GP views on strategies to cope with increasing workload: a qualitative study

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Abstract

Background: The existence of a crisis in primary care in the UK is in little doubt. General Practitioner morale and job satisfaction are low, and workload is increasing. In this challenging context, finding ways for GPs to manage that workload is imperative.

Aim: To explore what existing or potential strategies GPs describe for dealing with workload and their views on relative merits.

Design and setting: All GPs working within NHS England were eligible. Of those who responded to advertisements, a maximum variation sample was selected until data saturation was reached. Semi-structured, qualitative interviews were conducted. Data were analysed thematically.

Results: 171 GPs responded, and 34 were included. Four main themes emerged for workload management: patient-level, GP-level, practice-level and systems level strategies. A need for patients to take greater responsibility for self-management was clear, but many felt that GPs should not be responsible for this education. Increased delegation of tasks was felt to be key to managing workload, with innovative use of allied health care professionals and extended roles for non-clinical staff suggested. Telephone triage was a commonly used tool for workload management, though not all participants found this helpful.

Conclusions: This in-depth qualitative study demonstrates an encouraging resilience amongst GPs. They are proactively trying to manage workload, often with innovative local strategies. However they do not feel that they can do this alone and called repeatedly for increased recruitment and increased investment in primary care.

Keywords: Primary health care, General Practice, general practitioners, workload, qualitative research

How this fits in:

Within the challenging context of the current UK primary care workload crisis, finding the best ways for GPs to manage workload is imperative. This in-depth qualitative interview study with GPs in England uncovers the use of many, often innovative approaches to workload management. What strategies do GPs use to manage workload? What works and what doesn't, and what do GPs feel that they need to support them further?

Introduction

General Practice provides the usual first point of contact, and most preventative care and follow up management, in the UK's National Health Service (NHS). With 90% of NHS activity occurring in primary care,(1) a year on year rise in GP consultations in England since 2008(2) has been compounded by increased case complexity: the number of patients with multi-morbidities in England is set to rise by 53% between 2008 and 2018(3). This expansion in number, duration, and complexity of cases has not been matched by increased recruitment or funding in General Practice. Between 2009 and 2014, the headcount of UK GPs grew by just 0.2%,(4) whilst the population grew by 6%. Whilst the Royal College of General Practitioners estimates that 8000 more full time equivalent (FTE) GPs will be needed by 2020,(5) boosting the number of GP trainees is proving difficult(6). Meanwhile, the share of NHS expenditure allocated to General Practice has fallen by almost 20%, and even the most optimistic forecasts predict a substantial funding shortfall of £1.6bn by 2017/18 (2).

The growing workload crisis in UK General Practice has become a major issue. Two thirds of GPs describe their workload as 'unmanageable' or 'unsustainable',(7) and 93% report that their workload has negatively impacted the quality of patient care they can provide(8). 60% of GPs are considering early retirement and more than a third report actively planning for this.(7) Research has indicated that causes of increased workload, over and above population growth, include increased administrative load, a culture of target management, high patient expectation and increased risk of litigation(9). 90% of 15,000 GPs who responded to a recent British Medical Association survey believed that high levels of workload damage the quality of patient care, and that 10 minute consultations are inadequate to meet patient needs(8).

Whilst these concerns are certainly present and may be worsening, they are not new (10) (11).

Given the very real concerns about the sustainability of UK general practice, both change and resilience seem necessary for survival (12). This qualitative interview study of GPs in England aimed to investigate practitioner views of workload and, for this analysis, explore what strategies GPs reported and suggested for dealing with workload.

Method

This semi-structured interview study was approved by the University of Oxford Central University Research Ethics Committee. All qualified GPs working within NHS England were eligible. An advertisement was circulated via regional GP email lists and national social media networks, and those who responded were purposively selected to obtain a maximum variation sample in terms of GP characteristics (number of sessions, years as a GP, additional roles, GP role), and practice characteristics (list size, geographical location, rurality, number of other staff). Interviews continued until data saturation was reached. GPs were reimbursed with a £50 gift voucher.

Interviews were conducted in June and July 2015 by telephone or face-to-face, and participants provided oral or written consent respectively. CC, an experienced female non-clinical primary care researcher, conducted interviews using a flexible pilot-tested topic guide (Table 1). HA, an academic GP, reviewed the interviews throughout the study and collaborated in identifying data saturation.

Interviews lasted 30-70 minutes and were audio recorded, transcribed verbatim, and anonymised. Thematic analysis was carried out by CC and HA, who collaboratively produced a coding scheme and coded the data, with the assistance of QSR NVivo. Throughout analysis, codes and themes were added, merged and refined. Attention was paid to the diversity of participants' experiences and attitudes, discrepant cases, and differences between GPs with varying characteristics.

Data on participants' perceptions of workload and factors contributing to workload will be published separately. The analysis presented here is of participants' discussions of strategies for dealing with workload.

Results

171 GPs responded to advertisements, of whom 34 participated. A maximum variation sample was achieved (Table 2), including GPs from across England.

Participants discussed existing strategies for dealing with workload, strategies which have previously been attempted, and ideas for potential future strategies. We grouped emerging themes into 'levels' of strategies: patient-level, GP-level, practice-level and system-level approaches for managing workload (Table 3).

Patient-level strategies

Patient education on self-management

Lack of self-management of minor illness such as colds and sore throats was commonly identified, with many respondents already trying to address this by educating patients about

appropriate service use. Tools being used included posters, leaflets, and Powerpoint presentations in waiting rooms. Several participants said that their practice websites contained information about self-management and how/when to seek help, but these GPs also stated that they were not sure how much patients actually accessed this information.

Whilst the vast majority of participants identified patient education as a key strategy for workload management, the extent to which GPs should be responsible for delivering this was more contentious. Although some GPs felt that the government or patients should adopt this responsibility, others felt that GPs themselves should be doing more. The 10 minute consultation limited the potential for educating patients about where and when to consult:

I think you're on a bit of a losing battle when you're trying to do it in a small amount of time, what needs to happen is that it needs to be done in schools and it needs to be done in bigger places, in workplaces (GP28, female partner, 7 sessions, 6-10 years' experience, medium urban practice)

Several participants felt that delivering a consistent message throughout the practice was key to patient education, but this could be challenging:

'if you have a stable doctor population in your surgery and you have the same six doctors and they are there long-term then the messages the patients are getting is the same, which is 'if you ring up with a cold and you come in for a cold you're not gonna have any treatment for that because it's a cold'. (GP35, female locum, 6 sessions, 6-10 years' experience, medium urban practice)

Education through media and schools was commonly discussed, as was the idea that public health campaigns could focus more 'positively' on self-treating.

'…that's what the Government, that's what NHS England should be doing, they should be doing, you know, Press campaigns, you know, 'do you really need to see a doctor, couldn't you

go and see your pharmacist, couldn't you speak to your nan, couldn't you just do some saltwater gargles for your sore throat, you know, but if it's worse in two days, fine, see your GP'. (GP28, female partner, 7 sessions, 6-10 years' experience, medium urban practice)

Responsibility was frequently discussed, with GPs wanting patients to take more responsibility for self-management of minor illness, and to give greater consideration to their own individual responsibility to limit consumption of NHS resources.

Charging for services

A significant minority of participants raised the idea of some form of charge being levied for primary care appointments. This was viewed as a method of deterring patients from making *'oh I just thought I'd check'* appointments (GP 03). Either an actual charge for appointments, or the explicit demonstration of actual cost (for example by itemising cost on prescriptions) was seen as a tool for encouraging people to consider the real cost of their healthcare.

'People pay more and wait more and are politer to their hairdressers than they are to their GP. I mean, there has to be some identification of cost. I had suggested that when people come for their prescriptions they should have an itemised bill, they don't have to pay it but, "Today your consultation would have cost this. This drug would have cost this."' (GP04, female partner, 6 sessions, >20 years' experience, medium semirural practice)

'The only way people appreciate things is if they have to put their hands in their pocket and even if it was a tiny amount it would reduce demand because it certainly does where prescriptions are concerned, people that pay for their prescriptions say "Actually I don't think I'll take that", but when they don't pay for them they go "Oh I can have three lots of medicines for my hay fever please" (GP12, female partner, 8 sessions, >20 years' experience, small rural practice)

GPs strongly in favour of charging for appointments often acknowledged that their opinion is not universally shared. Other GPs expressed concerns that those most affected by charges for services would be the 'wrong people', or felt that the bulk of people whom they perceived to be consulting frequently (children, the elderly, people on benefits) were likely to be exempted under any charging system anyway.

GP-Level strategies

Improving the efficiency of the working day

A variety of strategies for maximising efficiency during the working day were suggested, including dealing with tasks as they are received (rather than putting them in a pile for later) and proactively ringing patients to complete a task rather than waiting for them to book an appointment.

Many participants had used remote access to complete patient-related tasks from home. Working from home was cited as an important factor in maintaining ability to deal with workload safely.

'Well doing letters and results at home is a big thing now. I think, you know, I decided, well I just get too hungry and tired…..that's when I'll make mistakes and that's scary'. (GP19, female partner, 6 sessions, 16-20 years' experience, medium rural practice)

Managing patients with multiple agendas

The challenge of managing burgeoning lists of patient issues in 10 minute appointments was frequently discussed, but some felt this was not a new problem. Many participants felt that they negotiated the boundaries of the consultation explicitly with patients where needed, but often recognised that this could be stressful.

'Patients have always tried to bring up 10 things in a 10 minute consultation, I think it's how you deal with that. I think if you try and deal with all 10, then inherently you have a long, complex consultation. I think if you put your foot down and say, "Look, this is inappropriate, I can't do a good job here" then you have a shorter one'. (GP 09, male GP partner, 5 sessions, 6-10 years' experience, large urban practice)

'Quite often there is some sort of hidden agenda or something that is not mentioned which is in the background. So as soon as you bring that to the forefront then it tends to speed up the consultation. That doesn't mean that I rush the patient out but it just means that you can do it more efficiently'. (GP27, male locum, 8 sessions, 1-5 years' experience, medium urban practice)

Personal coping strategies

Most participants discussed their personal mechanisms for coping with workload, with many citing social support as important. Several commented on the loneliness of consulting and felt that designated practice coffee times were important for camaraderie (although coffee breaks and team interaction generally were felt to be eroded by increased workload).

'I think it's good to get it off your chest. We had a really good moan this morning round the coffee machine' (GP25, male partner, 10 sessions, >20 years' experience, large rural practice)

Almost all participants felt that full-time working was not possible, and reducing the number of sessions was often cited as a strategy for managing personal workload, and coping with the job.

'the level of emotional and mental exhaustion means that if you work full-time you will burnout' (GP28, female partner, 7 sessions, 6-10 years' experience, medium urban practice)

'I think if I hadn't changed, reduced my sessions, I would be, I don't know where I'd be actually, I don't think I'd have survived the winter' (GP05, male partner, 8 sessions, 11-15 years' experience, medium urban practice)

Many GPs commented that despite reducing their sessions, they worked at home or came in on days off to enable them to manage their workload, recognising that payment does not represent work done. Having a special interest or 'portfolio' career was felt by some to be an effective coping mechanism. GP training, appraising, research, CCG work and GMC work were amongst the roles fulfilled by participants, with many feeling that doing something different

was important in reducing the relentlessness of clinical work. Participants currently working as locums identified their ability to work flexibly in different roles as an attractive element of locum work. A GP working in a larger recently merged practice described the use of a 'buddy system' (being paired with another GP to share a patient list) as a mechanism for managing workflow in a mostly part-time GP workforce.

Benefits and problems of taking leave

Several participants discussed the importance of taking their annual leave to preserve emotional health, but the impact of an absent colleague on practice workload was frequently mentioned. Different suggestions were made as to how practices manage this; some restrict the number of GPs allowed leave at once, others add additional appointments or locum sessions to cover absent colleagues.

Practice-level strategies

Delegating tasks

There was agreement that tasks should be delegated as far as possible to other practice staff to protect GPs' time.

'try and get the person who is the least qualified doing as much as possible so a job should descend to the person who can do it, so rather than having GPs do unnecessary paperwork and admin task' (GP17, male partner, 4 sessions, 11-15 years' experience, large urban practice)

However participants acknowledged that workload ultimately defaults to the GP (particularly partners) if this delegation process fails or is not in place. One participant, currently working

as a locum, felt that delegation of work to safeguard GP time was a feature of the better-run practices in which she had worked (GP35).

Sharing work with other clinical staff

Most participants' practices utilized nurses for minor illness, which was felt to free up GP time, although insufficient nurses available to manage minor illness led to spill over to GPs.

GPs across all practice settings reported that practice nurses are undertaking the majority of routine chronic disease management, running clinics for conditions including asthma, diabetes and hypertension, and this was seen as a positive phenomenon:

'absolutely fantastic, I mean, I think she's a doctor with a nurse's, you know, hat on, really, and she's brilliant on cardiology, rheumatology, she does joint injections, she interprets, you know, she manages all our rheumatology patients, manages all our asthmatics and COPDs' (GP02, female partner, 5 sessions, >20 years' experience, medium semi-rural practice)

Whilst this seemed to be universally regarded as time-saving for GPs, several participants felt that it may not actually be cost-effective because nurses, whilst cheaper to employ, may require more appointments/time to complete tasks. Concerns were also raised that an increasingly co-morbid population might challenge the sustainability of this model:

'hypertension would be nursing, the only problem with hypertension we're finding is usually by the time they've got hypertension they've also got diabetes, obesity and something else, so, and they're on a statin, so it's harder for the nurse to do comorbidity work'. (GP03, female partner, 5 sessions, 16-20 years' experience, medium semi-rural practice)

Whilst several participants raised the idea of their practice nurses taking on responsibility for telephone triage this was not currently a model in common use.

Extending roles of non-clinical staff

The importance of a good administrative team was frequently cited, and the majority of participants' practices had trained non-clinical staff to carry out tasks aimed at reducing the administrative burden on GPs. These included 'initial triage' of incoming letters to highlight medication changes, and the addition of new clinical codes to the medical notes.

A common theme regarding both clinical and non-clinical staff was the idea of 'stepping up a grade' – that GPs are managing situations once the preserve of hospital consultants, and so on:

'we're actually farming out work which can be done by other people to other people and my observation is that everybody's stepping up a grade if that makes sense, so effectively we are consultants, our practice nurses are doing, you know, simple minor illnesses and chronic disease management and healthcare assistants are doing what nurses used to do, etcetera '. (GP 14, male partner, 8 sessions, 16-20 years' experience, large suburban practice)

Concerns were raised that delegation of tasks might pose a risk to patient safety, and that the medico-legal implications of delegating work to non-clinical staff are unclear. This limited the willingness of some GPs to delegate tasks to other staff members.

'I would maybe delegate more but then that's not ideal because it might have a bit more of a risk, you know, the changes on the medication or something which, you know, I might end up asking reception to do maybe, I suppose, which is not, is not quite as good' (GP21, female partner, 7 sessions, 11-15 years' experience, medium suburban practice)

Use of telephone appointments

Although most used telephone consultations, participants did not universally agree on the effectiveness of telephone consultation at reducing workload. Some felt that certain tasks could easily be carried out over the telephone (e.g discussing medication dose alterations, or completing tasks related to QOF). These participants felt that pre-booked telephone

appointments enabled efficient workload management by reducing the number of face-to-face appointments required, and reducing the time needed during a face-to-face appointment if it followed a telephone call. Telephone consulting was also more flexible, allowing participants to make use of 'did not attend' appointments.

Paradoxically some participants felt that telephone consultations could increase workload or be hidden workload (if calls were not logged on the same system as other appointments). These participants described telephone calls being added as an extra to their existing surgeries:

'I don't know if that reduces workload though [laughs] it just, it moves the workload and what it does is actually it moves the workload out of eyesight of your staff which is not always a good thing'. (GP07, female partner, 6 sessions, 6-10 years' experience, large suburban practice)

One participant felt that telephone consultations are more positive for patients than GPs:

'I think that phone consultations are fantastic for patients, the difficulty as a doctor is that they, they're never finite, there is always something else the patient will want to ask' (GP15, female partner, 8 sessions, 1-5 years' experience, medium rural practice)

Telephone triage as a tool for managing workload

Significant variation in the ways in which practices used telephone triage were apparent within our sample: a minority did not use it at all, some had a dedicated GP doing telephone triage, in others all triage was done by a daily duty doctor, and in others triage was shared between GPs or added as extras to lists. A minority reported that their practice utilized nurse triage.

Opinions about the efficiency of telephone triage for managing workload were divided, particularly whether it reduced face-to-face contacts. Whilst some felt that telephone triage significantly reduced the number of patients seen in person, others found the opposite and pointed out that these patients effectively had two consultations.

'We reckon that cuts our consultation by 50%. So we'd see 50% of them and the other 50% we would advise on the telephone' (GP03, female partner, 5 sessions, 16-20 years' experience, medium semi-rural practice)

'We tried it and a couple of partners found it just really stressful and essentially they found that everybody they spoke to they brought down so…' (GP 08, female partner, 5 sessions, 16-20 years' experience, medium suburban practice).

Several participants recognised that conversion rate of telephone triage to face-to-face appointments varied between GPs at their surgery. These GPs explicitly discussed telephone triage as a skill to be learned or improved upon. One GP with out-of-hours experience discussed this in terms of individual acceptance of risk:

'…what levels of risk people are willing to kind of live with, so if you've got a high threshold you might deal with a significant amount of work over the phone, if you've got a low level of risk management you're going to end up seeing a lot of people face-to-face' (GP34, male partner, 4 sessions, 4 out of hours sessions, >20 years' experience, small rural practice)

Need to recruit more GPs

By far the most prevalent opinion expressed was that recruitment of more GPs is key to managing workload. Several participants however expressed concerns about how they would afford extra GPs, or stated this is not financially viable:

'The only way to help the workload is to have more doctors' (GP23, male partner, 8 sessions, >20 years' experience, medium suburban practice)

'there's no sort of, we haven't got the money, we'd love to employ another GP, but because there's no extra money, in fact it's being squeezed, we can't afford to employ another GP' (GP03, female partner, 5 sessions, 16-20 years' experience)

A significant proportion of participants discussed the possibility of employing allied health professionals such as pharmacists and emergency care practitioners to help manage workload, but only a minority said that their practice currently did this. A lack of funding was most frequently cited as the barrier and several raised the idea of shared employment of allied health professionals by their local GP Federation.

Where participants did have experience of working with allied health professionals, specific details such as emergency care practitioners having prescribing rights were raised as important factors in ensuring that the utility of these staff members is maximised.

Practice management

A minority of GPs discussed the role of IT systems in managing workflow. Electronic prescribing was particularly highlighted as a huge efficiency saving.

Participants frequently discussed the structure of their working day which varied greatly between practices, both in terms of session length, how duty systems are run, and

approaches to telephone appointments. Several GPs reported that this structure had recently been discussed by their practice in response to concerns about workload. There was however no consensus between participants on what structure is most effective at managing workload. A frequent theme was the idea of hidden workload (as opposed to booked appointments) – such as contacting patients with results, managing referral letters – which pervaded across different practice settings, appointment structures and IT systems.

Organisational and systems-level strategies

Need for additional funding

The vast majority of GPs felt that an increase in funding is central to managing workload. Many referred to reductions in their income in recent years, and felt that their practices were trying to do more with less.

'it's very hard not to see that the basic problem is that there's a huge budget deficit and not, and, you know, there's not enough money to go round' (GP15, female partner, 8 sessions, 1-5 years' experience, medium rural practice)

Strategies to improve staff recruitment to primary care

Most GPs believed that increasing funding would improve recruitment by increasing capacity to employ extra staff and making General Practice more appealing. Several pointed to perceived negative '*digging that goes on at general practice*' (GP 12) by the national media, and by the government as a factor hindering recruitment. Improving morale was seen as key to attracting new GPs.

'Um, I think one of the things is the nasty newspaper stuff is just <u>so</u> demoralising, it's just <u>really horrid</u> and when the government sort of go, "oh well, you know, the hospitals are overrun but that's because the GPs aren't doing anything", you feel like just, just, I actually feel like going

out and murdering them! It's just terrible, it makes me so upset' (GP19, female GP partner, 6 sessions, 16-20 years' experience, medium rural practice)

Several GPs wanted more junior doctors to rotate through General Practice, to manage workload and improve recruitment.

Reducing bureaucracy in primary care

Paperwork was viewed by many participants as a workload component that could be significantly reduced.

'seeing the patients is a piece of cake, the bureaucracy around seeing them is unbelievable' (GP12, female partner, 8 sessions, >20 years' experience, small rural practice)

Care plans and QOF were frequently described as overly bureaucratic, whilst perhaps adding little to quality of care. Sick notes were particularly singled out as time-consuming bureaucracy not necessarily demanding of GP expertise.

'QOF has its potentials but QOF for QOF's sake is just silly, you end up calling patients in just for the sake of ticking off you've done a review and it's, not quite right I don't think. A lot of the, kind of, I don't know, like these care plans that we're meant to be doing at the moment are just a complete waste of time' (GP31, female partner, 6 sessions, 1-5 years' experience, small suburban practice)

Redistributing workload and improved communication with secondary care

Several GPs described workload increasing as a result of shift in workload from secondary to primary care. One GP described inviting hospital colleagues to join them in General Practice for a day in an attempt to facilitate understanding of the GP role, and the pressures faced by primary care. Others felt that GPs need to be more 'resilient' and 'fight back'.

'some practices now try to sort of if letters come from the hospital to actually write back and say, "no, this is not what we're doing", sort of a little bit sort of fight back and put boundaries

in, which I think we have to do as well' (GP18, female partner, 9 sessions, 6-10 years' experience, medium suburban practice)

Several GPs felt that e-mail advice lines established with local hospitals provided rapid responses to queries that otherwise might have required referral.

'the dermatology email advice line which just transformed the way we deal with suspicious lesions and, you know, we've got I think three dermatoscopes in the practice now that we use and taking photographs of things' (GP20, male partner, 5 sessions, >20 years' experience, medium urban practice)

Utilising Federations and Hubs

Many participants pointed to GP Federations as a future mechanism for increasing efficiency and decreasing workload by sharing both work and resources between practices. Two frequently discussed models were the creation of minor illness hubs to which practices could triage patients (therefore freeing up time for their GPs to manage chronic disease), and the shared employment of nurse practitioners, emergency care practitioners or pharmacists.

A significant minority of GPs felt that the 'small-practice' model of primary care will be replaced by 'super-practices' running on a salaried employee model. Whilst some viewed mergers and federation as separate entities, others felt that federation was a pre-cursor to mergers in all but name. The need to create larger practices was stated by some as necessary for survival but not sufficient to reduce workload.

'I think what's gonna happen is it's gonna destroy and destroy and destroy and you're gonna end up with those super-practices that have the setup, got the money in the right place, got the innovation in the right place and who are expanding and then local practices failing' (GP35, female locum, 6 sessions, 6-10 years' experience, medium urban practice)

'I don't think there will be very many practices of our size still around in 10 years' time actually, I think practices of our size will have to merge or die….. Because, yeah, because there is so much work outside of normal patient care that unless you've got sort of 10 GPs and a couple of practice managers to share it it becomes overwhelming' (GP 11, male partner, 8-9 sessions, 1-5 years' experience, small semirural practice)

Several participants worked in practices where mergers had occurred, with small list size or GP retirement cited as catalysts. One recognised that a larger staff team facilitated more individual areas of expertise, increasing internal referrals, but also felt that with more doctors a '*collusion of anonymity'* (GP 20) was possible, challenging continuity and consistency. GPs who had merged and those considering mergers were not clear that mergers resulted in decreased workload.

'it will help in the sense that your survivability will be there, you'll be able to survive, but whether it will help the workload? I doubt very much. I don't think it will help the workload whatsoever'.(GP23, male partner, 8 sessions, >20 years' experience, medium suburban practice).

Discussion

Summary

These data indicate that GPs are proactively attempting to manage workload, using strategies at various levels. Some strategies were positive (role delegation, better use of digital health) but some carry the potential to worsen workload in the longer term (for example reducing sessions, using telephone triage which has been shown to not reduce workload)(13). Delegation of work to other allied health professionals or administrative staff was felt to be key for freeing more patient-facing GP time, with increased funding thought to be necessary for recruitment of pharmacists and paramedics. Patient education was seen as vital for reducing demand on limited resources, but the responsibility for this was often placed with public health, government or the media rather than GPs themselves (the 10 minute consultation being restrictive). The most common personal strategy for managing workload was reducing session numbers, which in the context of increasing patient demand and a static or reducing GP workforce, combined with the potential negative impact on continuity of care, is concerning.

Strengths and limitations

This qualitative study provides an in-depth exploration of GPs' strategies for managing workload. The large number of respondents allowed selection of a maximum variation sample of GPs from across England and it is possible that having the interviews conducted by a non-clinician enabled GPs to speak more freely.

A natural limitation of this work is that the views of our small but diverse sample are not necessarily representative of all GPs. Participants self-selected themselves which may have resulted in over-reporting of workload problems, or a skewed perspective of the ability to provide solutions. Strategies for managing workload were nested within a longer interview

exploring all dimensions of GP workload, which may have affected participants' responses to this area of questioning.

Comparison with existing literature

Previous research has described the perceived reasons for the rise in GP workload, and reviewed the numbers of GPs reducing their sessions, planning to retire/leave medicine, and the difficulties in GP recruitment (8, 14, 15). As far as we are aware, this is the first study to explore GPs strategies for coping with workload.

Telephone triage was frequently discussed, though views on the efficacy of this for reducing workload were notably polarised. This is reflected in a recently published trial demonstrating an overall increase in GP workload with telephone triage, but a substantial reduction in face-to-face contacts(13). Our team recently published a retrospective analysis of GP consultations in England which showed a doubling of GP telephone consultation rates between 2007-08 and 2013-14, on the background of an increase in overall GP consultations of 12% (16). There is a clear need to distinguish between redistribution and reduction of GP workload.

The eagerness of GPs within this study to delegate work within clinical and administrative teams, and consider employing allied health professionals such as pharmacists, echoes a 2015 call from the Royal College of General Practitioners (RCGP) to increase the number of pharmacists working as part of the general practice team (17). Interestingly no participants discussed the possibility of harnessing community assets (volunteers) to assist in managing workflow, though the Kings Fund is currently examining the scale scope and value of this (12).

The patient safety implication of over-worked GPs was a prescient issue for many participants, and has not been ignored by national bodies. The RCGP compared primary care to other safety-critical industries, recommending an 'urgent full-scale review in to how bureaucracy and unnecessary workload can be cut'(18). The British Medical Association offers a practical guide for practices to assist workload management (19), and our data suggest GPs are already using many of these strategies.

Implications for policy and research

A wide array of strategies were described by participants; some had been attempted across many practices, and others were more imaginative but less frequently employed. That our participants did not have a unified view on how to improve GP workload is unsurprising: GP practices vary enormously in almost every regard – from number of GPs and nurses, to patient list size, management arrangements and how they structure the working day. It is perhaps the very variation in General Practice that makes finding solutions to the workload crisis so challenging. A one-size-fits-all approach is unlikely to fit very many at all.

That said, some consistent themes emerged. Increased part-time working and portfolio careers are becoming increasingly common and policies for primary care need to embrace this. There is a danger that without more GPs to enable more varied working patterns, this strategy will make the pressures even greater. GPs are keen to look at more innovative ways of working with allied health professionals, and this is reflected at a higher policy level by the RCGP(17). Effectively introducing pharmacists, paramedics and other allied health professionals to the core primary care team requires research to ensure this strategy does not worsen patient care, and better understand how to maximise the utility of these roles, as

well as greater availability of funds.

It is perhaps funding that really lies at the core of this issue. Primary care can become more efficient, but implementation of new models of care requires significant investment in infrastructure. The April 2016 publication of the General Practice Forward View(20) promises increased investment in general practice, a reduction in bureaucracy and efforts to be made to reduce inappropriate demand, but has been criticised for lacking detail(21). Our work suggests that GPs are proactively seeking to manage workload in the face of little conclusive evidence as to how best to achieve this. A stronger evidence base is urgently required to drive policy promises in to practical change.

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Ethical approval

The study was approved by the University of Oxford Central University Research Ethics Committee (MS-IDREC-C1-2015-092).

Competing interests

FDRH is a practising GP and Research Lead for the Modality Super-Partnership. HA and RFRF are practising GPs. We have no competing interests.

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Table 1: Interview Topic Guide

Topic *(prompts if necessary)*
Can you describe your workload? (*Volume, working hours, intensity)*
Can you describe a typical working day/ week?
How do you feel about your workload? *(Manageability, sustainability, job satisfaction)*
What contributes to your workload? *(Patient care, other activities)*
Do you think that workload has changed over time? *(When, why, how)*
What are your thoughts about the content of consultations? *(Complexity, duration, change over time, what makes consultations complex)*
How is workload distributed across your practice?
What factors influence your workload?
How do you cope with your workload?
Do you/ your practice have any strategies for dealing with workload? (*How effective do you think these strategies are?)*
Do you have any ideas for other strategies for dealing with workload?
Are you expecting workload to change in the future?
Is there anything else about GP workload that you'd like to mention?

Table 2: Characteristics of participants

GP Characteristics		**n (34)**
Gender	Male	17
	Female	17
GP role	Partner	28
	Salaried	3
	Locum	3
Number of sessions in general practice per week	1-4	3
	5-6	13
	7-8	11
	9-10	7
Years as a GP	1-5	7
	6-10	7
	11-15	3
	16-20	9
	>20	8
Other roles	GP trainer	14
	Appraiser	6
	CCG roles	8
	Out of hours	7
	None of the above	13
Practice Characteristics*		**N (31)**
List size	≤5000 (small)	4
	5001-10,000 (medium)	10
	10,001-15,000 (medium)	13
	>15,000 (large)	4
Location	Rural	7
	Semirural	7
	Suburban	9
	Urban	8
Dispensing	Yes	9
	No	22
Number of other GPs**	1-3	4
	4-6	7
	7-9	12
	10-12	4
	13-15	2
	>15	2
Number of clinical staff who are not GPs**	1-3	6
	4-5	10
	6-7	5
	8-10	8
	11-20	2
Number of non-clinical staff **, ***	1-10	6
	11-20	14
	21-30	7
	>30	3

* For partners and salaried GPs only

** Absolute number, not full time equivalents *** Data missing for one participant

Table 3: Strategies for managing GP workload

Major Theme	Subthemes
Patient-level strategies	Patient education on self-management Charging for services
GP-level strategies	Improving the efficiency of the working day Managing patients with multiple agendas Personal coping strategies
Practice level strategies	Delegating tasks: clinical and non-clinical staff Telephone appointments Triage Staff recruitment Practice management
System level strategies	Need for additional funding Improving recruitment to general practice Reducing bureaucracy Federations and hubs