Why we can't do any more in primary care

The following is correspondence from a Thames Valley GP to their CCG Chairman which was provided to the inquiry by the Local medical Committee as evidence of GP workloads:

"What frustrates me is the lack of understanding about what a GP role should entail within its current format. How many of the managers working to decide what we should be doing actually know what it is like or understand the time allocated for each complex decision/patient contact

In a "blue sky thinking" way many of the ideas that are generated centrally have merit, and to a lay public constantly bombarded with messages that we are overpaid, lazy and just not providing a decent service, it must seem extraordinary that we don't provide the following as routine:

(The perfect GP - activities to be fitted into a normal working day)

- no waiting for a surgery to answer the telephone
- access to GP appointments on the day whenever a patient wants it, ideally with a gp of their choosing to ensure continuity
- consultations to replace hospital follow up appointments where possible i.e for chronic conditions, co-morbidity
- minor illness triage
- early morning and late evening appointments
- 15 minute consultations
- telephone access to a GP to discuss management
- email access to a GP for clinical discussion
- time each day for the GP to safely and systematically look at all prescription requests
- Time each day to look at all correspondence on patients and act promptly to provide reports, certificates
- Consideration of all hospital discharges promptly and cross checking of discharge medication with the patients' records
- Review of all lab results on our own patients daily, with failsafe messages to ensure appropriate followup or filing
- Dictation of letter for any referrals generated during consultations. Cross checking with colleagues as to the appropriateness of the referral
- Home visits at a patient's request for the housebound, elderly or unwell
- Enhanced access in the form of consultations or visits to look at care plans for the elderly, those at risk of admissions, those at the end of life,
- Personal development in the form of reflection on the days issues, recording in logs
- Teaching and support of students and colleagues
- Audit
- Meetings to be fitted into the working week to share good practice, implement strategic changes, gold standards meetings, referrals meetings, careplan reviews

This list is compiled just off the top of my head thinking about todays work I'm sure there is more. Now I know why I can't achieve 35 surgery consultations, 14

telephone consultations, 2 home visits + everything else on this list in less than 11 hours + an hour and a half working from home.

Do people understand how many patients we have? Perhaps this list would be achievable with a few hundred patients but we have no control over our list.

We cannot employ more doctors as we have no space. (many practices are already becoming financially unviable with the loss of MPIG and so taking on more staff is not going to happen)

Do managers understand that our headline income has 28% superannuation taken from it because of the employers contribution as we are self employed?

In the days when expectations were lower, reactive care was the norm there was capacity to enthuse over new initiatives, test things out but in a 10-12 hour day I simply don't have time to think about adding to the workload in any way without something being taken away first.

The other exhausting thing which I know only too well as "executive partner" is that after putting massive effort in at the end of the financial year to record our achievements and ensure accurate reporting, each April now brings an avalanche of new directives always portrayed in a positive light but always creating more work and new systems to be implemented in the practice. We are truly on a hamster wheel and it is only getting worse.
As a word of warning I can't think of a single friend of mine who doesn't plan to retire on their 60th birthday. That will involve a loss of experienced capable GPs - I'm not sure that there are replacements ready to step into their places.
Lots of GPs now regret being partners - salaried doctors are not bombarded with the administrative tasks and responsibilities of partners and their earnings are not substantially less.(and in some practices earnings are actually more than a partners and they have better working conditions)

When a salaried GP service replaces the current system then managers might realise the exact costs of commissioning a workload which is currently done for free by partners. They need to be careful what they wish for.

I love general practice, I love patient contact and devising practice systems to deliver good care but I need time and resources to do it.
I need a larger building so that we can employ more staff to support new initiatives, when we have those then we can talk about what those initiatives might be.
Meanwhile please don't volunteer us for additional work to add to the list above.

Please feel free to share this with anyone and everyone because as a natural enthusiast and I hope a "good GP", I hate being in this position where we are ground down by an unachievable workload in the effort to be the perfect GP”.