Workload and morale

Nationally held data on workload levels in general practice is generally poor. However, evidence from our members suggests that workload in general practice is unmanageable and is having a significant impact on morale. Our latest tracking survey shows that 67% of respondents feel so stressed they cannot cope at least once a month. 67% of GP respondents also reported that their current working levels are over 110% of capacity, when considering their current workload and contracted hours. The College has heard from GPs that they feel denigrated and undervalued, significantly affecting morale.

Such reflections raise real concerns for the future of general practice. In order to tackle the challenges of rising GP workloads, concerted action is required in the following areas:

- An assessment of, and reduction in, unresourced transfer of workload across the health service and improved interface working with funded primary-secondary care interface groups in each Health Board area.
- Reduction of unnecessary administrative workload.
- Management of public expectations of what general practice can realistically be expected to deliver given the current resources, and improved understanding of the new ways of working in general practice.

While the above offer short to medium term responses to the workload and morale crisis within general practice, we recognise that concerted efforts to boost both the GP and multidisciplinary team within primary care must also be taken, underpinned by adequate resourcing of the service.

Supporting the mental wellbeing of our workforce

Doctors across the NHS are known to be at a higher risk of poor mental health and suicide than the average population and also face a number of barriers in accessing care. GPs manage 90% of mental health presentations[12], without the supervision and opportunities to discuss difficulties afforded others providing such services. GMC surveys described in this paper outline that GPs fare worse in terms of perceived pressures, and lack of wellbeing.

Our latest tracking survey showed that 32% of respondents reported that their mental wellbeing while working in general practice over the past month has been poor. RCGP Scotland has campaigned over a number of years for the establishment of a dedicated mental health service for GPs and doctors.

In response to the COVID-19 pandemic and the undisputed additional pressures that this period presented for healthcare workers, the Workforce Specialist Service[13] (WSS) for health and social work and care professionals was launched, giving access to dedicated mental health support. Doctors account for over half of all registrants with the service (two thirds in April 2022) and half of those are GPs, despite their smaller numbers in the medical workforce. The vast majority are women. With our tracking survey demonstrating that a third of GPs responding felt that their mental wellbeing at work over the past month has been poor it is clear that a dedicated mental health service is much required.

We recognise and welcome progress that has been made in supporting the mental wellbeing of health and social care staff more widely, such as the National Wellbeing Hub[14] which was also launched during the COVID-19 pandemic. We welcome recent commitments from the Scottish Government to work with NES to increase the capacity and capability to provide psychological therapies and interventions for the health and social care workforce.[15] As we continue to recover from the COVID-19 pandemic, we must ensure that the mental wellbeing of all staff across the NHS is prioritised and protected.

Further action is required at earlier stages to help ensure that GPs feel supported and able to manage the demands of general practice: the WSS was much needed and should have always been considered as standard provision.

We also ask that, dedicated support services such as the Workforce Specialist Service continue to be evaluated and resourced to ensure that those who most require support for their mental health and wellbeing are able to continue to access it.

Ensuring the welfare of our workforce

We now need to consider upstream and systems factors, to protect and enhance the welfare of GPs: we can no longer afford to intervene only once they are struggling or unwell. Under the current significant workload pressures, there can be conflict between delivering Good Medical Practice standards, quality and safe and sustainable working conditions for GPs. We need those defined in terms of principles and what is required of national systems. That must start with considering why GPs become distressed, overwhelmed or unwell in the first place, evidence we already have. We talk of resilience, helping GPs manage themselves and others in profoundly difficult circumstances. We must now instead think - as we always should have - in terms of appropriate working conditions and staff welfare, in line with those we would afford people in other public sector workplaces. Currently practices receive a pre-defined resource for staffing, based on contractual calculations, whilst managing an ever-increasing workload, the primary mechanism for the latter being GPs simply working harder and longer hours. That happens in part because of the partnership model, where the workload is unrestricted, with little attempt by government or Health Boards to define or limit workload transfer, both factors already identified as the commonest reason for GPs to want to leave the profession.

Achieving sustainable working practices for GPs will require:

- An emphasis on welfare as well as wellbeing. This will need PLT as outlined earlier but also opportunities for peer support and reflective practice.
- Formal recognition of the cost-effectiveness of the partnership model.
- Numbers of GP partners are falling in Scotland, and we need full recognition of their role both in working on average longer hours[16], with the significant additional work of maintaining and developing partnerships.
- An understanding by all parties that the current partnership model has no workload regulation, other than that defined by the contract, which is insufficient. GPs need this if they are going to provide the most effective care of all – holistic care, delivered locally and with continuity, which itself allows other parts of the NHS to function.
- Integral structures afforded other clinicians and doctors with time for learning and being mentored or coached where additional support is needed.
- An agreement about what is an acceptable and safe workload and how that is maintained.

Increasingly, we need to consider new types of workers in our teams because we have not adequately planned for, or trained, the clinical workforce we need across multiple disciplines. The new members of our expanded MDT are welcome, but we may also need an extended and developed receptionist team with link worker functions and some able to support those acutely distressed; or non-clinical mental health workers who can do that too but also manage mild anxiety and depression; behavioural change workers to support our practice nurse teams with chronic disease management and so on. Of course, what we really need is more GPs and increasingly the evidence is that they provide a highly effective and flexible generalist service, able to manage undifferentiated illness and uncertainty, which is simply not replicated by others.

Targeted support at every career stage

We are hearing increasingly from GPs within the first five years of their GP careers, commonly referred to as 'First5s', of the mental toll of the transition from a stressful and crammed GP training programme to the intense pace and expectation of general practice.

RCGP has long set out the need for extending GP training to four years, with at least two spent in general practice. We simply cannot afford to lose GPs so early in their career. RCGP Scotland's AiT and First5 Committee has reported that GPs leave the profession soon after completion of training because of burnout. They feel a need to follow other paths, such as undertaking Fellowships, having career breaks and seeking portfolio careers, to enable them to continue working in general practice. They also feel unprepared for, and daunted by, the Expert Medical Generalist role, and particularly GP partnership, after just 18 months in the practice setting. Their early career course is in marked contrast to that of their specialist colleagues who have several further years of structured protected training time ahead of them. We need to see more induction and career support for early career GPs, and also better account for our emerging workforce with its higher numbers of International Medical Graduates and ethnic minority doctors.

Burnout should not be considered a feature of long service within general practice, but rather as a reflection of excessive work intensity and a lack of support mechanisms at any stage of a career.

Alongside a review of Fellowships, we need to explore ways to make general practice a sustainable environment for our early-career GPs with consideration given to improved induction and career support programmes.

Close attention must also be paid to how we can more effectively retain our mid-career GP workforce. An English mixed-model study of mid-generation GPs who leave general practice showed that almost three quarters (71%) were still working, but just not as GPs in the UK:[17]

- **A third were working elsewhere (outside of the EU).**
- **Almost a fifth had left for carer's roles.**
- **28% were undertaking other medical work in the UK.**
- **A tenth of GPs leaving the profession were no longer working.**

Given that the majority of those who left general practice remained working in the medical workforce (albeit not all in the UK), more action is required to ensure that general practice is viewed as a desirable and sustainable career for those in the mid-years of their career.

Reducing workload across general practice will undoubtedly benefit GPs across the lifespan of their career. Consideration must also be given to how we can better support those in the mid-point of their career, whom we simply cannot afford to lose. Professor Lindsey Pope, Professor of Medical Education at the University of Glasgow (Head of GP Teaching) and Co-Director of the Scottish School of Primary Care, has reviewed the evidence for how to retain mid-career GPs. She reports that interventions that help include managing perceptions and expectations of general practice; more face-to-face contact with patients and increased autonomy to deliver holistic patient-centred care, with less administrative and excessive workload. Better support systems are also key, especially for those with disabilities and caring responsibilities and dealing with bullying and complaints.

We agree with Professor Pope's call for longitudinal tracking of the GP workforce to examine their career trajectory, with funding to support this. That will allow us to make small course corrections with ongoing re-evaluation to understand what works.

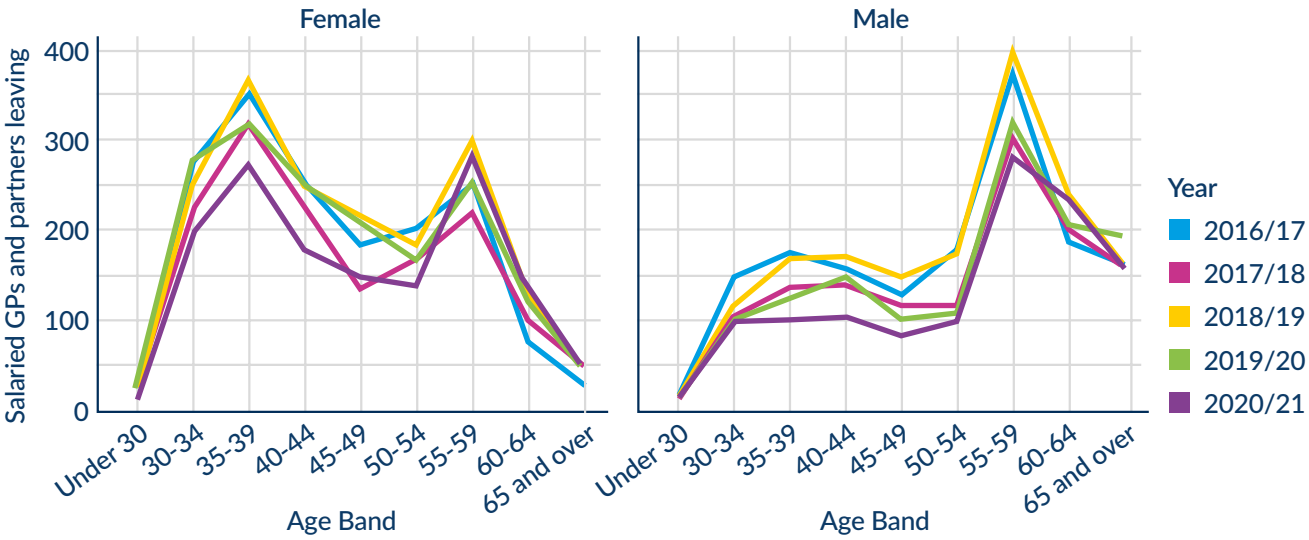
There are areas of innovative practice from which we can learn when considering how to support parents on maternity leave back into the profession, which is a group shown to be at high risk of leaving the profession.

The 'Bring Baby' scheme, established by a group of Cambridge doctors, provides much needed CPD and support to help those on maternity leave, including with the difficult transition back to the work.[18] Such innovation should be learnt from and rolled out across all Health Boards in Scotland. **We recommend that assistance is given to groups which aim to support those returning from maternity (or other significant) leave within every Board, with some support and funding, for those involved in running them.**

Retirement, pensions and GPs over 50

Our latest tracking survey shows that of those GPs who intend to leave the profession in the next two years, 70% are planning to retire[19] Recent workforce data from England, recorded between 2015 – 2021, shows that the biggest loss of GPs leaving general practice occurs in the 50 – 54 age group, although there is a worrying early peak too:

Leaver numbers England 2016/17-2020/21



Data from NHS Digital, General Practice Workforce, march 2021. Years run 1 April to 31 March.

While we do not yet have equivalent data in Scotland, we would expect similar trends. We simply cannot afford to lose this hugely valued and experienced workforce and urgent consideration needs to be given to why this trend exists and what needs to be implemented to retain this workforce.

Pension arrangements are often cited as a key driver for GPs retiring earlier than planned as small fluctuations in earnings can have significant tax implications, due to the functioning of the annual and lifetime allowances. This is a particular challenge for GP partners who are less able to adjust working hours in a year. Moreover, normal pension age in the NHS Pension is set at 60 and, since benefits for GPs in the 1995/2008 NHS Pension Scheme are based on career average earnings, it may be financially preferable to retire rather than work reduced hours.

Data from the NHS Pension Scheme shows that 55% of GPs claiming their pension for the first time in 2019/20 did so through voluntary early retirement. Pension arrangements are also commonly cited as a reason why GPs feel unable to work in the Out of Hours setting and this was born out by our 2022 RCGP Annual Tracking Survey.

We understand that consideration is being given by Scottish Government on what can be done to improve the current pension arrangements to ensure that they are not a disincentive to GPs remaining in the profession. Whilst it is outwith the scope of responsibility for RCGP Scotland to become involved in such discussions, we are supportive of a solution being found to the challenges with pension arrangements.

We have heard from members that they are working at a relentless pace, and do not always feel safe in doing so. Older GPs also worry about being complained against, or referred to the GMC, at the very end of their careers, whilst working in such pressurised environments and reportedly some leave earlier because of this. Many older GPs report that they would welcome a portfolio role, using their experience in other parts of the NHS, but do not feel that they can maintain their practice commitments. There are many areas where such highly experienced GPs could help: practice quality work, supporting teaching and training in medical schools and general practice, expanding mentorship programmes and contributing to academic work.[20] Expanding some of this work would also likely help retain other GPs by relieving pressure and providing positive local leadership. These GPs have also experienced working in a better-resourced system and have long-standing relationships with patients and their teams, a joy of general practice. They will know just how rewarding general practice is at its best, the fulfilment brought by working in a flexible, creative, supportive environment, able to deliver care that makes a difference. Leaving earlier than they might have wished, is their loss too. It is also a major loss to the wider health service and compromises the long-term continuity of care that we now know improves health outcomes and reduces health care costs.

Out of Hours general practice

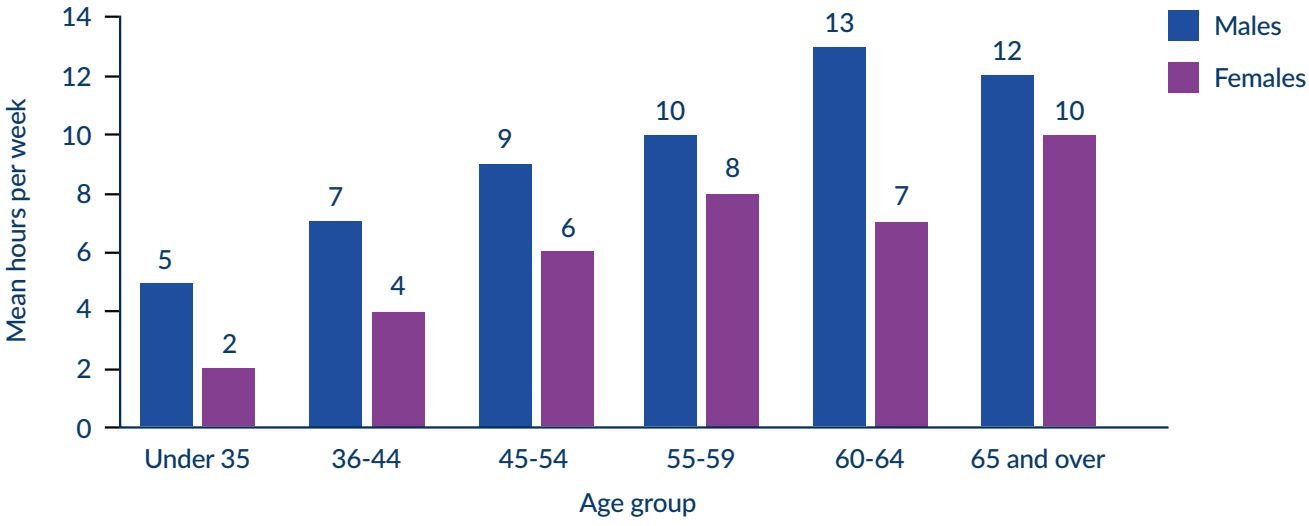
General practice delivers a 24/7 service to patients, with the Out of Hours service covering 118 hours each week. When considering retention within general practice, particular attention must be paid to retention of GPs within the Out of Hours service, which is facing significant challenge. Multiple Boards across Scotland have reached a critical status, regularly having to take additional action to ensure shifts are filled, with service managers describing this as extremely challenging in the latest national Out of Hours workforce survey.[21] Out of Hours leads also report pressures due to loss of some registrar contribution which was increased during Covid, issues round pensions, alternative roles for GPs, ANPs moving to daytime work. They also report losing clinical leads themselves, as some older, experienced GPs are leaving and there is inadequate resource for them to undertake the work needed.

GPs are not contractually obliged to work in the Out of Hours service, and with increasing pressures being experienced during in-hours general practice, many report not feeling able to work in Out of Hours too.

Our latest Tracking Survey showed that 77% of Scottish GP respondents currently do not work any Out of Hours sessions, which is an increase from 72% in 2020 and 68% in 2019.[22]

The Out of Hours GP workforce survey showed the following trends:

- The average hours worked per week by GPs has decreased since 2017.
- Older GPs (>55) worked more average hours than younger colleagues, and hours worked per week went up with age.
- 9% of GPs worked 1,000 hours or more over the year and their total annual hours accounted for nearly half (45%) of the total GP hours worked. Two thirds of these GPs were over 45.
- As can be seen in the graph below, both female and younger GPs worked fewer hours and currently, the younger workforce has a female majority. We will need to understand over time whether this trend will continue.



Source: Primary Care OoH Workforce Survey Scotland 2019

The survey outlines the difficulties with calculating the whole-time equivalent number of GPs working in the service, but nonetheless estimates this to be 329.6, which is a decrease from when the survey was last undertaken in 2017.[23]

Many of the significant challenges facing the Out of Hours service mirror those being reported for in-hours general practice and the relentless workload of the latter acts as a disincentive for GPs working in Out of Hours general practice. Another key barrier to working in the service is the current pension arrangements, previously described.

The service is also reporting an increase in the number of patients seeking care in the Out of Hours period, partly stemming from the level of concern by patients over their health, but also the result of patients presenting to the service, feeling unable to wait for an in-hours appointment at a later date, even when clinically appropriate.

The Scottish Government commissioned a national review of primary care Out of Hours in 2015 with the Group's report putting forward a series of recommendations to help put the service on stable footing.[24] Whilst some progress has been made in implementing the report's recommendations, many have not been fully implemented: it specifically mentions a "high morale workforce of sufficient capacity and capability" and a national primary care workforce plan. **We now require an urgent evaluation of the progress of its recommendations.**

Crucially, Out of Hours general practice needs to be a place where GPs and other doctors feel supported, not overwhelmed, and can work safely. Staff also need to have time for learning and training as in in-hours general practice. Traditionally, many GPs have hugely enjoyed this work – focussing entirely on the urgent, clinical work, maintaining those skills without having to consider the multiple other demands of daytime practice; comradeship and networks; learning opportunities; building relationships with other teams, contributing in a unique way to patient care at a critical point in people's lives.

RCGP Scotland members have recently reported working flat-out in Out of Hours, in high-risk situations with some having to manage on shifts with virtually no other medical colleagues available. This was considered to be a deterrent from working further shifts in the service. Some GPs described support and clinical supervision for less experienced GPs and trainees as stretched and patient expectation was viewed as high and often unrealistic. However, we have also heard from our members of the positive development of cohesive Out of Hours teams, working in a hybrid model with secondary care and able to access education and training; having salaried GPs working set sessions also helps. With adequate resource and planning, improvements to daytime working and changes to pensions, stability in the Out of Hours service is achievable. However, this will require significant and sustained efforts.

Specifically, to improve retention (and also recruitment) into the Out of Hours service we require every Out of Hours service to have:

- **Defined and sufficient senior GP leadership posts.**
- **Options for salaried doctors to work in the OOH service – with protected time for learning and training intrinsic to those sessions.**
- **Continue long term mechanisms for experienced GPST3s to undertake sessions in the service and consideration for other specialties with a generalist focus to participate too.**

Conclusion

Efforts to boost recruitment into general practice will be insufficient if significant efforts are not also taken to retain GPs within the profession. We recognise that there is not a single solution to this significant challenge and this paper seeks to put forward some of the actions that must be considered and implemented to ensure that general practice can be put on a stable footing.

A thriving general practice not only brings benefits for its patients, but also serves to protect the entire NHS. At a time when resources are stretched thin across health and social care, we must do all that we can to protect our valuable workforce.

We recognise that there is a key role for the College to play in improving retention within general practice. We stand ready to work constructively with the Scottish Government and others to ensure that GPs and their teams feel supported and able to continue working in general practice throughout their careers.

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RC GP SCOTLAND

RCGP Scotland represents a network of around 5,000 doctors in Scotland aiming to improve care for patients. We work to encourage and maintain the highest standard of general medical practice and act as the voice of GPs on resources, education, training, research and clinical standards.

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Registered Charity Number: 223106 | Scottish Charity Number: SC040430 | Patron: HRH The Duke of Edinburgh (1972-2021)