The changing general practitioner workforce: the development of policies and strategies aimed at retaining experienced GPs and those taking a career break in direct patient care (ReGROUP)

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Scientific Summary

Background

Despite being described as the 'jewel in the crown' of the NHS, UK general practice is facing a workforce crisis, with well-publicised difficulties reported by practices in filling vacancies, resulting in GP shortages and a clear risk to patient health and wellbeing. This workforce challenge is compounded by the ageing demographic of the UK population, and the challenge of providing care to individuals with complex healthcare needs.

New models of care are currently under consideration, along with a range of other policies and strategies that are potentially relevant to averting the crisis in the GP workforce. Evidence to support the development and implementation of such policies and other major initiatives is however limited – whether these interventions are focussed on national, regional, or local community or practice-based initiatives.

Primary care workforce capacity issues represent a problem in many other western health care economies and this research may both benefit from international evidence, and contribute to that evidence base. Given the high cost and long period of time required for the training of a GP, targeting the retention of the GP workforce is both important and urgent.

Objectives

Our research addressed two questions. First, what are the key policies and strategies that might (i) facilitate the retention of experienced general practitioners in direct patient care or (ii) support the return of GPs to direct patient care following a career break? Second, how feasible is the potential implementation of those policies and strategies?

We aimed:

- To develop a conceptual framework and undertake a comprehensive assessment of factors associated with GPs' decisions to quit direct patient care, to take career breaks from general practice, and/or to return to general practice after a career break
- To identify the potential content of, and assess the evidence supporting key potential components of policies and strategies aimed at retaining experienced GPs and/or supporting GPs returning to direct patient care following a career break
- To identify practices that may face supply-demand workforce imbalances within the next five years

- To assess the acceptability and feasibility of implementing any emergent policies and strategies.

Research workstreams included:

- A systematic review of past research into the factors influencing GPs' decisions or intentions to leave general practice (or reduce their work hours)
- A census survey of GPs in South West England
- Use of that census survey to provide a sampling frame to provide qualitative evidence from GPs intending to quit, those who are currently taking/planning a career break, and GPs who intend to remain working in direct patient care
- To outline the content of policies and strategies supporting the retention of GPs in direct patient care
- To prioritise emergent policies and strategies in respect of their feasibility and effectiveness using a validated methodology
- To draw on a range of data to specify, develop, and undertake preliminary evaluation of a model aimed at identifying supply-demand imbalance at the level of individual practices, and to demonstrate potential use of the approach to identify general practices in South West England at risk of workforce shortages
- To gather feedback from key stakeholders on the acceptability, feasibility and likelihood of implementing any emergent policies and strategies.

Whilst our initial thinking focussed round 'experienced GPs' with a particular view on considering the retention of GPs aged over 50 years old, our experience of conducting this research identified the extent of the problem, which appeared to span all ages of qualified GPs. Our investigation, therefore, did not focus exclusively on this age group. Experienced GPs were thus taken to be all fully qualified GPs, irrespective of their age.

Methods

A systematic review of quantitative and qualitative research to describe what factors in the UK and other high income countries affect GPs' decisions to (i) quit direct patient care (ii) take career breaks from general practice or (iii) return to general practice after a career break. Searches identified published articles and 'grey' literature written in English from 1990 onwards. Searches were conducted in January 2016 and updated in April 2016.

All GPs registered to practise in South West England were identified and surveyed between April and May 2016 using a previously-piloted bespoke questionnaire. We used online and postal modes of questionnaire delivery and two reminders if necessary.

A thematic analysis of Care Quality Commission practice report data was undertaken to explore examples of good and poor practice in South West England with findings informing the development of our interview schedule. We undertook semi-structured interviews with GPs identified from the census survey as meeting our inclusion criteria, and with other primary care stakeholders across the region. Transcribed interviews were analysed thematically.

Using the RAND/UCLA Appropriateness Method (RAM), a panel of GP partners and GPs working in national stakeholder organisations rated the appropriateness of potential policies and strategies emerging from the other research workstreams. Two rounds of rating were conducted. Fifty-four potential policies and strategies aimed at different levels of healthcare organisation were developed into 100 summarising statements. These statements were initially rated for appropriateness by the RAM panel members, based on the research evidence, and on the current known direction of national policy. The scope of statements fell into three major domains – human resources management systems and processes, human resource practices and operational functions, and day-to-day GP practice management. Ratings were analysed for consensus, and categorised based on panel-assessed appropriateness. The statements rated as 'appropriate' after Round One of the investigation were then rated for feasibility in Round Two.

A modelling framework was developed aimed at identifying those practices at highest risk of facing a workforce supply-demand imbalance within the next five years. A hybrid modelling approach was used to predict imbalance based on a range of practice factors, and on the predicted fraction and age profile of the existing GP workforce remaining in direct patient care. A predictive model was developed using historical data, and current data were then used to predict future risk over a five year window. The utility ('added value') of incorporating responses from GPs regarding their quitting intentions within the model was explored. The predictive model development used data for all general practices in England. Prediction of future supply-demand risk status was restricted to practices in South West England.

Potential 'emergent' policies and strategies aimed at supporting the retention of GPs in direct patient care were road-tested in two stakeholder consultation meetings. Participating stakeholders were drawn from a range of regional and national organisations, including national representatives from major primary healthcare organisations with an interest in the issue of GP workforce capacity and planning. Stakeholders explored the practicalities of implementing change across 11 broad areas

of emerging policy and strategy, focussing on barriers and facilitators, feasibility and acceptability, and key actions which might be undertaken to facilitate and support change.

Results

The systematic searches yielded 5,227 records after de-duplication. We identified and reviewed 34 survey-based (22 from the UK) and five qualitative-based studies (4 from the UK) in detail. GPs in the UK leave general practice for a wide range of reasons, both negative, job-related 'push' factors, and positive, leisure, retirement and home-life related 'pull' factors. Some factors operate at an individual level whilst others operate at the level of general practice, the whole profession or the national health system.

Four closely-related, job-related negative factors play a major part in decision-making about early retirement and part-time working: workload, job dissatisfaction, work-related stress, and work life balance. Many other detailed factors either underlie these higher level factors or may be more important for a significant minority of GPs. The factors identified could form a basis for developing GP retention initiatives.

In the census survey of South West GPs, 2,248 out of 3,370 eligible GPs participated (67% response rate). Thirty-seven percent of respondents reported a high likelihood of quitting direct patient care within five years, and 20% within two years. Overall, 70% of respondents reported a career intention that would, if implemented, reduce GP workforce capacity over the next five years.

GP age was an important predictor of career intentions; sharp increases in the proportion of GPs intending to quit patient care were evident from age 52 years. Fifty-four percent of GPs reported low morale. Low morale was particularly common amongst GP partners. Current morale strongly predicted GPs' reported career intentions, with those with very low morale being particularly likely to report intentions to quit patient care or to take a career break.

Interviews undertaken with 41 GPs identified from the census survey return, and with 19 stakeholders opportunistically sampled from primary-care related settings in the South West, identified that factors and issues of relevance to GP recruitment and retention need to be addressed collectively. Inherent tensions and contradictions within potential solutions need to be considered. There is a need to address the reality of GPs' lived experiences of their work and role within the current healthcare climate and provision. Three important themes emerged from the data relating to the identity and value of the GP role, fear and risk reported by GPs in respect of delivering that role, and choice and volition in respect of career planning.

Following two rounds of rating, the RAM panel identified 24 out of 54 potential policies and strategies which were judged to be 'appropriate'. Overall, most of the policies and strategies deemed 'appropriate' were also considered 'feasible'. Many of these related to providing support to GPs who were returning to work, with the aim of managing their re-entry into the workforce, providing options for flexible working, and/or targeting GPs in the first five years of professional GP practice or when nearing retirement. At national level, there was recognition that early self-reporting of practice at-risk status might enable timely, focussed support to be put in place. RAM panellists were more likely to reach consensus on policies and strategies which involved optional implementation rather than those involving compulsory implementation. Many of the policies and strategies considered to be appropriate and feasible related to human resource management or to addressing contractual arrangements, recruitment and retention, personal and professional development, training support, and incentivisation of the workforce. Such potential policies and strategies relating to operational functions and day-to-day management of GP practice often focussed on protective measures aimed at reducing work-related stressors, easing implementation of new models of care, establishing arrangements to actively manage workload, or provide for innovative contractual approaches aimed at reducing financial risk or increasing personal and practice flexibility.

Based on historic data, the predictive model we developed had fair to good discriminatory ability to predict which practices faced supply-demand imbalance. Predictions using data from 2016 suggested that practices at highest risk of a future supply-demand imbalance within a five-year window are those which currently: have larger patient list sizes, employ more nurses, serve more deprived and younger populations, and have poorer than average patient experience ratings. Findings from a survey of GP career intentions added very little information to the predictive capacity of the model when compared with a model using only data based on routinely available information regarding GPs' gender and age.

Stakeholder feedback was obtained in respect of: (i) Protecting GPs and managing the expectations of patients (ii) Providing incentives and support mechanisms for GPs (iii) Portfolio and wider working arrangements.

A range of actions were identified which, stakeholders suggested, might be usefully taken forward by some of the national organisations represented in the stakeholder consultation. These included, for example: collection of data on the current scope of GPs' portfolio roles, and the need to define formal training and career progression for key primary care team professionals, such as practice managers.

Conclusions

This research has identified some of the basis for the substantial concern about GP workforce capacity in the UK and documented the extent of the problems in South West England. The problems are urgent and compelling. A model developed in this research may have utility in identifying practices that are at risk of GP workforce supply-demand imbalance and may be of value to healthcare planners. Emerging from the research findings, we have identified policies and strategies which may be of relevance in addressing concerns regarding GP recruitment and retention. These emergent policies and strategies have been considered by expert stakeholders, who identified some ways in which relevant action might follow. These research findings should be disseminated widely to those organisations who are in a position to give them urgent consideration and initiate relevant action.

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