

Policies and strategies to retain and support the return of experienced GPs in direct patient care: the ReGROUP mixed-methods study

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Scientific summary

The ReGROUP mixed-methods study

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Scientific summary

Background

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

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

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

Objectives

This research addressed two questions. First, what are the key policies and strategies that might (1) facilitate the retention of experienced GPs in direct patient care or (2) support the return of GPs to direct patient care following a career break? Second, how feasible is the potential implementation of those policies and strategies?

The aims were to:

- develop a conceptual framework and undertake a comprehensive assessment of factors associated with GPs’ decisions to quit direct patient care, to take career breaks from general practice and/or to return to general practice after a career break
- identify the potential content of, and assess the evidence supporting key potential components of, policies and strategies aimed at retaining experienced GPs and/or supporting GPs returning to direct patient care following a career break
- identify practices that may face supply–demand workforce imbalances within the next 5 years
- assess the acceptability and feasibility of implementing any emergent policies and strategies.

Research workstreams included:

- a systematic review of past research into the factors influencing GPs’ decisions or intentions to leave general practice (or reduce their work hours)
- a census survey of GPs in south-west England
- use of the census survey to provide a sampling frame to provide qualitative evidence from GPs intending to quit, those who are currently taking/planning a career break and those who intend to remain working in direct patient care
- an outline of the content of policies and strategies supporting the retention of GPs in direct patient care
- a prioritisation of the emergent policies and strategies in respect of their feasibility and effectiveness using a validated methodology

- drawing on a range of data to specify, develop and undertake preliminary evaluation of a model aimed at identifying supply–demand imbalance at the level of individual practices, and to demonstrate the potential use of the approach to identify general practices in south-west England at risk of workforce shortages
- the gathering of feedback from key stakeholders on the acceptability, feasibility and likelihood of implementing any emergent policies and strategies.

Although the initial thinking focused on ‘experienced GPs’ with a particular view on considering the retention of GPs aged > 50 years, the study team’s experience of conducting this research identified the extent of the problem, which appeared to span all ages of qualified GPs. This investigation, therefore, did not focus exclusively on this age group. Thus, experienced GPs were taken to be all fully qualified GPs, irrespective of age.

Methods

A systematic review of quantitative and qualitative research was conducted to describe what factors in the UK and other high-income countries affect GPs’ decisions to (1) quit direct patient care, (2) take career breaks from general practice or (3) return to general practice after a career break. Searches identified published articles and ‘grey’ literature written in English from 1990 onwards. Searches were conducted in January 2016 and updated in April 2016.

All GPs registered to practise in south-west England were identified and surveyed between April and May 2016 using a previously piloted bespoke questionnaire. Online and postal modes of questionnaire delivery were used, and two reminders were sent if necessary.

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

Using the RAND/UCLA Appropriateness Method (RAM), a panel of GP partners and GPs working in national stakeholder organisations rated the appropriateness of potential policies and strategies emerging from the other research workstreams. Two rounds of rating were conducted. Fifty-four potential policies and strategies aimed at different levels of health-care organisation were developed into 100 summarising statements. These statements were initially rated for appropriateness by the RAM panel members, based on the research evidence and on the current known direction of national policy. The scope of statements fell into three major domains: (1) human resources (HR) management systems and processes, (2) HR practices and operational functions and (3) day-to-day general practice management. Ratings were analysed for consensus and categorised based on panel-assessed appropriateness. The statements rated as ‘appropriate’ after round 1 of the investigation were then rated for feasibility in round 2.

A modelling framework was developed that aimed to identify those practices at highest risk of facing a workforce supply–demand imbalance within the next 5 years. A hybrid modelling approach was used to predict imbalance based on a range of practice factors, and on the predicted fraction and age profile of the existing GP workforce remaining in direct patient care. A predictive model was developed using historical data, and current data were then used to predict future risk over a 5-year window. The utility (‘added value’) of incorporating responses from GPs regarding their quitting intentions within the model was explored. The predictive model development used data for all general practices in England. The prediction of future supply–demand risk status was restricted to practices in south-west England.

Potential ‘emergent’ policies and strategies that aim to support the retention of GPs in direct patient care were road-tested in two stakeholder consultation meetings. Participating stakeholders were drawn from a

range of regional and national organisations, including national representatives from major primary health-care organisations with an interest in the issue of GP workforce capacity and planning. Stakeholders explored the practicalities of implementing change across 11 broad areas of emerging policy and strategy, focusing on barriers to and facilitators of change, feasibility and acceptability, and key actions that might be undertaken to facilitate and support change.

Results

The systematic searches yielded 5227 records after deduplication. Thirty-four survey-based (22 from the UK) and five qualitative-based studies (four from the UK) were identified and reviewed in detail. GPs in the UK leave general practice for a wide range of reasons, both negative, job-related 'push' factors and positive, leisure-related, retirement-related and home-life-related 'pull' factors. Some factors operate at an individual level, whereas others operate at the level of general practice, the whole profession or the national health system.

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

In the census survey of GPs in south-west England, 2248 out of 3370 eligible GPs participated (67% response rate). Thirty-seven per cent of respondents reported a high likelihood of quitting direct patient care within 5 years, and 20% reported a high likelihood of quitting within 2 years. Overall, 70% of respondents reported a career intention that would, if implemented, reduce GP workforce capacity over the next 5 years.

General practitioner age was an important predictor of career intentions; sharp increases in the proportion of GPs intending to quit patient care were evident from the age of 52 years. A total of 54% of GPs reported low levels of morale. Low morale was particularly common among GP partners. Current morale strongly predicted GPs' reported career intentions, with those with very low levels of morale being particularly likely to report intentions to quit patient care or to take a career break.

Interviews undertaken with 41 GPs identified from the census survey return, and with 19 stakeholders opportunistically sampled from primary-care-related settings in south-west England, identified that factors and issues of relevance to GP recruitment and retention need to be addressed collectively. Inherent tensions and contradictions within potential solutions need to be considered. There is a need to address the reality of GPs' lived experiences of their work and role within the current health-care climate and provision. Three important themes emerged from the data: (1) the identity and value of the GP role, (2) fear and risk reported by GPs in respect of delivering that role and (3) choice and volition in respect of career planning.

Following two rounds of rating, the RAM panel identified 24 out of 54 potential policies and strategies that were judged to be 'appropriate'. Overall, most of the policies and strategies deemed 'appropriate' were also considered 'feasible'. Many of these related to providing support to GPs who were returning to work, with the aim of managing their re-entry into the workforce, providing options for flexible working and/or targeting GPs in the first 5 years of professional general practice or when nearing retirement. At a national level, there was recognition that early self-reporting of practice at-risk status might enable timely, focused support to be put in place. RAM panellists were more likely to reach consensus on policies and strategies that involved optional implementation rather than those involving compulsory implementation. Many of the policies and strategies considered to be appropriate and feasible related to HR management or to addressing contractual arrangements, recruitment and retention, personal and professional development, training support, and incentivisation of the workforce. Such potential policies and strategies relating to operational functions and the day-to-day management of general practices often focused on

protective measures aimed at reducing work-related stressors, easing the implementation of new models of care, establishing arrangements to actively manage workload, or provide for innovative contractual approaches aimed at reducing financial risk or increasing personal and practice flexibility.

Based on historical data, the predictive model that was developed had fair to good discriminatory ability to predict those practices that faced supply–demand imbalance. Predictions using data from 2016 suggested that practices at highest risk of a future supply–demand imbalance within a 5-year window are those that currently have larger patient list sizes, employ more nurses relative to GPs, serve more deprived and younger populations and have poorer than average patient experience ratings. Findings from a survey of GP career intentions added very little information to the predictive capacity of the model compared with a model using only data based on routinely available information regarding GPs' genders and ages.

Stakeholder feedback was obtained in respect of (1) protecting GPs and managing the expectations of patients, (2) providing incentives and support mechanisms for GPs and (3) portfolio and wider working arrangements.

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

Conclusions

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

Study registration

This study is registered as PROSPERO CRD42016033876 and UKCRN ID number 20700.

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