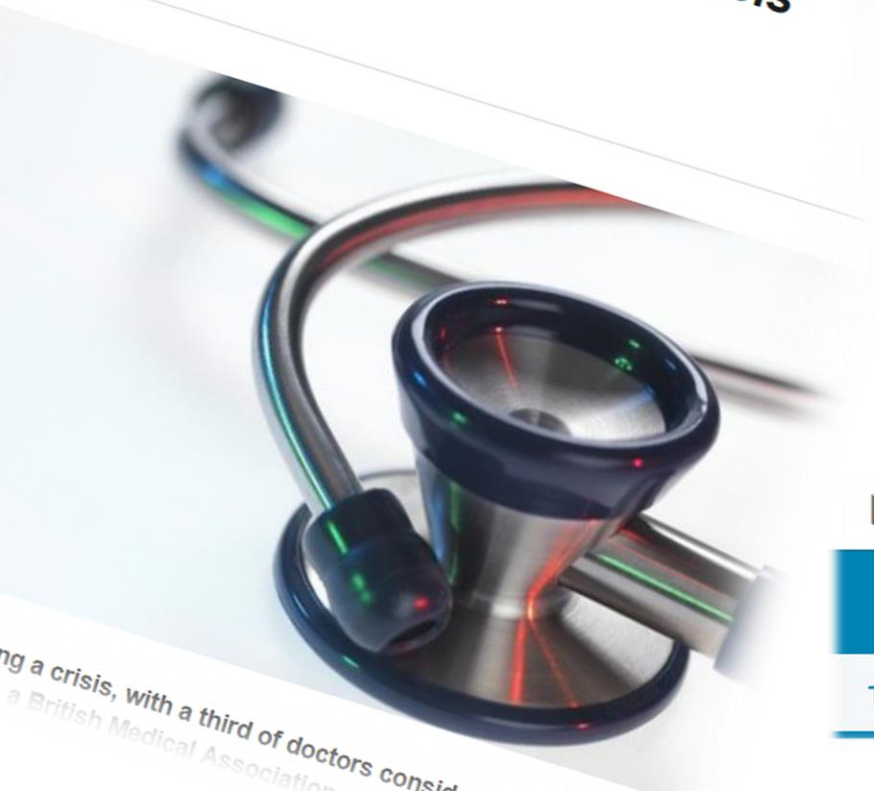
Health

GP services face 'retirement crisis'

By Nick Triggle

Health correspondent

15 April 2015 | Health



ng a crisis, with a third of doctors consi

a British Medical Association

Messages

#GPstateofemergency

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One in 3 trainee GP posts are empty, amid warnings of crisis shortage

Warnings of looming crisis as new figures show widespread vacancies for trainee GPs, with two in three posts empty in large swathes of the country

Messages

#GPcrisis

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Background

- NHS spend
- GP workload
- Complexity and co-morbidity
- Recruitment and retention
- Restructuring of care
- Problematic work-life balance

Research Questions

1. What are the key policies and strategies that might:
   i. facilitate retention of experienced GPs in direct patient care and
   ii. support the return of GPs to direct patient care following a career break?

2. How feasible is the implementation of those policies and strategies?

Project timeline

	2016												2017									
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O
1.	Systematic review																					
2.	Census Survey																					
3.	Qualitative Interviews: GPs & stakeholders																					
4.								RAM Expert Panel														
5.	Predictive Risk Modelling																					
6.																				Stakeholder Consultations		

Census Survey

Quitting patient care and career break intentions among general practitioners in South West England:
findings of a **census survey of GPs**.

Fletcher E, Abel GA, Anderson R, et al *BMJ Open 2017;7:e015853*

Aim: To describe GPs' career intentions which might impact on GP workforce availability over the next 5 years

24 items on **quitting, career breaks, reducing hours, morale, demographics, employment status**

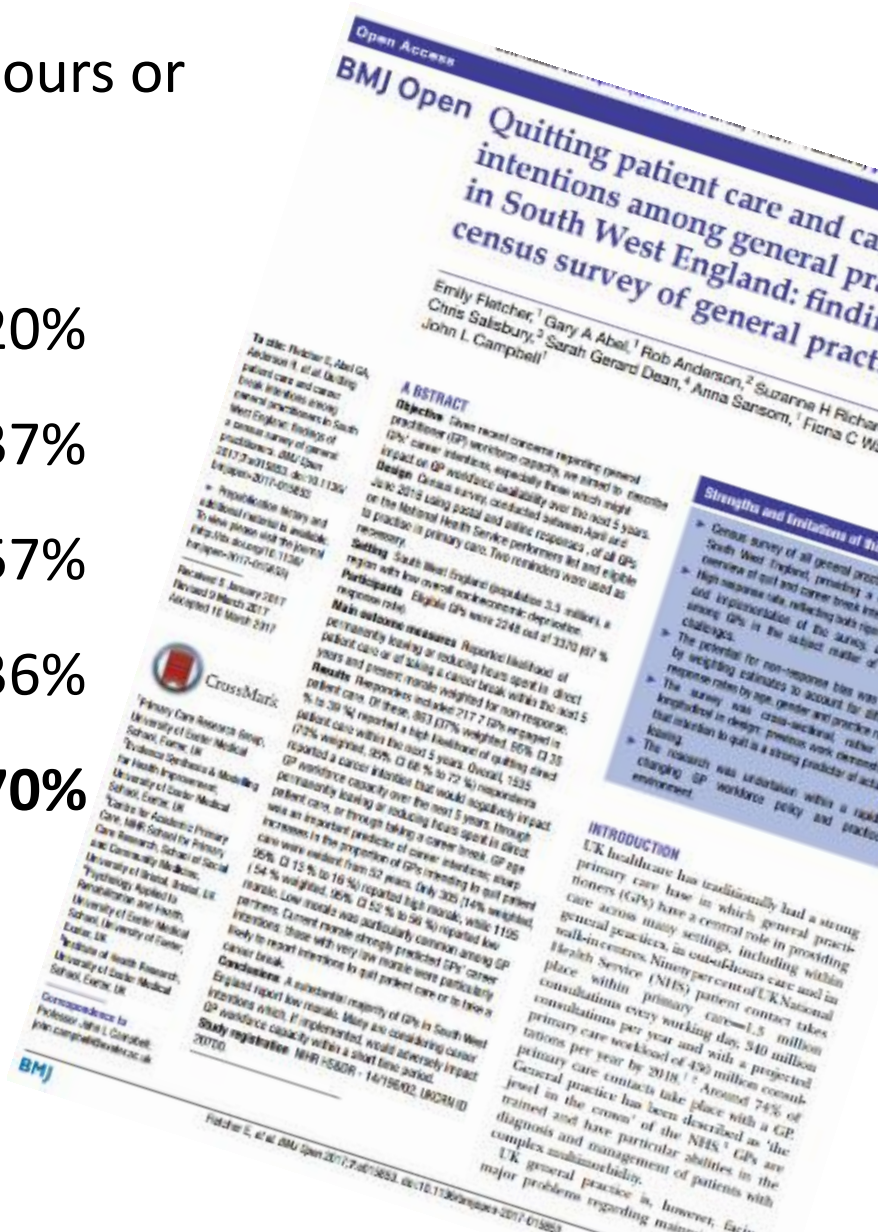
Postal/online completion

2248/3370 (**67%**) GPs responded

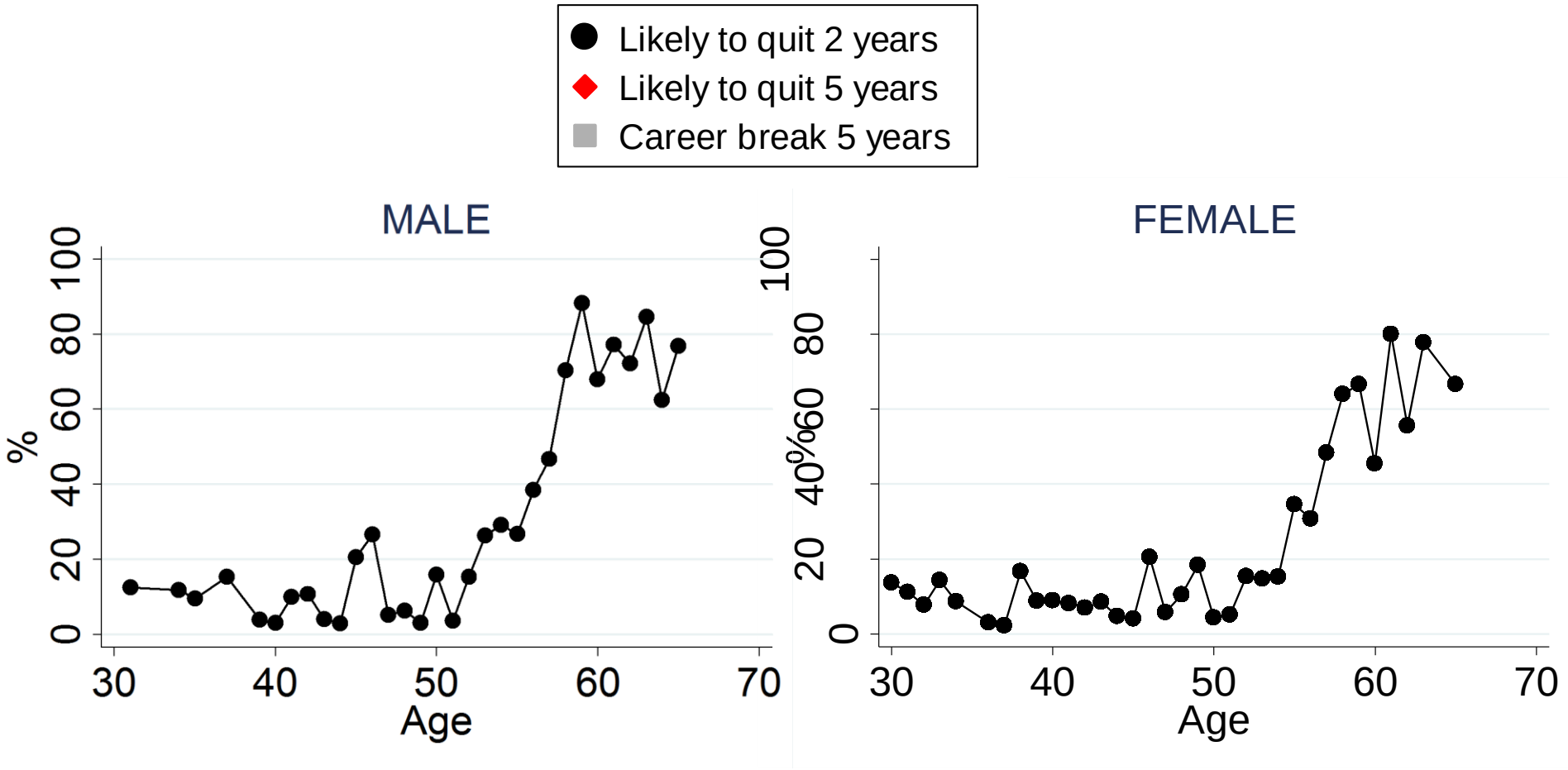
Census Survey

High likelihood of quitting, reducing hours or taking career breaks

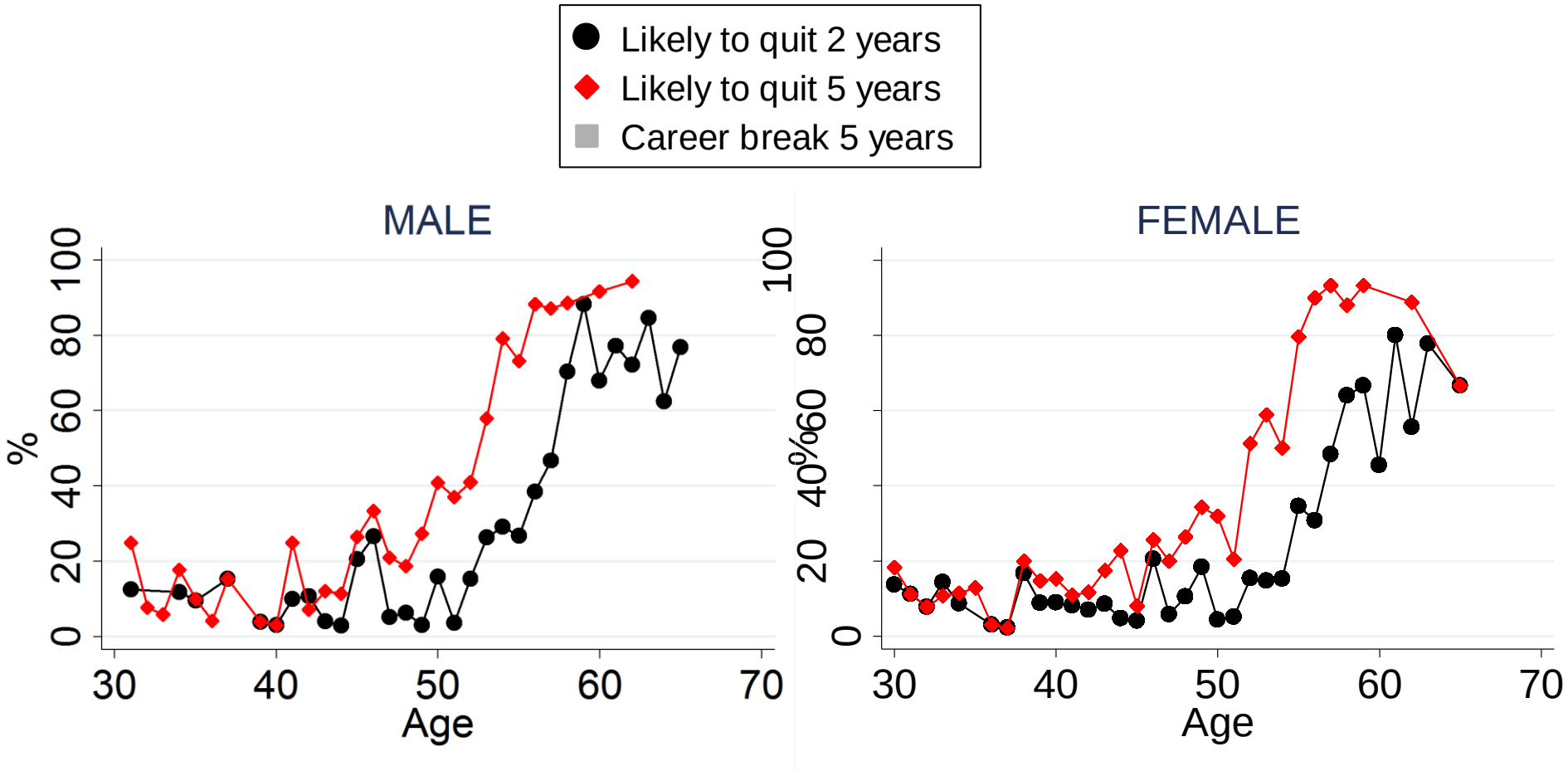
- quit within 2 years 20%
- quit within 5 years 37%
- reduce hours within 5 years 57%
- career break within 5 years 36%
- **any one of above** **70%**



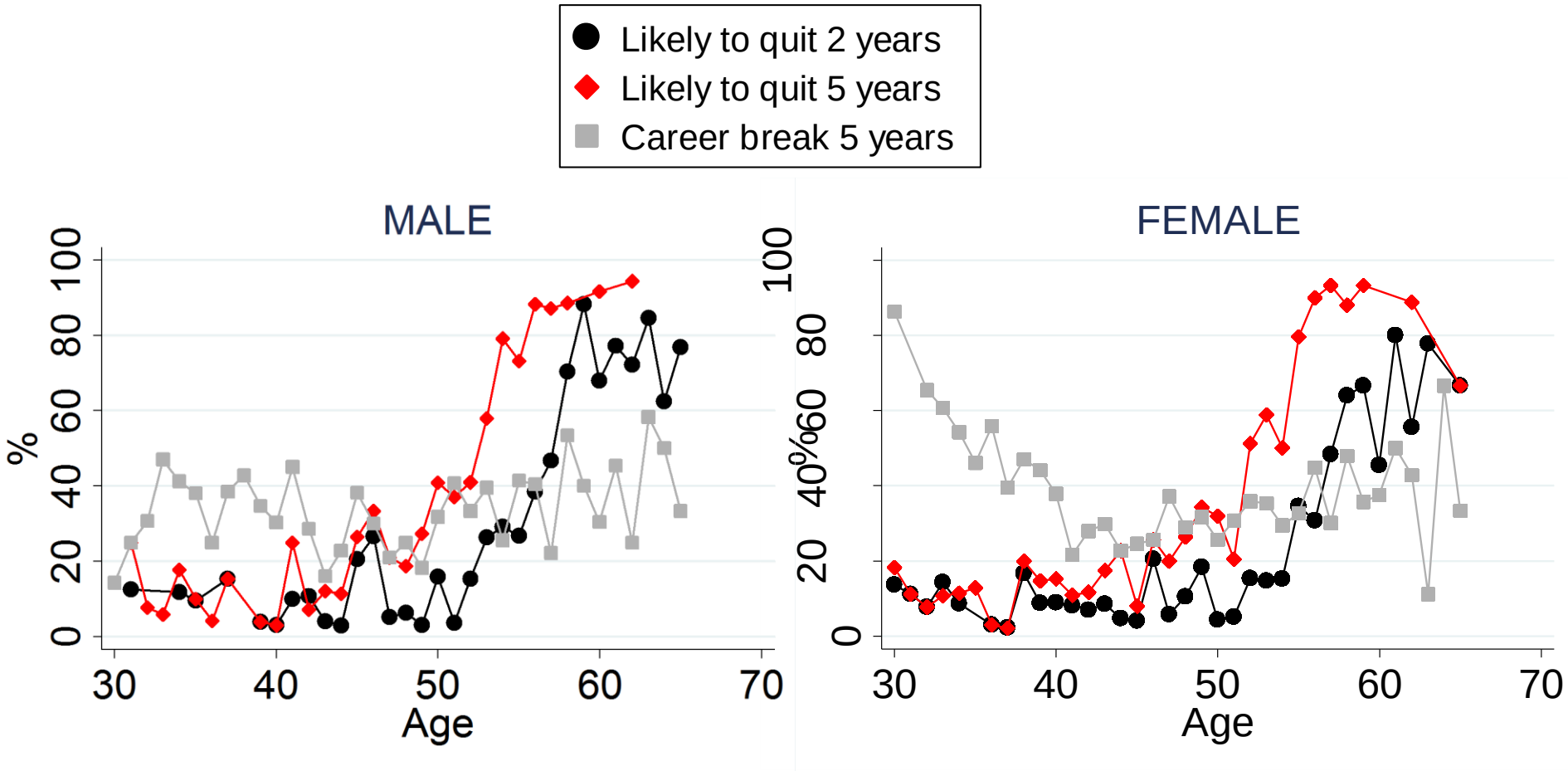
Census Survey



Census Survey



Census Survey



Census Survey

Predicting quit, reduce hours, and career break intentions:

- Older age highly predictive of quit/career break intention
- Intention to quit independent of role/ ethnicity/ country of qualification
- Locums most likely to reduce hours or plan career break
- Low morale (especially ‘very low’ morale) associated with all four quit outcomes

Census Survey

Predicting GP morale:

- 14% ‘high/v high’ morale; 54% ‘low/v low’
- Morale not related to gender, country of qualification, or ethnicity of GP
- GPs aged 50-54 with lowest morale
- GP partners with lowest morale,
  Locums and ‘other roles’ with best morale

Census Survey - summary

- **Substantial proportion** intend to permanently quit within 5 years (**<u>one in five within the next 2 years</u>**)
- Further risk to workforce through **reducing hours/career breaks**
- **Age** highly predictive of intentions to quit, reduce hours and take a career break
- Intention to **quit** is **independent of role** (partner/salaried/locum)
- Intention to **reduce hours varies with role**:
  - locums most likely to reduce hours vs partners / salaried GPs
  - non-partners reducing hours could add strain to partners
- **Morale is low** and is an important contributor in career intentions

Systematic Review

Why do UK GPs quit patient care?

- 4 high-level job-related 'push' factors dominate:
  - dissatisfaction, workload, job-related stress, work-life balance
- BUT many other specific factors at personal, practice or regional or national level affect individual GPs
- Factors not isolated or static:
  - Cumulative or relative to career expectations
  - Trade-offs take place
  - Complex: e.g. working part-time to enhance/protect competence and enjoyment of working as a GP

Qualitative Interviews

In-depth interviews with 41 GPs and 19 stakeholders to gain a deeper understanding of why GPs are quitting direct patient care and what might help to retain them

Theme 1: Identity and Value

"…the buck stops with the GP."
Stakeholder

- General practice lacks clarity and boundaries
- GP identity, professionalism and morale
- Being listened to and being valued

"You over burden yourself and you won't cut corners, and that has its consequences at the end of the day."
Male GP, age 40-49

Theme 2: Fear and Risk

- Risk to patient care and safety
- Fear of complaints and being sued
- Risk to professional status and identity
- Risk to own health and wellbeing
- Uncertainty about the future of general practice
- Financial risk

"If I make a mistake I will be held responsible, and nobody will ask 'how busy were you that day? Were you being supported?'"
Male GP, aged 40-49

"I was just working at such a pace and I knew I was making myself ill"
Female GP, age 50-59

Theme 3: Choice and Volition

- Accumulation, compounding, and combinations of factors
- GP resilience
- Decisions do not happen in isolation
- The only route left (is quitting)

"I think I have probably been in survival mode for the last 5 or 6 years" *Male GP, aged 50-59*

"If the purpose of resilience is to enable the same workforce to cope with every increasing demand, that's not on, we actually have to make the job doable" *Stakeholder*

Qualitative Interviews

What does this mean for policy and strategy development?

‘Sticking plasters’

Increase the perceived value and clarify the identity of general practice

Reduce the levels of fear and risk that GPs experience

Provide GPs with feasible and acceptable routes to remaining in direct patient care

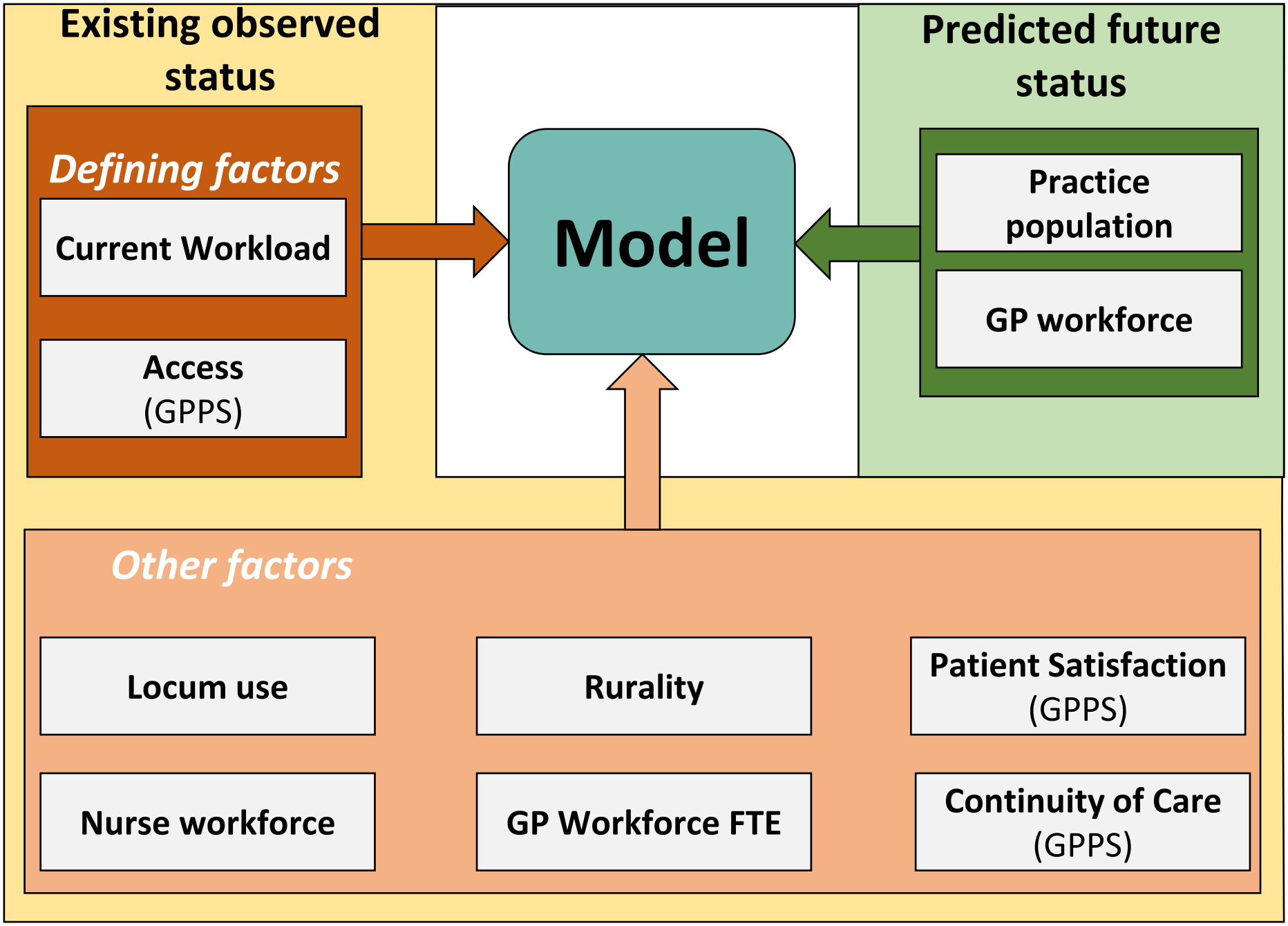
Predictive Risk Modelling

Predicting which practices are at risk of a future **supply-demand imbalance**:

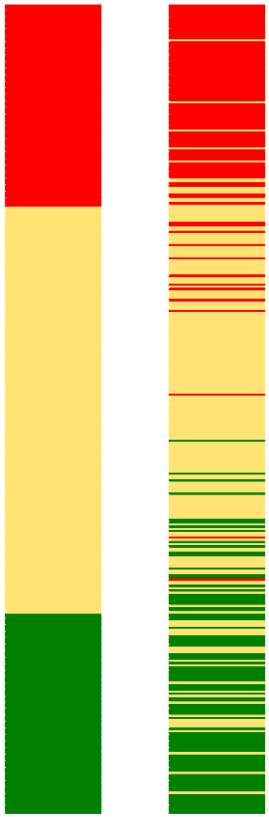
- Use 2012 data to understand predictors of 2016 status
- Predict forwards to 2021
- Explore scenarios ("stress test" the model) to find practices vulnerable to:
  (i) Harder recruitment
  (ii) Larger than expected population growth

Patients' access to services (GP Patient Survey, GPPS)	Poor			**Under-supply**
	Medium			
	Good			
		Low	Moderate	High
		Workload per FTE GP (Weighted list size per FTE GP)		

Patients' access to services (GPPS)	Poor	**England 8.6% SW 4.3%**	**England 10.6% SW 5.4%**	**Under-supply England 13.5% SW 5.1%**
	Medium	**England 11.5% SW 9.4%**	**England 11.6% SW 12.4%**	**England 10.6% SW 6.7%**
	Good	**England 13.2% SW 24.5%**	**England 11.1% SW 21.8%**	**England 9.2% SW 10.2%**
		Low	Moderate	High
		Workload per FTE GP (Weighted list size per FTE GP)		

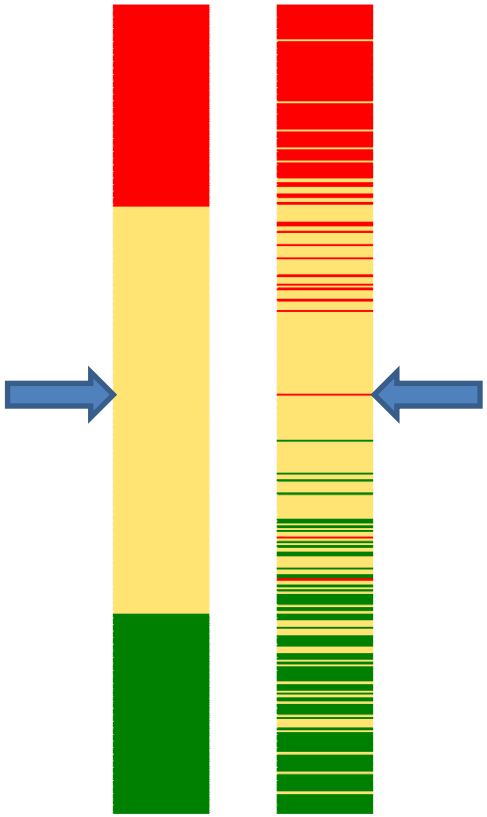

Existing observed status
Defining factors
Current Workload
Access (GPPS)
Model
Predicted future status
Practice population
GP workforce
Other factors
Locum use
Rurality
Patient Satisfaction (GPPS)
Nurse workforce
GP Workforce FTE
Continuity of Care (GPPS)

Harder recruitment



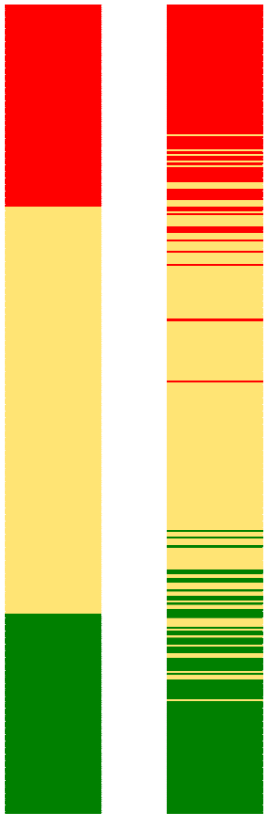
- Change of order indicates practices at particular risk from recruitment challenges
- Now 66% have an absolute risk >10%

Harder recruitment



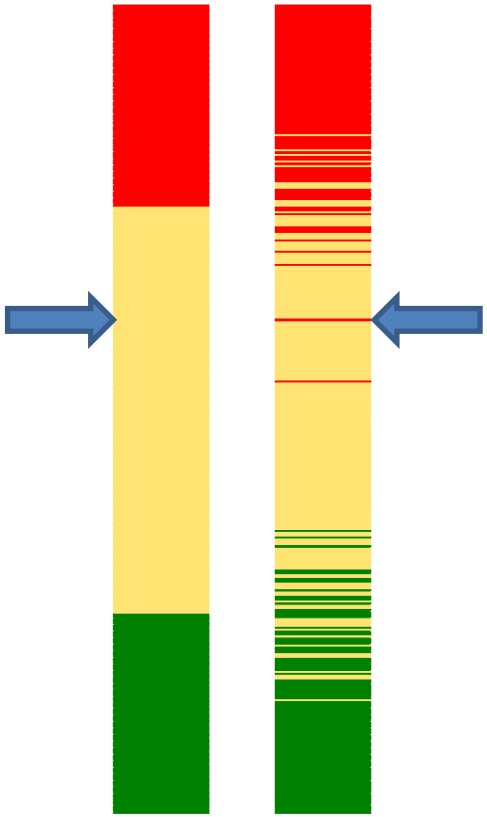
- Change of order indicates practices at particular risk from recruitment challenges
- Now 66% have an absolute risk >10%

Increased practice populations



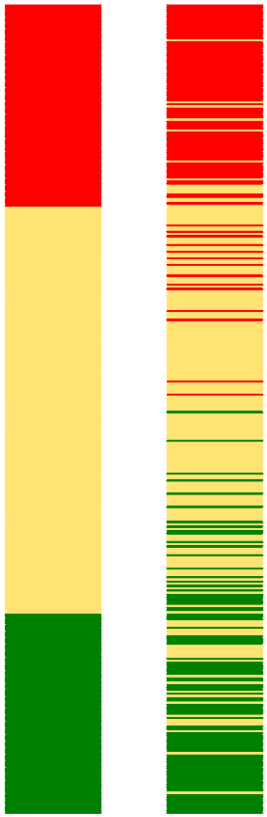
- Change of order indicates practices at particular risk from increased list size
- Now 44% have an absolute risk >10%

Increased practice populations



- Change of order indicates practices at particular risk from increased list size
- Now 44% have an absolute risk >10%

Combined harder recruitment and increased populations



- Substantial reordering
- Now 81% have an absolute risk >10%

Predictive Risk Modelling

Who is at greatest risk?

- Larger practices
- Practices serving younger and deprived populations
- Practices employing more nurses
- Practices with poor patient experience
- Practices in North Somerset and Bristol

Predictive Risk Modelling - summary

- Our survey of SW GPs' career intentions adds little to the value of the model
- Practices can be characterised on their vulnerability to:
  - recruitment challenges
  - increased populations
- Most practices are vulnerable to combined harder recruitment and dramatic workload increases

RAM Expert Panel

Overview of the potential policies and strategies

National/regional

GP Practice

GP

54 potential policies and strategies

24 rated as <u>appropriate</u>

16 rated as <u>feasible</u>

24 potential policies and strategies (appropriate)

Potential policies/strategies rated as appropriate

39. GPs should consider portfolio working as part of their career pathway and this

39. GPs should consider portfolio working as part of their career pathway, and this should be optional.

10. GP practices identified as being 'at-risk' should be provided allocated a specialist team for managing recruitment and retention, and this should be optional (uncertain for compulsory) – Optional
11. New incentive and support packages should be available to GPs and other organisations setting up new practices or new ways of working in under-doctored areas.
18. There should be a publicity campaign focussing on managing expectations of patie
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21. GPs who are returning to work after a period of absence or after a career break should have access to schemes that use a mix of online education and face-to-face meetings to ensure timely access to induction and refresher courses
27. GP practices should implement strategically planned exits for retiring GPs.
33. Peer support initiatives should be made available to GPs aimed specifically at health and well-being. – Specifically for those not near retirement age
34. GPs should have access to their own specialised health care service to ensure a quick and confidential occupational health care service.
36. A structured programme of training and support should be made available to all GPs in their first 5 years following qualification as an independent GP to help them establish healthy, productive careers. Engagement with such a course should be optional (uncertain for compulsory). – Optional

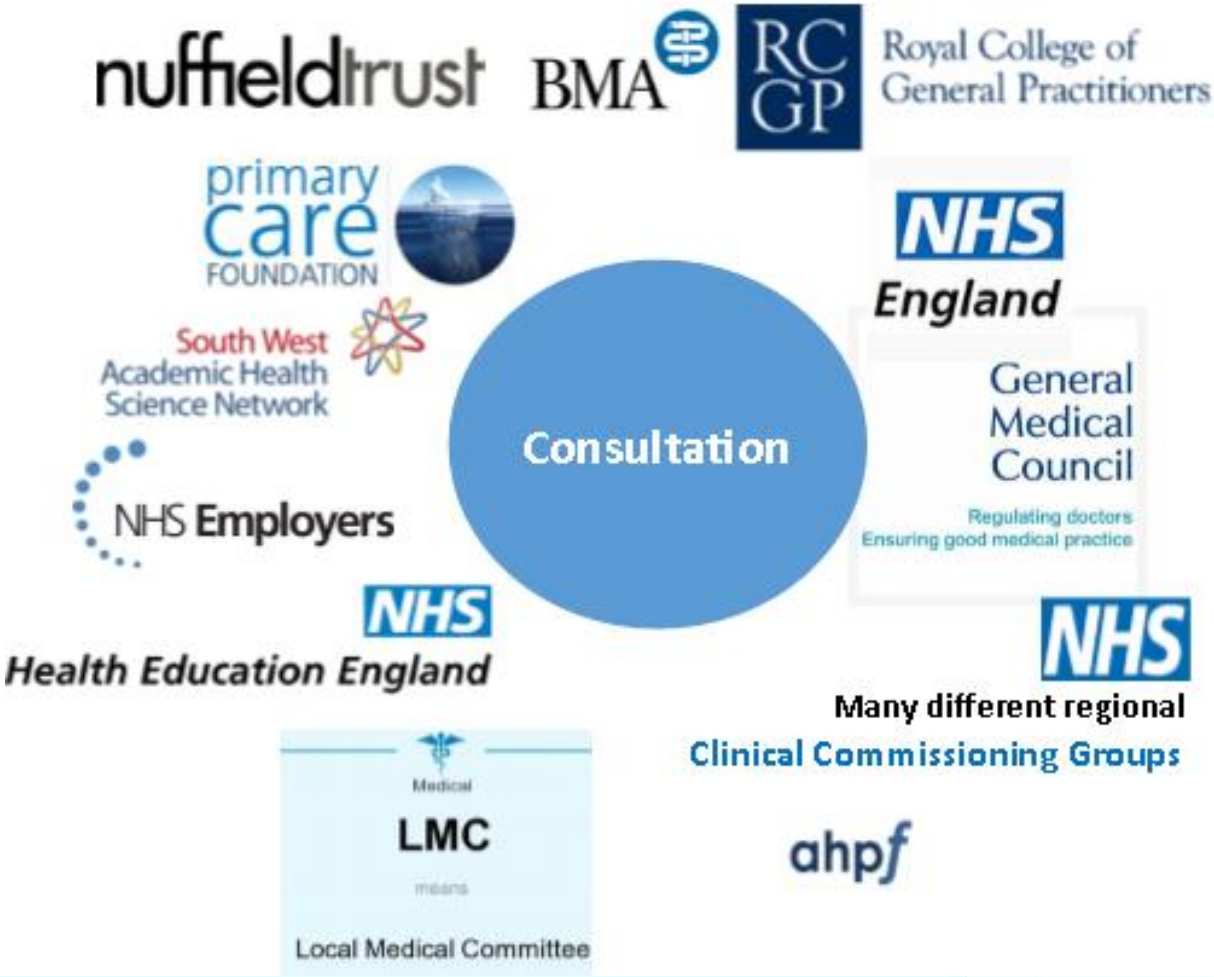
the work of the Practice (e.g. ownership of premises), GPs should have access to schemes to reduce financial burden (e.g. buy back schemes for premises). - All GPs or those close to retirement, but no reason to single out those not nearing retirement.
45. There should be an agreed maximum in the number of consultations that a GP should be allowed to conduct in a working day in order to protect patient safety as well as the health of the GP.
46. There should be contractual changes to encourage longer consultations where

48. Contracts based on specified programmed activities should be available to GPs to work across several GP practices and on other health related activities

supporting annualised hours, part-time working, and/or ad-hoc contributions to direct patient care.
50. There should be financial incentives for such GPs who have maintained a prolonged/sustained period of direct patient care.
51. The annual appraisal and revalidation process for such GPs should be reviewed with a view to streamlining and simplifying the process for such GPs who have not encountered any concerns in the previous revalidation/appraisal processes/. for such GPs who would like to work with a specified and limited scope of practice – only for a specific group of GPs nearing retirement, not all.

Stakeholder Consultations

London 7 Jun/Leeds 8 Jun



Stakeholder Consultations

1. "Protection" of GPs and managing patients expectations

- Consultations – maximum number and longer
- Using marketing strategies to manage patient expectations/demand

2. Incentives and support mechanisms for GPs

- Identification of practices' "at-risk" status and providing support
- External HR interventions and monitoring/support
- Supporting uptake of health and wellbeing interventions for GPs
- Professional support in the first 5 years of career and supporting planned exits for GPs nearing retirement/implications of losing pension incentives

3. Portfolio and wider working arrangements

- Portfolio working and linking activities with local population priorities
- Contractual arrangements for working across practices
- Widening multidisciplinary teams and role substitutions

ox 1: Working patterns considered risky in the rail industry

Planned day shifts of longer than 12 hours or night shifts longer than 10 hours

Planned early shifts of greater than eight hours (starting between 2000 and 0500)

More than four consecutive night shifts of any duration

More than three consecutive nights of more than eight hours

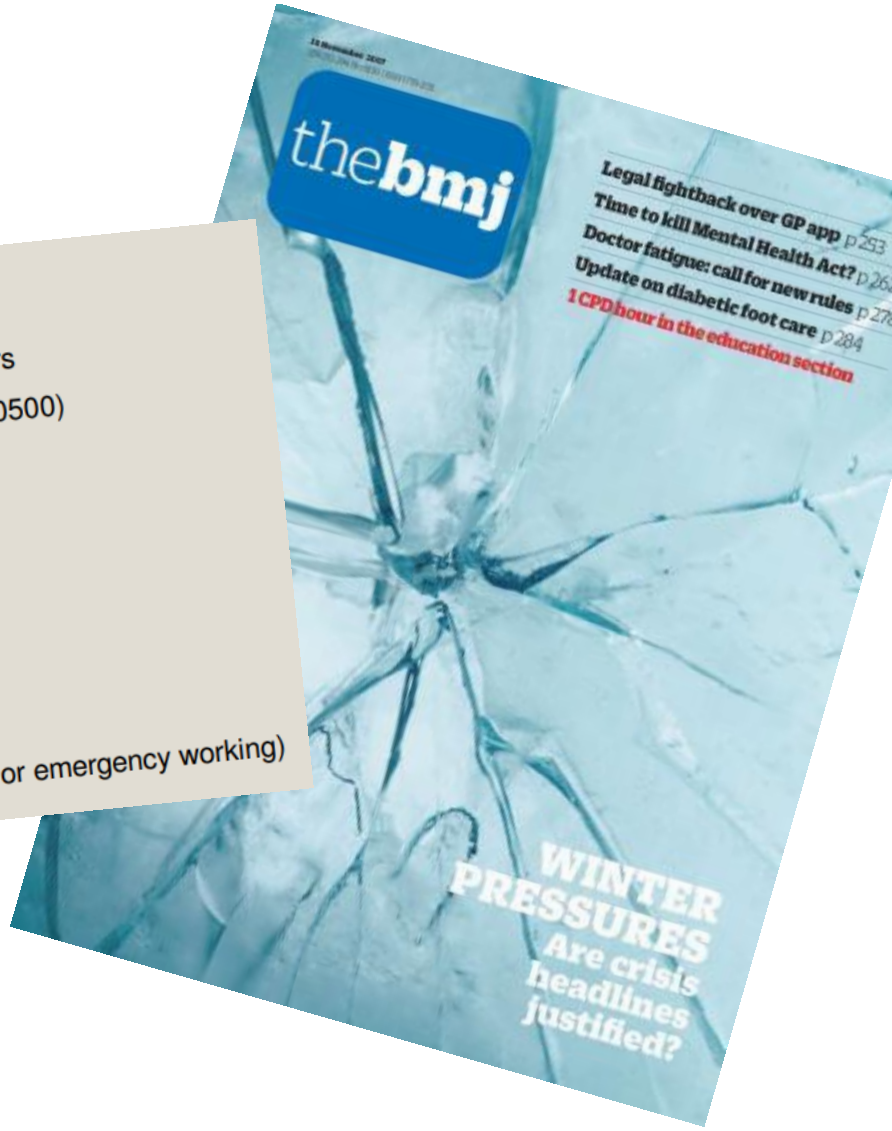
More than 12 consecutive day shifts

More than seven consecutive shifts of more than eight hours

More than four consecutive shifts of more than 12 hours

Working more than 55 hours in any single week

Any rest period of less than eight consecutive hours (unbroken by on-call or emergency working)



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www.medicine.exeter.ac.uk/research/healthserv/regroup/

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