Royal College of General Practitioners

# Uncovering the GP workload burden: A study of the drivers and costs of "unnecessary" and hidden workload

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# Executive summary

This study investigates the nature, burden, and impact of “unnecessary tasks” in general practice in England, drawing from a literature review, semi-structured interviews with 14 GPs and one practice manager, and a time and motion study involving 11 GPs. While the term “unnecessary” often refers to administrative, clinical, or regulatory duties that do not require GP-level expertise or are seen to add little direct clinical value, the study reveals that this concept is far from straightforward. GPs frequently described these tasks as “pointless paper exercises” or “behind-the-scenes work,” yet also acknowledged that some tasks, though operationally inefficient, hold relational or ethical significance. The literature review confirmed the prevalence of excessive administrative burdens, misaligned system processes, and regulatory demands as major contributors to this hidden workload.

A key finding from the qualitative interviews is the shifting and often ambiguous boundary between necessary and unnecessary work. While some tasks may seem unsuitable for GPs to handle, such as short school absence notes or form-filling for non-clinical agencies, others blurred the line between essential clinical care and compensating for gaps elsewhere in the healthcare system. GPs reported engaging in time-intensive activities, like writing housing letters or managing secondary care tasks, not because they are contractually obliged, but because of moral commitment, patient vulnerability, or lack of alternative support. These activities are often driven by cascade effects, safety netting to compensate for system gaps, duplicative responsibilities, or poorly defined inter-agency roles. In such contexts, the label “unnecessary” may fail to capture the nuance, value, or drivers of these tasks.

The time and motion study attempted to quantify the burden, estimating an average of £410.53 per GP per day in costs attributable to unnecessary activities. The small sample size of the study means that it is difficult to generalise these results, and further research is needed here, but this nevertheless suggests a significant potential burden that could be alleviated. Reducing unnecessary workload may help free up time for patient care, but this should not be assumed to equate directly to more appointments. A proportion of the time spent on these unnecessary activities is likely to have been completed in overtime, i.e. beyond the GP’s contracted hours, and therefore will not currently be funded, and could be contributing to high burnout levels amongst GPs. Some activity will be completed within contracted hours and could therefore reduce the time that GPs are available to spend directly with patients.

Tasks such as navigating fragmented referral pathways, inappropriate triage, and test result follow-up represented the highest time burden and cost of lost time. However, beyond financial implications, this workload has a profound impact on GP morale, wellbeing, and job satisfaction. GPs spoke of emotional fatigue, the erosion of clinical time, and the demoralising effect of routinely completing tasks they believe should lie elsewhere. The perceived impossibility of pushing back, or the futility of doing so, leads many to simply absorb the workload, often outside of contracted hours, contributing to burnout and workforce attrition.

Crucially, the findings highlight the need to recognise the complexity of what is often labelled as “unnecessary.” Further work is needed to distinguish which elements of this hidden workload are truly avoidable or wasteful, and which play a vital role in the delivery of holistic, relational care but require improvements to policy or processes to make them more efficient.

# Introduction and background

The growing intensity and complexity of workload in general practice continues to pose a critical threat to its sustainability. Reducing unnecessary workload is a core strategic priority for the Royal College of General Practitioners (RCGP), as general practice continues to face mounting challenges related to workload, workforce pressures, rising demand and increasing clinical complexity. Despite national attention on expanding workforce numbers and reforming clinical pathways, far less is known about the scale and nature of the work GPs undertake that may be clinically unnecessary, administratively avoidable, or more appropriately delivered by other parts of the system.

Initial scoping by the RCGP[1] and its members highlighted a wide range of tasks perceived by some GPs as potentially unnecessary or avoidable. These included non-essential requests for medical evidence (e.g., from gyms, airlines, or housing authorities), duplicated or inefficient processes such as Driver and Vehicle Licensing Agency (DVLA) activities or benefits paperwork, and system-level inefficiencies such as unclear referral and management pathways between services. It was noted that certain tasks, for example, benefits and housing paperwork, may not always appear clinically essential from the perspective of direct medical care, yet some participants described them as contributing to patient care in a broader, person-centred context. Although initiatives such as the Government's 'Red Tape Challenge' (2025, unpublished), 'Bureaucracy Busting Concordat' (2022)[2], and reforms to the Quality and Outcomes Framework (QOF) have aimed to address elements of unnecessary workload in England, these efforts have not been systematic enough to deliver sustained change.

This study was commissioned by the RCGP to begin addressing the research gap and to help lay the groundwork for an evidence-informed, systematic approach to tackling unnecessary workload in general practice. The aim of this research was to define, explore, and quantify unnecessary tasks within general practice in England through a mixed-methods approach, combining a narrative literature review, qualitative semi-structured interviews with GPs, and a time and motion study. Data collection for the time and motion component took place in February, and the findings should therefore be interpreted within the context of clinical activity during that month. The study sought to capture aspects of general practice that are typically overlooked in national appointments data, including hidden labour that takes place before, after, and beyond formal consultations, as well as the cognitive and emotional burden of tasks that participants viewed as avoidable, misdirected, or inappropriate.

# Methodology

## Literature review

To assess existing literature on unnecessary or avoidable workload in general practice, this review employed a structured search strategy across multiple databases. The primary aim was to identify and analyse tasks perceived as unnecessary within general practice in England and understand their impacts on GP workflows and wellbeing. The search strategy incorporated a combination of terms targeting unnecessary tasks, administrative burdens, and primary care settings.

The literature review questions used are as follows:

1. **What tasks are considered unnecessary in general practice?**
2. **How do unnecessary tasks impact the workflow and wellbeing of general practice staff?**
3. **What recommendations exist to reduce or eliminate unnecessary tasks in general practice?**

The databases utilised included PubMed, the Cochrane Library, and Google Scholar (for grey literature). The search string used was as follows: ("unnecessary task*" OR "administrative burden" OR "task inefficiency" OR "avoidable task*" OR "inefficient task*" OR "redundant task*") AND ("primary care" OR "general practice" OR "family practice" OR “Family Medicine” OR “General Practitioner” OR "GP" OR "primary healthcare").

To narrow down relevant studies, Boolean operators were employed to combine search terms effectively, with limits applied to ensure the articles were published in English and within the past ten years (2013-2023 at the time of this research stage). The inclusion criteria were set to focus on studies conducted within general practice settings in England, examining unnecessary or inefficient tasks in this context to remain consistent with the further study stages. Both qualitative and quantitative studies were included, along with grey literature such as policy documents, audits, and reports from recognised bodies like the King’s Fund and the RCGP.

The initial search yielded a combined total of 71 results from PubMed and Cochrane Library. Upon title and abstract screening, 66 studies were excluded, as they did not focus on unnecessary tasks within general practice settings. This exclusion left five peer-reviewed articles deemed relevant for full-text review. Additionally, a grey literature search on Google Scholar was conducted to broaden the study’s scope, producing four further pieces of relevant literature. These grey literature sources were included due to their relevance in discussing policy-based and regulatory tasks that contribute to GP workload.

Following the initial screening, all selected studies underwent a full-text review. This process aimed to verify that each source aligned with the study’s objectives and research questions. Relevant data from each study were then extracted using a predefined form, capturing details on study characteristics (author, year, setting, population, location), types and frequency of identified unnecessary tasks, and the documented impacts on GP workflow and staff wellbeing.

## Semi-structured interviews

Participants for the qualitative interviews were selected using a structured sampling approach designed to capture a diverse range of perspectives across practice size, location, and region within England. The research team developed a recruitment matrix stratified by Integrated Care Board (ICB) region and practice characteristics. GP practices were categorised as small (list size under 5,000), medium (5,000–15,000), or large (15,000+), and further classified as urban or rural using the Office for National Statistics (ONS) rural/urban postcode classification. A sample of small, medium, and large practices in both urban and rural areas was selected in each region, and invitation packs, including participant information sheets and consent forms (Appendices 1 and 2) were distributed by the research team.

Due to initial low response rates, the RCGP supported recruitment by circulating the study invitation via a national email to members. This approach ensured representation from a broad cross-section of general practice settings across England. GPs and practice managers who expressed an interest in participating were sent the information sheet individually and asked to provide informed consent by digitally signing a consent form prior to interview.

Interviews were conducted with a total of 15 participants, with the breakdown of practice location and role detailed in Table 1 below:

**Table 1: Participant practice regions and role within the practice**

| GP practice region | Role of interview participant |
|---|---|
| **East of England** | GP Partner |
| **East of England** | Salaried GP |
| **London** | GP Registrar |
| **London** | Salaried GP |
| **North West** | Salaried GP |
| **North West** | GP Partner |
| **South East** | GP Registrar |
| **South West** | GP Partner |
| **South West** | GP Partner |
| **South West** | GP Registrar |
| **West Midlands** | GP Registrar |
| **West Midlands** | GP Registrar |
| **West Midlands** | GP Registrar |
| **Yorkshire and the Humber** | GP Partner |
| **Yorkshire and the Humber** | Practice Manager |

Interviews explored personal interpretations and lived experiences of what constitutes “unnecessary tasks,” the contextual factors that led to their occurrence, and the perceived impact on clinical care and wellbeing. A semi structured format was used to ensure consistency across interviews while allowing flexibility for participants to elaborate on issues

of personal relevance. Structure was provided through a topic guide covering key themes such as examples of unnecessary tasks, contributing factors, and associated impacts. The topic guide is available in Appendix 3.

Interviews were transcribed verbatim and analysed thematically. An Excel based tracker was used to code and organise data, enabling the research team to identify, group, and compare patterns across participants. Themes were developed iteratively, informed by both the topic guide and emergent findings from the data.

## Time and motion study

All 15 participants that took part in the semi-structured interviews were invited to join the time and motion study, of which nine GPs and one practice manager accepted the invitation. To increase the sample size of the time and motion study, further invitations were sent to GPs and practice managers who had expressed interest in participating in earlier semi-structured interviews but had not been selected due to oversubscription. From this, two additional GPs accepted the invitation, bringing the time and motion study participants to a final total of 11 GPs and one practice manager (see Appendix 4). However, the practice manager was excluded from final analysis as the objective was to estimate the day-to-day workload of GPs from their own perspective.

Each participant completed a structured Excel based task diary, segmented into 10-minute intervals, for a self-selected typical working day. For each interval, participants recorded all tasks undertaken, indicated whether each task was necessary or unnecessary, and could provide optional free text commentary. The research team subsequently categorised each task into predefined domains (for example housing letters, insurance forms, navigating referral processes).

An estimated monetary cost of the time GPs spent on unnecessary tasks was calculated using the Unit Costs of Health and Social Care 2024 Manual (Jones et al., 2025)[12] total cost per hour of patient contact at £268 per GP for 2023/24, or £4.46 per minute. This indicative ‘cost per minute’ was multiplied by the mean minutes GPs spent on each task, as self-reported by participants in their task diary, and by the percentage of GPs who reported completing the task in a typical day to give a weighted value. The weighted costs per task were collated to provide an estimated average daily cost per GP attributable to unnecessary activities.

# Results

## Literature review

Table 2 provides a summary of the literature review findings. The literature identified three main categories of unnecessary tasks in general practice: administrative burden, clinical inefficiencies, and regulatory compliance requirements. These tasks were associated with reduced time for patient care, increased stress and burnout, and a perceived loss of professional autonomy. Recommended strategies from the literature included delegating non-clinical tasks, streamlining external requests, investing in digital systems, and reassessing compliance frameworks.

**Table 2: Summary of the results of the literature review**

| Focus Area | Key Findings | References |
|---|---|---|
| **Unnecessary task types** | • Administrative burden<br>• Clinical inefficiencies<br>• Regulatory compliance | Sinnott, 2022[3]<br>Dale, 2015[4]<br>Doran, 2015[5]<br>Watson, 2024[7] |
| **Impacts identified** | • Reduced time for patient care<br>• Increased stress and burnout<br>• Perceived loss of professional autonomy | Baird, 2016[9]<br>Odebivi, 2021[8]<br>Doran, 2015[5]<br>Dale, 2015[4] |
| **Recommendations** | • Delegate non-clinical tasks<br>• Streamline external requests<br>• Invest in digital systems<br>• Reassess compliance frameworks | Sinnott, 2022[3]<br>Baird, 2016[9]<br>Croxson, 2017[6]<br>Fisher, 2017[11] |

## What tasks are considered unnecessary in general practice?

Unnecessary tasks in general practice span administrative, clinical, and regulatory domains, often adding minimal clinical value while significantly increasing workload. These tasks, described as "pointless paper exercises," "mundane," or "inappropriate," are frequently imposed by external systems and contribute to inefficiencies, stress, and burnout.

A range of literature affirms these concerns. Sinnott et al. (2022)[3], Dale et al. (2015)[4], and Doran et al. (2015)[5] describe a growing administrative burden, often unrelated to clinical care. GPs report becoming "data clerks" for public health initiatives, spending excessive time on documentation at the expense of patient interaction. An RCGP (2023)[1] consultation identified non-clinical demands from organisations like the DVLA and Department for Work and Pensions (DWP), while Croxson et al. (2017)[6] discussed overwhelming bureaucracy that eclipses clinical tasks.

Unnecessary clinical tasks, such as routine overuse of blood tests, were documented in Watson et al. (2024)[7], which estimated that up to 25% of tests may be avoidable. These tests create cascade effects, additional follow-ups and consultations, without clear benefit. Sinnott et al. (2022)[3] and Doran et al. (2015)[5] also emphasise how inefficiencies in hospital

systems, including unclear responsibilities and poor communication, increase GP workload unnecessarily.

Regulatory frameworks also play a role, with compliance requirements, such as those linked to QOF and Care Quality Commission (CQC) inspections, placing substantial demands on GPs' time for documentation and data entry, often diverting attention away from direct, patient-centred care. Odebiyi et al. (2021)[8] found high levels of stress associated with paperwork and quality reporting, while Sinnott et al. (2022)[3] described the burdens of mandatory disease reporting and audit activities like hand-washing checks.

## How do unnecessary tasks impact the workflow and wellbeing of general practice staff?

Research consistently links unnecessary tasks with increased workload, reduced job satisfaction, and heightened risk of burnout. Baird et al. (2016)[9] and Odebiyi et al. (2021)[8] highlight the direct emotional toll of excessive paperwork and compliance obligations, which divert time from core clinical responsibilities and reduce the sense of professional autonomy.

Dale et al. (2015)[4] and Doran et al. (2015)[5] report that GPs are leaving the profession due to the overwhelming administrative load, with many describing emotional exhaustion and anxiety about clinical errors resulting from time pressures. Croxson et al. (2017)[6] notes that participants viewed a full-time GP career as unsustainable, and many raised concerns about increased risk and deteriorating work conditions.

The impact of compliance was further emphasised in Odebiyi et al. (2021)[8], where tasks related to QOF and CQC were seen as particularly frustrating. Sinnott et al. (2022)[3] argued that reporting requirements, though important for public health, often add workload without directly improving patient outcomes. Dale et al. (2015)[4] also found that compliance training and audits, while mandatory, were seen as low value and disruptive. Manual tasks, such as paper-based prescribing in regions lacking digital systems, were seen as outdated and inefficient.

Interactions with secondary care seem to further compound the problem. Doran et al. (2015)[5] highlight inefficiencies in referral systems and duplicative tasks that fall to GPs due to poor coordination. These tasks disrupt clinical focus and contribute to an already heavy administrative burden.

## What recommendations exist to reduce or eliminate unnecessary tasks in general practice?

### Administrative Burden

Literature recommendations were broadly categorised into administrative reforms, clinical guidelines, digital infrastructure improvements, and compliance framework revisions. Drawing on insights from the included studies, these recommendations aim to reduce administrative burden, streamline clinical practices, and enhance workflow efficiency.

The DVLA's application process could benefit from automation. GPs currently perform repetitive and manual data entry for DVLA forms, often followed by supplementary inquiries.

Streamlining this process through digital integration, as proposed by the RCGP, could minimise these time-consuming steps. Baird et al. (2016)[9] also supports this shift, recommending that agencies requiring GP certification develop more efficient, standardised forms and reduce reliance on GP validation for non-essential matters. By alleviating the bureaucratic burden of third-party documentation, these recommendations would enhance GPs' capacity to prioritise patient care.

Sinnot et al. (2022)[3] suggests that the current lack of standardised testing criteria in general practice fosters a culture of precautionary testing. By establishing high-value diagnostic guidelines, unnecessary tests, and the associated administrative work required for follow-ups, could be minimised. This shift would reduce the cascading of administrative tasks that follow non-essential tests, creating a more efficient, cost-effective and focused workflow within general practice.

Digital infrastructure improvements represent another critical area for reducing unnecessary workload. Odebiyi et al. (2021)[8] highlights poor digital infrastructure as a persistent issue, particularly in areas without access to electronic prescribing systems. The survey recommends that regions lacking digital prescribing systems prioritise electronic integration, which would enable more efficient processing of prescriptions.

Improving digital systems would also streamline other administrative processes, such as referrals and patient documentation. Croxson et al. (2017)[6] stresses that digital access and reliable technology reduce the risk of task duplication, such as re-sending lost referrals or re-issuing prescriptions. Enhanced digital infrastructure could prevent repetitive administrative work, reduce manual errors, and ensure smoother communication between primary and secondary care. Baird et al. (2016)[9] supports this recommendation, emphasising that digital investments are essential for reducing the administrative load and enabling a more efficient operational flow.

### Compliance and Regulatory Framework Revisions

Another key recommendation is the need for a review of compliance and regulatory frameworks, aimed at streamlining documentation requirements while maintaining robust quality and safety oversight. For example, Odebiyi et al. (2021)[8] and Baird et al. (2016)[9] recommended streamlining QOF criteria to focus only on high-priority care metrics. Simplifying quality assessment frameworks would maintain quality standards without overburdening GPs with exhaustive data entry tasks that contribute little to immediate patient care.

Similarly, the CQC inspection criteria could be adjusted to focus less on extensive documentation and more on critical clinical outcomes. Currently, GPs report that CQC inspections require substantial preparation, diverting time from patient care. Croxson et al. (2017)[6] advocates for more focused CQC criteria that prioritise quality of care over bureaucratic compliance, reducing the preparatory load on GP practices.

### Task Optimisation and Role Delegation

Role delegation and optimisation of task assignments within GP practices could also help reduce the unnecessary workload. Croxson et al. (2017)[6] suggest that routine administrative and non-clinical responsibilities, such as handling patient paperwork or scheduling follow-ups, could be delegated to administrative staff or practice managers.

# Semi-structured interviews

## Summary

Of the 15 participants interviewed, six were GP Registrars, five were GP Partners, three were salaried GPs, and one was a practice manager. The GPs had varying work patterns (both full and part-time) and were located in England, with most regions being represented.

Table 3 is a summary of the themes that emerged from the qualitative, semi-structured interviews.

**Table 3: Description of the themes identified in the semi-structured interviews**

| Thematic pattern | Description | Example quote |
|---|---|---|
| **Cascade event** | Tasks that triggered a series of additional activities, such as a referral generating a chain of forms, blood tests, or administrative steps that might not have been anticipated at the outset. | "Pushback processes, they themselves are really burdensome… it takes half an hour, an hour a week just to action all of these pushback emails." |
| **Safety netting** | Responsibility landing with GPs to monitor, follow up, or check on issues even when it wasn't clearly required or should be overseen by secondary care, often to avoid the risk of something being missed. In these cases, the task itself might be appropriate, but the surrounding system failures led to extra work being picked up in general practice. | "If there's nobody else, it falls to us… and you can't not do it, even if you're drowning in work." |
| **Complex record management** | The effort involved in retrieving and reconstructing a patient's history to complete a task and facilitate decisions, such as for housing, benefits, or insurance. This often involved sifting through records for context that was requested by external agencies. | "You don't want to make a mistake because it's... about someone driving." |
| **Duplicative origins** | Tasks that appeared or escalated through overlapping sources, such as patient requests mirrored by hospital letters, or unclear delegation between services such as education and Human Resources (HR). These tasks often created duplication or ambiguity around who was responsible. | "At least a patient a day could have been signposted elsewhere." |
| **External paperwork** | Described non-NHS paperwork, such as housing support letters, DVLA forms, or insurance documents, as time-consuming and of limited clinical value, yet routinely expected of them. Some of these tasks also had the potential for adding additional income streams for the practice which further complicated their definition of necessary or unnecessary. | "GPs aren't very good at saying no, because generally they're, you know, caring people and they want to help people." |

These themes illustrate that what made many tasks feel unnecessary was not their existence per se, but the inefficiencies, duplication, and misallocation surrounding them. This complexity reinforces the need to examine not just whether a task is necessary, but how it is generated, handled, and by whom.

Table 4 outlines how the themes were distributed across the tasks that were identified by the GPs within the semi-structured interviews, and informed by the literature review.

**Table 4: Which tasks were identified within each theme**

| Task | Safety netting | Cascade event | Complex record management | Duplicative origins | Non-NHS paperwork |
|---|---|---|---|---|---|
| Housing letters | ✓ | ✓ | ✓ | ✓ | ✓ |
| Insurance reports | ✓ | ✓ | | | ✓ |
| Personal Independence Payment (PIP) forms/reports | | | ✓ | ✓ | ✓ |
| DVLA forms/reports | | | ✓ | | ✓ |
| Fit notes | | ✓ | ✓ | ✓ | ✓ |
| Child protection reports | ✓ | | ✓ | | ✓ |
| Education-related requests | ✓ | ✓ | | ✓ | ✓ |
| Prescription-related requests | ✓ | ✓ | ✓ | ✓ | |
| Action requests from secondary/ private care | | ✓ | ✓ | ✓ | |
| Inappropriate triage | ✓ | ✓ | | ✓ | |
| Test results & specialised drug monitoring | ✓ | ✓ | ✓ | ✓ | |
| Navigating referral processes | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dental issues | ✓ | ✓ | | | |

A prevailing theme was a shared understanding among most GP participants (13 of 14) that “unnecessary tasks” were those that could be undertaken by someone other than a GP, such as another healthcare professional, administrative staff, or the patient themselves. This perspective reflected a desire to preserve GP clinical time for cases that require their expertise: “Could be done by the patient, could be done by secondary care, could be done by somebody else at practice, or doesn't need to be done at all.” (GP8).

However, as interviews progressed into deeper exploration, particularly around administrative burden, inefficient secondary care interactions, and regulatory paperwork, GPs began to reflect on the difficulty of drawing clear lines between what is necessary and unnecessary. Many tasks appeared operationally inefficient but were still perceived as valuable for understanding social determinants of health, strengthening patient relationships, ensuring continuity of care, or ensuring sustainable revenue for the practice. As GP7 put it, "I love the holistic side where you know what's going on and you know what's going on with their family and the social side of things. I think it's really important that we know about it." Similarly, GP3 noted the emotional and relational complexities involved: "GPs aren't very good at saying no, because generally they're, you know, caring people and they want to help people."

Attempts to push back were often more time-consuming than completing the task itself. One GP noted, "Pushback processes, they themselves are really burdensome… it takes half an hour, an hour a week just to action all of these pushback emails." In some cases, rejecting an inappropriate task required redacting and submitting an incident report, taking "15 to 20 minutes per request" before any resolution could be reached.

This culture of assumed compliance was described as frustrating. "I push back, but not everybody does. Some of my colleagues don't even realise what they're being asked isn't their job… though I think that's changing. Our threshold for saying no has gone down." Task migration not only added practical workload but also reshaped professional boundaries and expectations of the GP role.

Specific task areas explored in the interviews illustrated these dynamics. Housing letters, for instance, were described as complex, frequent, and emotionally fraught, especially when patients were vulnerable or at risk. GPs spoke of spending "45 minutes to an hour" on a single housing letter, mining records and composing persuasive narratives, even when it was "not contractually our responsibility to provide letters to housing." Despite this, the moral imperative to support patients remained strong: "I'm prepared to do it... because I think if I can actually help them get off the street, that's a worthwhile thing to do."

Fit notes (previously referred to as sick notes), although contractually required, were described as administratively heavy and often misaligned with clinical judgement. GPs observed that many requests stemmed from HR departments rather than clinical need: "The sick note is more for their boss than for them. Sometimes you just think: why is this even me?" Though each note may only take 5–10 minutes, the cumulative volume resulted in significant time drain.

Other examples of low-clinical-value but time-intensive tasks included PIP and DVLA forms and reports. PIP forms, often requested weekly, were seen as deeply inefficient: "They don't need a doctor to write down the diagnosis… someone else could easily get all that information from the notes." DVLA requests, while less frequent, could take up to an hour and required cautious record-checking due to legal implications: "You don't want to make a mistake because it's... about someone driving."

Education-related referrals and documentation, particularly for ADHD and ASD assessments or school absence verification, were also described as increasing. GPs found themselves serving as gatekeepers to services they believed should be accessed directly by schools or

parents: “We don't… not needed at all.” This placed them in a non-clinical role that many saw as inappropriate and disruptive to patient care.

Child protection work stood out for its emotional intensity and resource demands. Although seen as vital and unavoidable, it required hours of careful documentation and often came with no additional support: “You can’t just do a quick job on a safeguarding review. It’s got to be right.” The ethical burden was significant: “If there’s nobody else, it falls to us… and you can’t not do it, even if you’re drowning in work.”

Prescription-related tasks, especially those initiated by secondary care or other providers, were described as daily, duplicative, and risk-laden. GPs reported spending evenings and weekends verifying instructions, checking for interactions, and chasing missing details: “All the tasks and also reading the lab results during the medication requests, all these at least two to three hours after work every day.”

Inappropriate triage and receptionist signposting also contributed to unnecessary workload. GPs described receiving requests that could have been filtered out but weren’t: “At least a patient a day could have been signposted elsewhere.” Even in practices with triage systems, poor boundary-setting or unclear delegation meant unnecessary tasks continued to land with the GP.

Referral pathways, although essential, were described as highly inefficient due to clunky systems, form inconsistencies, and frequent rejections. GPs expressed deep frustration over these processes: “If they’d just seen the patient, they’d be doing those things anyway.” This administrative burden often took place outside of consultation time, intruding into evenings and creating fatigue.

Blood tests and specialised drug monitoring added another layer of responsibility, especially when secondary care-initiated treatment but expected GPs to conduct and interpret follow-up testing: “This is how it should be as per contract… the prescriber takes responsibility over it. And unfortunately, we don’t always see that in primary care.”

## Impacts of unnecessary tasks and task components

Unnecessary tasks, or unnecessary components within necessary tasks, carry a cumulative weight that extends far beyond mere inconvenience. For GPs, these burdens represent a hidden tax on time, focus, wellbeing, and ultimately, on the quality of care delivered. While any one task may seem minor in isolation, their volume, frequency, and embedded inefficiencies multiply their impact.

The most visible consequence is time displacement. Every moment spent clarifying a vague request, navigating a non-integrated form, or chasing a response from a service that should own the task, is time pulled away from direct patient care. One GP described this as “about two clinics’ worth of jobs” off the back of residual admin from just one session. Another admitted, “I already go in an hour early, I leave two hours late,” just to keep up with the spillover. Tasks are routinely completed during so-called “rest days,” lunch breaks that don’t exist, or at night, at the expense of recovery, family life, and mental health.

Unnecessary task components, such as overcomplex referral forms, duplicated monitoring, or chasing missing documentation, often serve no added clinical value. In fact, many GPs reported performing actions they believe are more about "ticking boxes" or compensating for broken communication channels than improving patient outcomes. "It's just not worth the battle to push back," one GP admitted. "So you end up just doing it, even though you know it's not your role." This tension between knowing what is clinically appropriate and doing what the system now expects can cause profound moral injury.

The psychological impact of task volume is compounded by lack of clarity and closure. Many tasks arrive without sufficient context, or without confirmation that they were ever needed in the first place. As one GP put it, "I send tasks to myself… usually to do later, after hours, or the next day. But it's never-ending. I've never had zero tasks." Even the act of pushing back on inappropriate work adds labour: incident forms must be redacted, processed, and reported, each pushback taking as long as the original task.

Finally, unnecessary task load erodes clinical safety. GPs spoke of having to rush through complex decision-making, skipping documentation, or taking shortcuts just to move the list along and meet workload demands. "It becomes a half-baked job just to make sure things sort of make sense… and that's a massive risk - and we take it every day."

## Variation in perception by role and career state

Perceptions of what constitutes an unnecessary or unsuitable task varied between participants and appeared to reflect their role and stage of career. GP partners at times described accepting certain administrative or compliance-related work as part of their wider responsibilities. One partner noted that "you just end up doing it because it needs to be done for the practice," while another reflected that some documentation "is not strictly clinical but it's part of running things properly." Salaried GPs were more likely to question tasks falling outside their contracted clinical role, with one describing sick notes as "more for their boss than for them" and adding "why is this even me?" GP registrars sometimes linked their acceptance of tasks to their training position, with one explaining, "we find it quite difficult in training to push back" and another saying, "it all depends on what kind of system you work in… you just do it." These accounts indicate that views on necessity were shaped not only by the nature of the task but also by the participant's contractual position and professional context. Differences in caseload and levels of exposure across career stages also appeared to influence how tasks were defined, with registrars describing more limited opportunities to decline work, while partners and salaried GPs drew on broader experience to assess appropriateness.

## Time and motion study

A total of 11 GPs and one practice manager participated in the time and motion study, however, the practice manager was excluded from final analysis as the objective was to estimate the day-to-day workload of GPs from their own perspective.

An assumption used for this study is that the day completed by the GP represents a typical workday. Based on information gathered from the semi-structured interviews and informed by the literature review, the tasks set out in Table 5 below were used for the digital task diary:

**Table 5: Tasks used in the digital task diary for the time and motion study**

| Task category |
|---|
| Housing letters |
| Insurance reports |
| Personal Independence Payment (PIP) forms/reports |
| DVLA forms/reports |
| Fit notes |
| Child protection reports |
| Education-related requests |
| Prescription-related requests |
| Action requests from secondary/private care |
| Inappropriate triage |
| Test results & specialised drug monitoring |
| Navigating referral processes |
| Unnecessary home visits |
| IT issues |

Within the test results and specialised drug monitoring category, participants described work that was clinically necessary but included activities transferred from secondary care to general practice. In these instances, the “unnecessary” classification used in this study reflected participants’ perspectives on the allocation of responsibility or the volume of time required, rather than an assessment of the clinical necessity of the task itself.
No GPs recorded any dental issues, DVLA tasks or education-related requests in their ‘typical day’ diary.

**Figure 1: Number of minutes GPs spent completing unnecessary tasks**

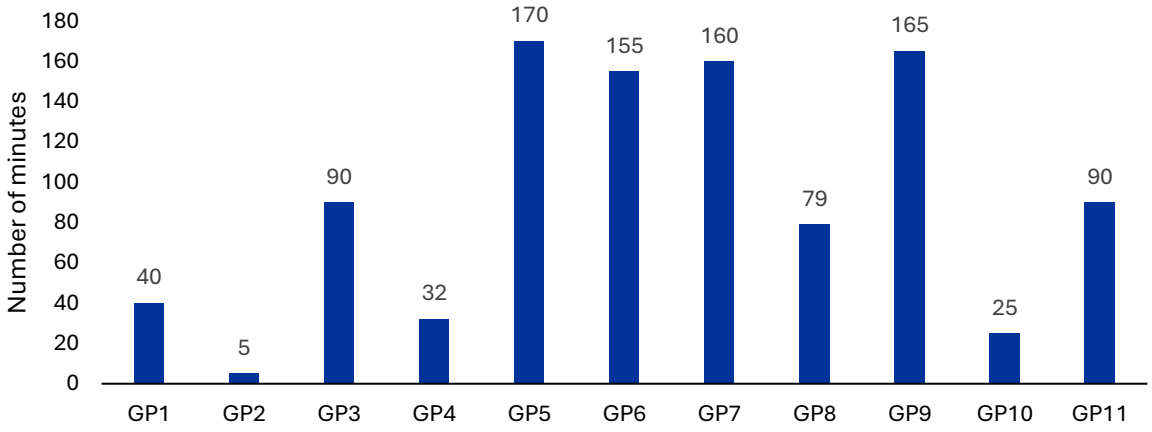



Figure 1 highlights the total number of minutes each GP spent completing tasks that they consider to be unnecessary. With GP5, GP6, GP7 and GP9 spending more than 100 minutes of their workday completing what they considered as unnecessary tasks. There is a wide variation in the total time that was spent on unnecessary tasks on their chosen workday. GP2 for example only reported five minutes of unnecessary task work, compared to 170 minutes of reported time spent on unnecessary tasks for GP5. This could be due to variation in the types of tasks that were required to be completed by the GP on their chosen day, which could be influenced by the participant's career stage, experience and caseload. The median time spent by the sample of GPs on tasks they consider unnecessary was 90 minutes, which is close to the mean time of the sample, which was 92 minutes.

Table 6 presents the number and percentage of the sample GPs who reported completing an unnecessary task segmented by task category.

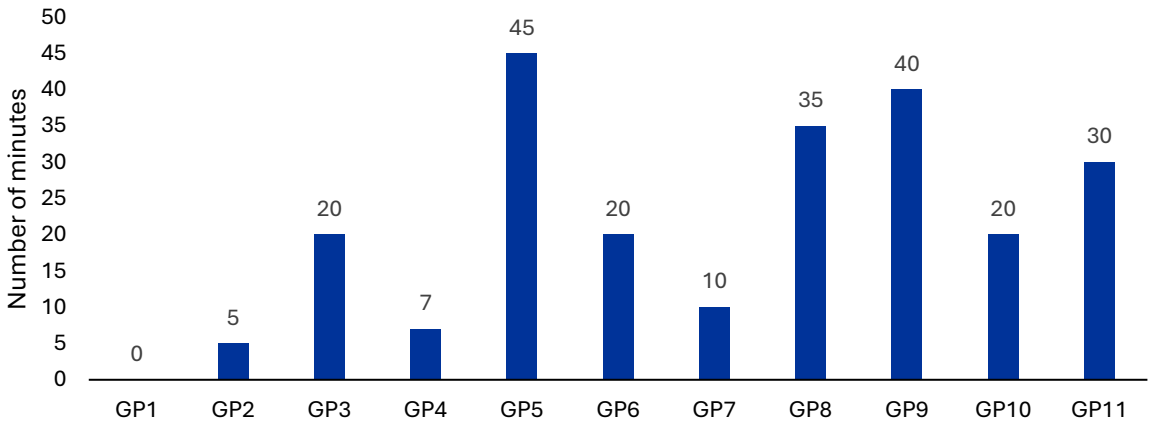
**Table 6: Number of GP-reported tasks segmented by category**

| Task | n (%) |
|---|---|
| **Navigating referral processes** | 10 (91%) |
| **Inappropriate triage** | 7 (64%) |
| **Test results & specialised drug monitoring** | 7 (64%) |
| **PIP forms/reports** | 5 (45%) |
| **Fit notes** | 3 (27%) |
| **IT issues** | 3 (27%) |
| **Housing letters** | 2 (18%) |
| **Child protection reports** | 2 (18%) |
| **Prescription-related requests** | 2 (18%) |
| **Unnecessary home visit** | 2 (18%) |
| **Insurance reports** | 1 (9%) |
| **DVLA forms/reports** | 0 (0%) |
| **Education-related requests** | 0 (0%) |

As can be seen in Table 6, 10 (91%) of the GPs reported completing a task related to navigating referral processes, which in our sample included dealing with referral rejections and performing manual data entry of non-integrated forms.

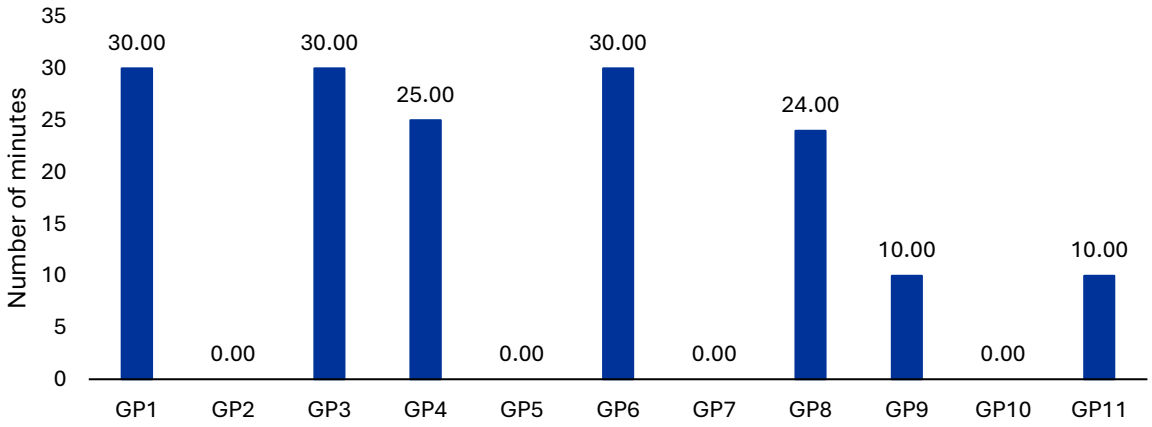
Figure 2 breaks this down further, with the number of minutes GPs spent on unnecessary tasks related to navigating referral processes during their workday.

**Figure 2: Number of minutes GPs spent navigating referral processes during their workday**




Similarly, Figure 3 shows the breakdown of the number of minutes GPs spent completing a task relating to an inappropriate referral during their workday.

**Figure 3: Number of minutes GPs spent completing a task relating to an inappropriate referral**




Inappropriate referral tasks included having phone calls with patients that should have been triaged/booked as face-to-face appointments, or reception staff sending requests through computer systems seeking confirmations on standard processes that do not need a GPs input. One example was when a GP was asked to complete a fit note for a patient, who was able to self-certify as it was the first week of illness, so the appointment should have been

declined. Figure 3 demonstrates the majority of GPs spent 25 to 30 minutes per day completing tasks relating to an inappropriate referral.

## Estimating the potential costs of GP time on unnecessary activity

The next phase of the time and motion study involved translating the time GPs spent on unnecessary tasks into an estimated monetary cost, providing a picture of the potential financial impact of this hidden workload. The Unit Costs of Health and Social Care 2024 Manual (Jones et al., 2025)[12] estimate the cost per hour of patient contact at £268 per GP for 2023/24. This figure includes direct care staff costs, GP training, salary, and on-costs. This measure was used as a proxy for estimating the cost of unnecessary tasks, as more precise estimates of NHS GP time are not readily available, highlighting a notable evidence gap. However, it should be noted that not all tasks identified in this study involve direct patient contact, and some may occur outside core hours, meaning this figure may not accurately reflect the cost of specific non-clinical or administrative tasks.

Reducing unnecessary workload may help free up time for patient care, but this should not be assumed to equate directly to more appointments. A proportion of these “unnecessary” activities or time spent is likely to have been completed in overtime, i.e. beyond the GP’s contracted hours, and therefore will not currently be funded. When these tasks are undertaken within core hours, they are likely to result in less available time for direct clinical care.

**Table 7: Estimated cost per day per GP attributable to unnecessary tasks**

| Task | Mean minutes per GP | +/- Range | % of GPs performing the task | Cost per day per average GP (weighted by % of GPs performing the task) | +/- Range |
|---|---|---|---|---|---|
| Housing letters | 15.00 | 8.78 - 21.22 | 18.18% | £12.18 | £7.13 - £17.23 |
| Insurance reports | 5.00 | 3.56 - 6.44 | 9.09% | £2.03 | £1.44 - £2.62 |
| PIP forms/reports | 21.00 | 3.66 - 6.44 | 45.45% | £42.64 | £7.44 - £77.84 |
| Fit notes | 18.33 | 8.93 - 27.74 | 27.27% | £22.33 | £10.88 - £33.79 |
| Child protection reports | 45.00 | 26.35 - 63.65 | 18.18% | £36.55 | £21.40 - £51.69 |
| Prescription-related requests | 7.50 | 4.39 - 10.61 | 18.18% | £6.09 | £3.57 - £8.61 |
| Inappropriate triage | 22.71 | 9.85 - 35.58 | 63.64% | £64.56 | £27.99 - £101.13 |
| Test results & specialised drug monitoring | 27.86 | 7.91 - 47.80 | 63.64% | £79.18 | £22.50 - £135.87 |
| Navigating referral processes | 23.20 | 8.96 - 37.44 | 90.91% | £94.21 | £36.36 - £152.05 |
| Unnecessary home visit | 35.00 | 17.7 - 52.30 | 18.18% | £28.42 | £14.38 - £42.47 |
| IT issues | 18.33 | 8.46 - 28.21 | 27.27% | £22.33 | £10.30 - £34.36 |
| **Total** | | | | **£410.53** | |

The time and motion study recorded the mean time spent per GP on each task categorised within this study as unnecessary, alongside the corresponding estimated cost per GP per day. For some categories, such as test results and specialised drug monitoring, the tasks themselves may be clinically necessary; however, participants described that these activities included work originating from secondary care. In such cases, the term “unnecessary” reflected participants’ views regarding the time required to complete the task or the allocation of responsibility, rather than the inherent necessity of the activity.

As seen in Table 7, the tasks with the highest mean times were child protection reports, (45 minutes), unnecessary home visits (35 minutes), and following up test results and specialised drug monitoring (27.86 minutes). Using the mean time spent on each task and the Unit Costs of Health and Social Care 2024 Manual (Jones et al., 2025)[12] cost per hour of patient contact per GP as an indicator of the cost per minute, the estimated daily costs of these tasks were: child protection reports (£36.55), unnecessary home visits (£28.42), test results and specialised drug monitoring (£79.18) while navigating referral processes was estimated to cost £94.21 daily. These costs were weighted by the proportion of GPs who self-reported completing the task in their Excel based task diary representing a typical working day.

Some tasks were less frequently reported, for example, only 9.1% of GPs recorded insurance-related work on the observed day, but incurred costs when present. Across all categories, the total estimated cost of tasks in this study was £410.53 per GP per workday.

It is important to note that there was substantial variation in the time recorded for individual tasks, as indicated by the wide ranges relative to the mean values. For example, the range for test results and specialised drug monitoring (±19.94 minutes) and navigating referral processes (±14.12 minutes) approached or exceeded half of the corresponding mean times. This variation reflects both differences in how often particular tasks were undertaken and the amount of time they required when performed. Given the small sample size (n = 11 GPs), these figures should be interpreted as indicative estimates rather than precise measures of task duration or cost across the wider GP population.

# Discussion

This study set out to explore the nature, impact, and complexity of "unnecessary tasks" in general practice, through a mixed-methods approach combining literature review, qualitative semi-structured interviews, and a time and motion study. While the concept of unnecessary tasks might suggest a clear-cut category of avoidable or redundant work, our findings indicate that the boundaries between necessary and unnecessary activity are often fluid, context-dependent, and shaped by wider system pressures.

The literature review highlighted concerns within general practice about the growing volume of administrative and regulatory workload that is perceived to add little clinical value. Commonly cited were inefficient referral processes, duplicative documentation, and rising expectations from non-healthcare bodies, such as employers, housing authorities, and education services. This "hidden workload" was often framed as contributing to burnout, professional dissatisfaction, and misallocation of scarce GP time and expertise. Yet, much of the published literature treated unnecessary work as a relatively fixed category, something that could be cleanly defined and removed through task shifting or system redesign.

Our qualitative semi-structured interviews, however, painted a more nuanced picture. Most GPs were quick to identify tasks they felt did not require their input, such as fit notes, PIP forms, housing letters, and prescription follow-ups initiated elsewhere. These were frequently described as “pointless,” “bureaucratic,” or “not a GP’s job”. Yet, as conversations deepened, a more complex reality emerged. Many of these tasks, particularly those involving letters, safeguarding documentation, or coordination with external agencies, were viewed as time-consuming but important. They supported continuity of care, deepened understanding of patients’ social circumstances, and reinforced the relational and holistic ethos of general practice. In these cases, inefficiency was not the same as irrelevance.

This ambiguity reflects the broader tension within modern general practice: between delivering high-quality, person-centred care and navigating a fragmented, under-resourced system that increasingly shifts tasks onto GPs by default. A number of tasks considered “unnecessary” in one context (e.g. housing letters for patients) could feel appropriate in another (e.g. when no other advocate exists for a vulnerable patient). This suggests that defining a task’s necessity cannot be reduced to whether it falls within the formal GP contract, but must instead consider its purpose, impact, and who else might realistically take it on.

The time and motion study helped quantify the scale of this often hidden burden. GPs reported spending significant time on tasks they deemed inappropriate or misdirected, with the costliest categories being navigating referral processes, managing test results and drug monitoring from secondary care, and dealing with inappropriate triage or signposting. The estimated average daily cost of such “unnecessary” workload amounted to £410.53 per GP. These findings offer evidence for system-level reform, particularly around reducing duplication, clarifying inter-agency roles, and simplifying referral and prescribing responsibilities.

The true cost may be greater than what the financial figures alone suggest. The emotional and professional toll of these tasks was evident throughout the interviews. Many GPs spoke of working long hours to complete administrative tasks outside clinical time, often during evenings or on supposed rest days. The inability to “switch off,” the frustration of completing tasks for which they felt unqualified or undervalued, and the knowledge that such work was pulling them away from patient care, all contributed to what several described as moral injury.

Moreover, GPs often described a culture of quiet compliance, in which pushing back against inappropriate requests took more time and emotional energy than simply completing the task. Formal rejection processes, incident reporting, or attempts to reassign tasks were described as “burdensome” and “unrewarded,” further disincentivising resistance. This not only reinforces systemic inefficiencies but also redefines the boundaries of the GP role, often in ways that feel misaligned with professional purpose.

Our findings suggest that truly addressing unnecessary workload in general practice requires more than just identifying which tasks should or shouldn’t be done by GPs. It requires a system-wide understanding of how tasks are generated, who is best placed to carry them out, and how the broader goals of continuity, trust, and holistic care can be maintained.

These findings align with ethnographic observations by Barnard et al. (2024)[10], who describe much of GPs’ non-patient-facing workload as “hidden work” tasks that are integral to delivering safe and effective care yet remain largely invisible in standard workload metrics. Their study highlights how structural factors such as deprivation, patient complexity, and policy-driven requirements shape the scale and nature of this work. Importantly, they note that the distribution and perception of such tasks are influenced by practice configuration, with partner-heavy practices tending to absorb more organisational and compliance-related work internally. The cumulative effect of these tasks, while individually small, can be substantial, contributing to reduced time for patient care and impacting wellbeing. This echoes the present study’s finding that perceptions of necessity vary not only by task type but also by professional role and contractual position.

In summary, while the concept of “unnecessary tasks” is useful for highlighting inefficiencies and redirecting attention to core clinical work, it must be handled with caution. Many tasks currently burdening GPs are the result of systemic dysfunction rather than individual inefficiency. Tackling them will require investment, redesign, and cultural change, not only to reduce avoidable burden, but to preserve the values of general practice. Only by addressing both the visible and hidden components of GP workload can we hope to improve working conditions, protect clinician wellbeing, and safeguard patient care.

# Limitations

This study employed a mixed-methods approach to explore the nature and estimated impact of unnecessary tasks in general practice in England. Several limitations are noted in relation to sampling, data collection methods, and generalisability.

The qualitative component included semi-structured interviews with 14 GPs, and one practice manager, across a range of regions, practice sizes, and rural/urban classifications. While efforts were made to ensure diversity of perspectives, the sample was limited in size, and findings may not be representative of the wider general practice workforce in England. The potential for self-selection bias is acknowledged, as participation was voluntary and may have attracted individuals with particular interest or experiences related to administrative burden.

Task classification was based on participants' own assessments of whether an activity was necessary or unnecessary within the context of their role. These classifications were informed by personal experience, professional judgement and local context, and may vary between practitioners and career stage. No objective or externally validated criteria for "unnecessary" tasks were applied.

The time and motion study relied on self-reported task diaries completed by 11 GP participants over a single working day. While this method enabled structured data collection across task categories, it may not capture intra-week variability or atypical workload patterns. Reporting may also be influenced by recall limitations or task categorisation decisions made by participants. Tasks that occurred less frequently than daily were recorded but excluded from the extrapolated estimates, which may result in underestimation of certain forms of workload. The small sample size and the subjective nature of self-reported activities and definitions of "unnecessary tasks" limit how confidently these findings can be extrapolated or generalised.

The literature review was restricted by the limited number of peer-reviewed studies focused specifically on unnecessary workload in general practice in England. To address this, relevant grey literature and policy documents were included. These sources vary in methodological approach and have not been subject to peer review.

Estimates of lost clinical time and associated cost were derived from a small sample and based on several assumptions regarding GP behaviour, task frequency, and appointment duration, using the Unit Costs of Health and Social Care 2024 Manual (Jones et al., 2025) as a proxy measure. These figures should be interpreted as illustrative rather than conclusive and are presented to inform further investigation rather than to quantify definitive system-wide impacts.

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# Appendix 1 – Participant information sheet

Introduction

You are invited to take part in the Royal College of General Practitioners (RCGP) Workload Research Project. This project is seeking to define and quantify “unnecessary tasks” performed by GPs and practice managers within Primary Care.

Purpose of the evaluation

Apollo Innovation and Here have been commissioned by RCGP to conduct a mixed methods research project to identify and quantify unnecessary tasks performed in Primary Care.

The research contains three main stages

Literature review of the current evidence surrounding unnecessary tasks performed in Primary Care

Semi-structured interviews with GPs and Practise Managers to validate data gathered in the literature review, as well as gather insights and information on what they consider to be unnecessary tasks performed within their day-to-day work.

Time and motion study to quantify the time spent performing unnecessary tasks and calculating the cost of the time spent performing unnecessary tasks.

Why are you receiving this information?

You have been invited to participate in this research because as part of your day-to-day role and experiences you will be able to provide valuable information and insights into what tasks are considered to be unnecessary, as well as how long you spend doing those tasks.

Who is funding the study?

The study is funded by the RCGP.

What will participation involve?

Semi-structured interviews

We aim to conduct 18 remote semi-structured interviews on MS Teams.

During the interview, you will be asked about your day-to-day tasks, and what tasks you consider unnecessary. The interview will be conversational, allowing you to share your thoughts and experiences in detail. The interview will be audio-recorded using MS Teams or Dictaphone depending on the method of interview, and transcribed, with any identifying information removed so you will not be able to be identified. The audio file will be deleted once the identifying information has been removed from the interview transcript.

The interview is expected to last approximately one hour. We recognise that this may be an additional demand on your time, particularly factoring in your busy schedule. We will make every effort to schedule the interview at a convenient time for you.

Time and motion study

We aim to conduct a time and motion study with 12 GPs.

The time and motion study will consist of filling out a digital task diary containing a list of tasks considered “unnecessary” as evidenced from the semi-structured interviews and literature review. Over the course of one working day, you will be asked to fill out the task diary with which tasks you performed, how long they take you to complete, and how often in a normal week you perform that task.

Do I have to take part?

No. Your participation in this research is entirely voluntary.

In recognition of you volunteering your time, we are offering to pay £100 for taking part in the semi-structured interview and £100 for taking part in the time and motion study.

Right to withdraw

You may choose to withdraw at any time before or during the research without affecting your role or legal rights. If you decide to withdraw after the interview, your data can still be excluded from the study if the anonymisation process has not yet been completed.

Benefits of taking part

Contributing to policy and practice improvements

By participating, you will help to identify and quantify unnecessary tasks that GPs and practice managers face. Your input could directly influence future policy recommendations aimed at reducing these burdens, potentially improving job satisfaction and efficiency in Primary Care.

Opportunity to share experiences

The interview provides a platform to share your experiences and frustrations regarding unnecessary tasks. This allows you to voice concerns that may influence change.

Enhanced understanding of task distribution

Participating in the time and motion study could provide you with insights into your own work patterns and help highlight areas where your time is not being used effectively, which may be beneficial for your own time management and task delegation.

Professional development

Being part of a research project can be a valuable addition to your professional experience and may offer opportunities to engage with the broader research community, contributing to evidence-based practice improvements.

Reimbursement

In recognition of you volunteering your time, we are offering to pay £100 for taking part in the semi-structured interview and £100 for taking part in the time and motion study.

Risks of taking part

Time Commitment

The interview and time and motion study require a commitment of your time, which could add to your workload, particularly if you have a busy schedule. We will strive to minimise any inconvenience by scheduling interviews at times that suit you best.

Potential Discomfort

Discussing your experiences, especially regarding frustrations with unnecessary tasks, may bring up feelings of stress or dissatisfaction. If you feel uncomfortable at any point, you are free to pause or stop the interview.

Your information

All information collected during the interview will only be accessed by the research team at Apollo Innovation. It will be securely stored on Apollo Innovation's OneDrive, which has strict access controls, is password-protected, and uses multi-factor authentication. Only the Apollo Innovation research team members directly involved in this study will have access to the file. You will not be personally identifiable in any reports, outputs, or publications.

As an independent data controller for this evaluation, Apollo Innovation is committed to ensuring your personal data is handled in compliance with the UK GDPR and the Data Protection Act 2018. This includes secure processing, lawful use, and protection against unauthorised access or disclosure. We collect only the necessary data for this evaluation. You have the right to access, correct, or request the deletion of your data. Here's how you can exercise these rights:

Accessing your data

You can request access to your personal data by contacting us. Please provide sufficient information to help us identify you and the data you are requesting. We will respond within one month of receiving your request.

Correcting your data

If you believe any of your data is incorrect, you can request a correction. Please specify the data in question and provide any supporting evidence. We will address your request within one month.

Deleting your data

You have the right to request the deletion of your data. Submit your request clearly stating which data you want erased and why. We will respond within one month.

Contact Us

To exercise any of these rights, please contact the Apollo Innovation research team using the details provided below. For verbal requests, we recommend following up in writing to ensure there is a record of your request.

This is how your interview data will be processed

Apollo Innovation will audio-record the interview between you and the researcher to capture your insights accurately and ensure the researcher does not miss important information.

The audio recording will be securely stored on Apollo Innovation's OneDrive, which has strict access controls, is password-protected, and uses multi-factor authentication. Only the Apollo Innovation research team members directly involved in this study will have access to the file.

Apollo Innovation will transcribe the audio file onto a Microsoft Word document, which will also be stored securely on the same server.

During the transcription process, any information that could be used to identify you, such as your name, role, or any other identifiable details, will be removed to ensure your anonymity.

Once transcription and anonymisation are complete, the audio file will be permanently deleted. The transcript will be given a unique ID number for our analysis purposes.

We will then analyse the anonymised transcript to identify key themes and insights valuable to the study.

Direct quotes from the interview may be used to illustrate key findings, but these will be anonymised and any potentially identifiable information removed so that you cannot be identified in any research outputs, such as reports.

After the transcript analysis is complete and the research outputs have been produced, Apollo Innovation will securely delete the transcripts. Any analysed data sets will be securely stored on our server until the study is fully concluded, after which they will also be deleted after 2 years.

This is how your time and motion data will be processed

You will be given a excel-based digital task diary and asked to complete it during your normal workday or at the end of your normal workday

You will send the file to Apollo where it will be stored on our secure OneDrive and only the Apollo Innovation research team will have access to it.

We will combine all the individual task diary entries into a large anonymous dataset, meaning your responses will not be identifiable in any research outputs or datasets provided to the RCGP.

Apollo will analyse the dataset to establish the time spend on each task, the frequency of the task and the corresponding cost associated with the task.

What will happen to the results of this study?

The information you provide will be part of a final report that Apollo Innovation will provide to the RCGP upon conclusion of the study. You will not be identified in the report.

Contact details

If you have any questions or would like more information about this evaluation, please contact the research team at Apollo Innovation:

Saul Stevens, Operations Director

**Email:**

**Phone:**

Sebastian Stevens, Managing Director

**Email:**

**Phone:**

Thank you for considering participating in this evaluation.

# Appendix 2 – Consent form

Please provide your initials in the boxes if you agree with each of the following statements:

| | Initials |
|---|---|
| I confirm have read the information sheet dated 19/09/2024 (version "Information_Sheet_Apollo_v1") for the above study. I have had the opportunity consider the information, ask questions and have had these answered satisfactorily. I understand that I can request more information at any time. | |
| I consent to the research team holding my contact details so that they can contact me about the study. I understand these details will be held securely and destroyed at the end of the study. | |
| I agree for my contact information, a copy of this consent form and the information I provide, to be stored on a secure online server strictly controlled by Apollo Innovation through password protection and multi-factor authentication. | |
| I give permission for the interview to be audio recorded, which will then be transcribed by Apollo Innovation and any identifying information for individuals or Trusts will be removed. The audio recording will be deleted once transcription and the removal of identifying information is complete. | |
| I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without this affecting my medical care or legal rights. I am free to refuse to answer any questions that I do not wish to. | |
| I understand that the information I provide will be held confidentially unless myself or others are considered as being at risk of harm. I understand that my data will not be personally identifiable in publications or reports and will be anonymised. | |
| I understand the information will be held securely in a password protected multi-factor only accessible environment and only accessible to key members of the research team. | |
| I give permission for written material from the interview transcript that has been de-identified and has had all my personal identifying details removed (e.g. name), to be used as research material and in reports, publications and presentations related to the study. | |
| I understand that, under the UK GDPR and Data Protection Act 2018, I can at any time, ask for access to the information I provide, and I can also request the destruction of that information if I wish. | |
| I understand that my data will be stored securely on Apollo Innovation's server whose access is strictly controlled by Apollo Innovation through | |

| | |
|---|---|
| password protection and multi-factor authentication for the duration of the study and in accordance with the UK GDPR and Data Protection Act 2018. | |
| I agree to take part in this evaluation by answering all of the questions in this section. | |

Signed:

| | Name | Signature | Date |
|---|---|---|---|
| Participant | | | 9th December 2024 |
| Researcher | Nicole Thomas | Nicole Thomas | 9th December 2024 |

Contact details

If you have any questions or concerns about the project or your participation in the evaluation, please contact us:

Phone:

Thank you for considering taking part in this evaluation.

# Appendix 3 – Topic guide

**Introduction**

**SCRIPT:** My name is ****, and I am the Research Associate for this project. I will be conducting the interviews and working to bring together the insights from these conversations to better understand the collective experiences, thoughts, and opinions shared. You've been invited to participate in the Royal College of General Practitioners (RCGP) Workload Research Project because you are either a GP or a practice manager.

Our goal is to define and quantify "unnecessary tasks" performed by GPs and practice managers in Primary Care. Beyond identifying what these tasks are, we want to understand why they are considered unnecessary and the potential solutions. If there are existing processes you know of that help address these tasks, we'd love to hear about those as well. Before I go into what our understanding of unnecessary tasks are, I'll just go over the formal requirements...

You should have received an information sheet and consent form. The first part of our conversation will be around defining and understanding unnecessary tasks. It would be great to name tasks specifically and I will collate a list as we go along and then we can explore the tasks in more detail, looking at how much time they take and whether they feel clinically relevant or not. We will then talk more about the potential solutions.

All data we collect will be anonymised, and no personal information will be disclosed. We want you to feel safe and open in sharing your experiences and opinions so please do ask questions if you are unsure about anything.

Our conversation today will be recorded, and the transcript will be used for analysis. We will remove any personal or identifying information during this process. If you'd like, I can send you a copy of the transcript afterward, giving you 48 hours to review and add any further thoughts, as sometimes additional ideas come up after reflection.

Do you have any questions about the study or our conversation today? Are you happy to continue?

**Interview Questions**

So, before we move onto unnecessary tasks, could you briefly describe your role in the practice and your typical daily responsibilities?

**Prompts:**

- What is your role (GP, practice manager, etc.)?
- How long have you been working in this role?
- What are your main tasks and responsibilities?
- What clinical system do you use in your Practice?

**SCRIPT:** Looking at the literature and some preliminary conversations with GPs, there are a few different terms being used for potentially unnecessary tasks. These have been “inappropriate” “unimportant” and “burdensome”. It is also possible that what might be necessary for one person might be different to another. Therefore, we want to understand the types of tasks that might not be backed by a clear rationale, justified by evidence or do no add clinical value, but has still become an obligatory part of your practice. In addition, we want to identify the types of tasks that are necessary on a system-level but should not be part of the GP remit. Or GP contract. Finally, we want to identify tasks that are impacting and potentially harmful to patient care.

**Interview Questions**

Thinking about your role and responsibilities, how would you define an unnecessary task?

Tell me more specifically about the tasks you consider unnecessary within your role. It’s ok if we take time on this as this will help me compile our list to go through a bit later in our conversation.

This may seem obvious but tell me a little bit about why these tasks feel unnecessary?

How do you personally differentiate between these task that are necessary/unnecessary? Do they change depending on circumstances?

Do others think differently to you about what’s necessary or unnecessary? What makes you say this? Who else gets impacted by the unnecessary tasks? (e.g., colleagues, patients, your family)

Are there any tasks you feel conflict with your values or the role of a GP/practice manager? Why? Are there any tasks that, while unnecessary, you feel obligated to complete for ethical or personal reasons?

Tell me more about the burden of unnecessary tasks (e.g., time, efforts, out of hours, emotional burdens, impact on core responsibilities, what keeps you up at night). What are the things you feel you’re unable to do or spend time on because of unnecessary tasks?

How do you manage the burden of these tasks in your daily work?

How confident do you feel in your ability to manage unnecessary tasks effectively?

Do you think these unnecessary tasks achieve anything positive? Why or why not?

What guidance or support do you receive in deciding what tasks are necessary or unnecessary?

**SCRIPT:** Now we’ve gone through the list, it would be great if you can take a few moments to reflect and see whether there are any further thoughts on what we have already discussed.

Do you have anything you would like to add before we move on?

Can you tell me about any strategies you or your practice have implemented to manage or reduce unnecessary tasks? Have you used any technological solutions, such as automation or AI, to reduce unnecessary tasks? If so, how have these tools impacted your workload?

Can you describe any personal administrative strategies or workflows you've implemented to reduce unnecessary tasks?

What challenges or barriers have you encountered when adopting strategies to manage unnecessary tasks, whether they involve technology or other approaches? How have you dealt with these challenges?

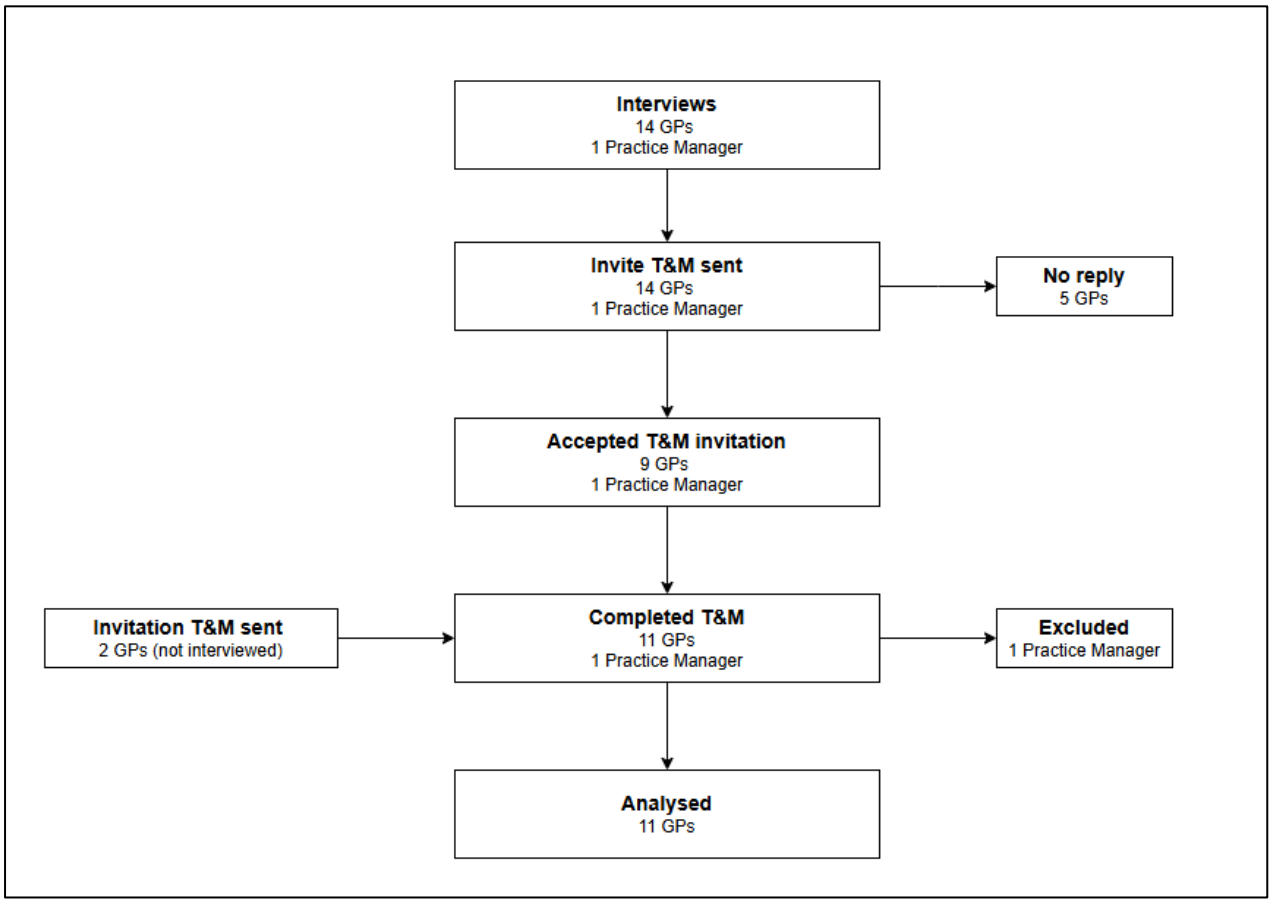
Are there any tasks where you think technology, like AI or automation, could be beneficial but hasn't been implemented yet? What do you think is holding this back?

Of the strategies you've tried, whether technological, administrative, or workflow-related, what have you found to be the most effective in reducing unnecessary tasks?

**SCRIPT:** Thank you so much for taking the time to talk with me today. Is there anything else you would like to add before we bring this to a close?

# Appendix 4 – Participation flow chart

The flow chart below demonstrates the inclusion of participants for the semi-structured interviews and the subsequent time and motion (T&M) phase of the study.



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The Royal College of General Practitioners is a network of over 55,000 family doctors working to improve care for patients. We work to encourage and maintain the highest standards of general medical practice and act as the voice of GPs on education, training, research and clinical standards.

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