The GP Workforce Pipeline: increasing the flow and plugging the leaks

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Background

The 2017 annual meeting of the Society for Academic Primary Care included a workshop for participants with an interest in recruitment and retention of GPs. This article presents emergent themes following presentations about factors affecting the attractiveness of GP work at three stages; (i) during medical school, (ii) when choosing a specialty, and (iii) retaining experienced GPs until normal retirement age.

Attendees encompassed 15 UK Medical Schools. Many were involved in undergraduate and postgraduate teaching, some with leading educational roles, some involved in Admissions and Career Support, also GPs, researchers and students.

'Career': 'a journey through life and work'

Career decisions are an ongoing process, a continuum alongside vocational maturation[1]. This article separately considers issues raised in presentations and by workshop participants as they affect Medical Schools, Foundation Training, and experienced GPs.

Stage 1: Medical Schools and the Wass Report

Health Education England (HEE) commissioned a task force to investigate how students' experiences during undergraduate training influenced their views of a GP career[2]. Published recommendations to improve recruitment to GP training programmes and recent BJGP editorials[3,4] were discussed.

Workshop participants discussed four of the recommendations applying to medical schools[Table1].

(i) Participation in Medical School selection procedures

Admissions procedures define the future workforce and need to facilitate '*appointing appropriate applicants*'. Despite stating that; *'All medical schools must ensure that General Practitioners contribute significantly in all selection processes*' (p7), delegates confirmed that this currently varies across UK medical schools.

(ii) Tackle the 'hidden curriculum' and encourage mutual professional respect

The effects of undermining GP as a career have been demonstrated[5] and remain problematic[6]. Addressing *'all doctors whether in primary care or secondary care',* the recommendation is to *'take personal responsibility to create caring mutual respect in the clinical environment'* (p38).

(iii) Encouraging Role Models and Near-Peer support

The importance of GP tutors as role models who *'help students feel a useful and integrated part of the team'* (unattributed participant quote), and potentially inspirational contact between GP Speciality Trainees and students, should not be underestimated. Examples of positive *'near-peer support'* indicate that buddy schemes involving GP registrars and medical students should be encouraged[7].

(iv) Facilitate student GP Societies

Many of the Royal College of General Practitioners (RCGP) Faculty Boards have appointed student liaison officers and the RCGP has supported setting up GP Societies in medical schools. Workshop participants felt that fluctuations in Societies' activities, due to the inherent variability of student cohorts, could be mitigated by involvement of enthusiastic local GPs.

Stage 2 Early career plans; Foundation Programme doctors' choice of specialty training (ST)

The proportion of doctors entering ST programmes on completing Foundation Programmes (FP) has dropped from 71.3% to 50.4% during 2011-16[8,9]. Workshop participants expressed concern that HEE appears indifferent to this trend. The introduction of less-flexible training programmes was felt to have increased doctors' difficulty committing to a specialty when they lacked broad experience of medical work[10] and, in addition, the absence of comprehensive data on subsequent career trajectories (e.g. leaving medicine, leaving UK etc.) undermined purposeful workforce planning.

Emerging evidence indicates that doctors completing FP training (F2 doctors) weigh up many factors when making career decisions, including perceptions and experiences of GP work[11,12]. Since around 38% of F2s change specialty choice during the 2-year programme[9], it was hoped that greater opportunities to experience work (2012 43.8%; 2016 47.7%) would increase recruitment[9,13]. Despite mixed evidence on the success of this, many workshop participants felt that GP placements should be more readily available (or mandatory) for FP doctors, but that this could only have a positive effect if it occurred prior to ST recruitment.

Workshop participants also proposed that prior training in another specialty be a valid component of GPST requirements. A need for positive and supportive GP role models and peer-to-peer learning was felt important for inspiring early career doctors to become GPs, although participants recognised that doctors have a wide range of preferences and GP will not be attractive to all.

Finally, more research should investigate doctors' career choices, and the inextricable links between medical education and careers demand that we should not consider these in isolation from each other.

Stage 3 Retention of experienced GPs

The NIHR ReGROUP project[1] was commissioned to develop policies to retain experienced GPs and those taking a career break from patient care. Findings include a survey of South West GPs indicating a high likelihood of quitting (37%), reducing hours (57%) or taking a career break (36%) within 5-years[14].

Using an established methodology[2] a panel of GP partners rated draft policies according to 'appropriateness' and 'feasibility' for retention of GPs. Consultations with representatives of organisations involved in workforce planning considered three categories of policies/strategies aimed at: (i) Protecting GPs and managing patients' expectations of general practice; (ii) Incentives and support mechanisms for GPs; (iii) Supporting portfolio careers and the wider skill mix in primary care.

Workshop participants discussed issues as follows:

GPs leaving the profession; two risk groups were identified

- 'Last5' GPs (nearing retirement) whose career could be extended by strategies including altering pension arrangements, and developing a concept of restricted practice to focus interest and increase motivation for continued practice.
- 'Middle generation' (i.e. GPs in their 40s). Potential support could include the GP Returners Facebook page[3] and establishing informal, virtual 'Beyond-First5' groups, to share issues and solutions.

Proposed retention initiatives have included: RCGP Fellowship to recognise senior GP's experience; GP mentorship; peer support networks; career breaks; and targeted CCG support.

Portfolio working

A GP 'portfolio' career describes those who have multiple roles within their working week, alongside their primary GP role[15,16]. There is a huge range of potential additional roles, including those involving a specialist clinical interest, medical education, or in external provider or commissioner management roles. Participants highlighted the need to understand the activities of 'portfolio' GPs and to consider what would increase their involvement in patient care. Incentivised portfolio roles could potentially match GPs' interests. Participants felt that portfolio career development should be delayed until at least 10-years post-clinical training, and that protected time and funding for GPs' involvement in medical school teaching, would provide positive role models for students.

Discussion

Achieving growth of the GP workforce is currently being undermined at several points and by multiple pressures. Since each individual's career is a continuum, collaboration and support for GPs throughout different career stages is important. Consistent with the principle of linking 'lead responsibility, supported by, outcome measures' with Wass report recommendations, suggestions emerging from this workshop are similarly linked under three broad categories:

Structure and organisation

Inflexible requirements of training programmes can deter recruitment of doctors from other specialties. Changes in relation to this would need involvement from both the RCGP and HEE, and would require building in to existing structures. For GPs nearing retirement, the BMA and NHS England could facilitate a change in contract to allow GPs to focus on a narrower range of practice; this would require both the primary care workforce and patients to alter their current expectation of career-long unrestricted practice.

Education and training

GPs are not routinely involved and lack a strong voice in medical school selection procedures; the GMC, perhaps in conjunction with the Medical Schools Council, should mandate medical schools to ensure that GPs have a tangible influence on admissions processes. An increased presence of GPs as Medical School clinical tutors would allow students to appreciate the depth and breadth of knowledge underpinning GP work, as well as provide role models whose expertise differs from hospital specialists. These roles could form part of portfolio careers.

Maximising the peer factor

Educational benefits have been shown from peer-to-peer learning and positive outcomes reported with close-peer support; similar benefits are likely to emerge from supportive working during doctors' later careers. Individual medical schools, could coordinate educational activities with local GP training schemes and Deaneries. Later in GPs' careers, such approaches might be organised at regional-, local- or practice-level by GPs who co-ordinate their ways of working.

Factors contributing to high attrition of GPs urgently need to be reduced. Importantly, the future of GP also requires a healthy flow of students and junior doctors who are convinced that choosing GP will lead to professionally rewarding and sustained careers.

Footnotes

1. http://medicine.exeter.ac.uk/research/healthresearch/regroup/
2. A RAND/UCLA Appropriateness Method (RAM; a modified Delphi study)
3. https://www.facebook.com/groups/150370435366726/#_=_

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