

Sustainable working in general practice

Guidance from the Scottish General Practitioners Committee

Recognising the full scope of GP work to support
safe, sustainable and relationship-based care



Foreword

General practice remains central to the sustainability of the NHS, yet for more than two decades it has operated under growing and increasingly unsustainable pressure. This has coincided with a significant reduction in the proportion of NHS funding allocated to general practice, falling from around 11% of NHS spend in 2008 to approximately 6% in 2025. During that time, practices have absorbed rising levels of multimorbidity, increasing treatment options, greater bureaucracy, ageing infrastructure and workforce pressures, often through professional goodwill and personal sacrifice.

As a profession, we have worked hard to accommodate increasing complexity while continuing to deliver high-quality, relationship-based care. However, much of that work has been sustained through effort that is often unseen, unmeasured and ultimately unsustainable. It is therefore unsurprising that many GPs feel the profession has been operating on an increasingly fragile footing.

Recent investment presents an opportunity not simply to relieve immediate pressures, but to build a more sustainable future for the profession. To do so, we must recognise the full scope of modern GP partner work and organise services in ways that are safe, realistic and sustainable over the long term.

This guidance describes the breadth of work undertaken within modern general practice. Direct patient care remains at its heart, but safe and effective practice also depends on indirect clinical care, supervision, leadership, business management, quality improvement and professional development. Not every GP will undertake every aspect of this work, and the balance will vary between practices and individuals. What matters is that these responsibilities are recognised, appropriately shared and given sufficient time.

The document is intended as a supportive framework rather than a prescriptive model. It sits separately but alongside our previous publications on [Safe Workload Guidance](#) and [Guidance on Maintaining Practice Profitability](#). Practices across Scotland serve very different populations and operate in very different circumstances. Sustainable working will therefore look different in different settings. The aim is to help practices recognise hidden or unsupported work, reduce reliance on invisible labour and develop working patterns that are safer for patients, fairer for teams and more sustainable for the future.

If we can better recognise the whole GP role, protect the conditions that support continuity of care and create careers that remain professionally rewarding over the long term, we can strengthen both the partnership model and the wider NHS. The future of the NHS depends on a strong and sustainable general practice.

Dr. Iain Morrison

Chair, Scottish GP Committee

Contents

Introduction	3
Principles for sustainable working	4
Key recommendations	6
The breadth of GP work	8
Promoting relational continuity of care	11
Using this guidance in practice	12
Worked examples	16
Conclusion	18
Further reading on continuity of care	19
Appendix: Practical prompts for practices	20

Introduction

General practice in Scotland delivers exceptional, relationship-based care and remains one of the most effective and efficient parts of the NHS. Yet the environment in which that care is delivered has changed significantly. Patients are living longer with multiple conditions. Clinical knowledge continues to expand. Treatment options are more numerous and more complex. Expectations from both patients and the wider healthcare system have increased. At the same time, workforce, premises and infrastructure challenges continue to place pressure on practices across the country.

In response, practices have repeatedly adapted. New services have been developed, additional responsibilities absorbed and increasing demand accommodated. However, much of this adaptation has relied on professional goodwill and on work being undertaken outside the formal structures through which practices organise and recognise workload.

The consequence is that many of the activities required to deliver safe, high-quality care remain partially hidden. Clinical consultations are highly visible and easily counted, but much of the work that makes those consultations effective takes place before, after and between appointments. Reviewing results, prescribing safely, managing referrals, supervising colleagues, running the practice, improving services and maintaining professional standards are all essential functions of modern general practice.

The purpose of this guidance is to help practices recognise and value this wider contribution. It seeks to support conversations about how work is distributed, how time is protected and how sustainable models of practice can be developed. It is not intended to define how individual practices should organise themselves, nor to prescribe fixed proportions of clinical and non-clinical work.

Instead, it offers a framework through which practices can examine their current arrangements, identify areas of hidden workload or risk, and consider whether changes might improve sustainability, safety, and fairness to ourselves, our colleagues and patients. By making the full scope of GP work more visible, practices may be better placed to develop working patterns that are resilient, professionally rewarding and capable of supporting high-quality patient care into the future.

We recognise that practices operate in very different circumstances. Rurality, deprivation, health literacy, English literacy, age and many other determinants of health and demand mean all our practices are unique with their own challenges. The intention of this guidance is therefore not to define one model of sustainable working, but to support practices in understanding their own context and making locally appropriate decisions with confidence.

Principles for sustainable working

1. Sustainability is about the whole practice, not only consultations

A sustainable practice is not created simply by increasing appointment numbers. Safe, effective care depends on having sufficient capacity for the full range of work required to support patients, staff and the organisation itself. This includes indirect clinical work, supervision, leadership, governance, business management and service development.

When all available capacity is consumed by direct patient contact, these functions are often displaced into evenings, weekends or unrecognised effort. Over time, this creates risk for patients, leads to burnout for clinicians, places considerable stresses on outside commitments such as family, and creates fragility within the practice.

2. Invisible work is still real work

Direct clinical contact is often the most visible part of general practice, but it represents only one element of the role. Reviewing results, managing referrals, responding to correspondence, prescribing safely, supervising colleagues, supporting staff, handling complaints, investigating learning events and leading organisational change are all legitimate and necessary aspects of GP work.

Building these responsibilities into contracted work allows practices to have more realistic conversations about workload, capacity and sustainability.

3. There is no single template for every practice

Practices across Scotland serve populations with very different needs and operate within very different local contexts. Workforce availability, geography, deprivation, infrastructure, service configuration and partnership arrangements all influence how work is organised.

For that reason, this guidance does not prescribe fixed percentages, sessional models or workforce configurations. Instead, it aims to support practices in considering whether their current arrangements remain safe and sustainable and makes recommendations on how to make improvements where this is not currently the case.

4. Sustainable change requires permission to think differently

Many practices have responded to increasing pressure by stretching further, often at considerable personal and organisational cost. While that response has reflected professionalism and commitment, it is not always sustainable.

Developing safer ways of working may require practices to challenge longstanding assumptions, make different choices about how time is used and openly discuss responsibilities that have previously been taken for granted. Sustainable change is more likely when practices feel supported to have those conversations and to test alternative approaches without fear that they are somehow working less. In reality, sustainable working is about creating the conditions in which high-quality care can continue to be delivered over the long term.

Key recommendations

1. Understand the full extent of existing workload

BMA Scotland recommends that all practices should seek to review the actual work being carried out by GP partners, in particular the amount of time spent working outside contracted sessions. The [BMA's GP Diary app](#) is available to members and can assist in this process.

It is particularly important for practices to carry out this exercise at this time as they make decisions on how workforce funding will be used to increase capacity within their practice. The current expansion in practice workforce will give practices the opportunity to make changes to working practices that would be far more challenging without the availability of that resource.

2. Build time to do all work within working patterns

Practices should aspire to build adequate time for non patient-facing work into GPs' working templates. Time spent doing other critical activities is no less important to patient outcomes than direct patient contact. Doing this while making no overall change to the amount of time a GP is contracted for may ordinarily have meant a reduction in patient contacts, but the new workforce funding for 2026-2029 will enable practices to use their expanding capacity to both better support the workload of GPs and to maintain or improve consultation availability to patients.

3. Moving from sessions to hours

Sessions have been the basic unit of GP time for decades, but come from a time when individual GPs would be expected to manage to provide whatever level of care their patients required. In today's modern health system with the enormous pressures GPs face and so much work falling outside contracted sessions, BMA Scotland believes that sessions are no longer helpful as a unit of GP time.

Instead, we recommend that practices begin to consider GP time in hours. While hours are always likely to be indicative rather than directive for partners, this will help to enable practices to build adequate time for all of a GP's responsibilities into working weeks. It will also provide more flexibility to practices for changes in working patterns to be made in units of less than a full session.

Once practices have successfully achieved more sustainable working patterns that encapsulate all aspects of GP work, they should consider reflecting these changes in their partnership agreements.

4. Develop an iterative plan over multiple years

Bringing all aspects of GP work into contracted time along with the other suggestions in this guidance represents a radical change to the way practices have operated for a very long time. Practices will likely need to plan to implement changes in a phased approach and should therefore develop a clear plan for what they want the practice to look like several years into the future and what steps they will need to take to get there. The recommendations in this guidance should be used in conjunction with BMA Scotland's [safe workload guidance](#) and [guidance on maintaining practice profitability](#) to support practices in reaching a future where GP careers are safe, sustainable and fairly remunerated for the critical role they perform.

The breadth of GP work

The domains below are not intended as a job plan or checklist. Rather, they describe the broad areas of work that commonly sit within modern general practice. Not every GP will undertake every element, and the balance will vary between practices and across careers. What matters is that these functions are recognised, distributed appropriately and given sufficient time and attention.

Direct clinical care

Direct clinical care remains at the heart of general practice. It includes face-to-face consultations, telephone and video consulting, asynchronous and electronic consulting, triage, urgent and unscheduled care, home visiting, chronic disease management, procedures and follow-up care.

In some settings, this work may also extend to care homes, community hospitals, dispensing services or other locally commissioned responsibilities. The exact mix will vary between practices and communities.

Sustainable working does not diminish the importance of direct patient care. It recognises that good clinical care depends on having sufficient time around consultations to assess complexity, manage uncertainty, communicate effectively, coordinate care and follow through on decisions safely.

It also supports relational continuity, particularly for patients with complex, chronic or multimorbid conditions who benefit most from ongoing therapeutic relationships.

Indirect clinical care and interface working

A substantial proportion of clinical responsibility in general practice sits outside the consultation itself.

Examples include; reviewing and acting on results, medicines management and prescribing, processing referrals, responding to correspondence from hospitals and community services, preparing reports, dealing with subject access requests, participating in multidisciplinary discussions, managing interface issues and responding to concerns raised by patients, carers or third parties.

Although less visible than appointments, this work is fundamental to patient safety, continuity of care and is an integral part of a GP's professional responsibilities. Failure to recognise it in a GP's working week risks creating unrealistic expectations about capacity and workload. Practices should consider indirect clinical care as a core component of service delivery rather than an activity that occurs around clinical work.

Running the practice

General practice in most instances is both a clinical service and an independent business.

Practices require leadership and management to deliver contractual responsibilities, maintain safe systems and ensure organisational resilience. This work includes partnership and practice meetings, financial oversight, staffing decisions, complaints handling, governance, recruitment, strategic planning, premises management, human resources and regulatory compliance.

Many practices also face the practical challenges of maintaining buildings, equipment, IT systems and day-to-day operations while responding to unexpected events and workforce pressures which can all absorb significant amounts of partner capacity.

Responsibilities may be shared equally or distributed according to experience, expertise and interest. Sustainable working does not require every GP to undertake the same managerial role, but it does require practices to recognise that these responsibilities are essential to the functioning of the organisation and should be valued accordingly. Time spent training in, and delivering, leadership to the practice team is also very important for partners.

Supervision, training and workforce support

Modern general practice increasingly relies on supervision, education and support across a diverse multidisciplinary workforce.

This includes supervision of GP registrars, foundation doctors, medical students, nurses, pharmacists, allied health professionals, newly qualified GPs and colleagues returning to practice. It also includes case discussion, clinical advice, appraisal, mentoring, educational support and day-to-day supervision.

Much of this activity occurs alongside clinical work and can therefore be underestimated when workload is considered. Yet it is fundamental to quality, safety, professionalism and workforce development.

Recognising supervision as a necessary component of core workload supports more realistic planning and helps to create the conditions for a stable and confident workforce.

Quality improvement, cluster working and service development

Sustainable practice involves more than responding to today's demand. It also requires practices to improve systems, learn from experience and contribute to the development of care over time.

This includes audit, quality improvement activity, cluster work, protected learning, service redesign, pathway development, population health initiatives and collaboration with wider system partners.

These activities are often among the first to be displaced when pressure rises. However, they frequently provide the greatest opportunities to improve quality, reduce inefficiency and influence the wider healthcare system. Protecting some capacity for improvement and development is therefore an investment in future sustainability.

Professional responsibilities

Continuing professional development, appraisal, reflective practice, revalidation and engagement with professional guidance are fundamental responsibilities of clinical practice.

These activities are not optional extras to be undertaken only when time permits. They help ensure that clinicians remain current, safe and professionally supported throughout their careers.

Practices that are unable to make space for professional development may find it harder to recruit and retain staff, respond to change and maintain professional standards over time. Sustainable working therefore includes protecting sufficient time for clinicians to learn, reflect and develop.

Promoting relational continuity of care

Relational continuity of care has consistently been associated with improved outcomes for patients as well as greater GP job satisfaction. Systematic reviews have found that higher continuity with a doctor is associated with lower mortality, while more recent evidence suggests continuity may reduce hospital admissions, emergency department attendance, demand for GP appointments and fragmentation of care.

Continuity also contributes to patient trust, professional satisfaction and more personalised decision-making. For patients with multiple long-term conditions, frailty or complex psychosocial needs, continuity can be especially valuable.

Importantly, continuity does not occur by chance. It depends on working patterns that allow relationships to develop over time and on systems that support clinical responsibility, follow-up and knowledge of patients as individuals.

At the same time, continuity has become increasingly difficult to sustain. Rising demand, workforce pressures and growing service complexity have all contributed to more fragmented patterns of care. While evidence suggests that specific interventions may help improve continuity, the effectiveness of individual approaches varies considerably between settings.

This reinforces the importance of local adaptation rather than a single prescribed solution. Practices are best placed to determine which aspects of continuity are most important for their populations and how those can be protected within available resources.

The wider evidence also highlights that continuity should not be viewed in isolation from sustainability. Demand, capacity, workforce availability and organisational resilience all influence a practice's ability to maintain relationship-based care. Sustainable working therefore requires deliberate consideration of how continuity can be preserved alongside the equally important goals of timely access, patient safety and workforce wellbeing.

For practices in Scotland, this suggests that sustainability is not simply about increasing activity. It is about creating the conditions in which high-quality, relationship-based care can flourish despite increasing complexity and demand.

Using this guidance in practice

This guidance is intended to support reflection rather than be directive. Its purpose is not to create additional processes or reporting requirements, but to help practices develop a more realistic understanding of how work is currently organised and support practices in moving to models that are more sustainable.

For some practices, the guidance may simply validate arrangements that are already working well. For the majority, however, it should prompt discussion about hidden workload, role distribution, partnership expectations or areas where current ways of working depend too heavily on goodwill.

Useful questions may include:

- Which parts of our work are visible and which remain largely unseen?
- Where are we relying on unrecognised effort to keep the practice functioning?
- Is our current distribution of work fair and sustainable?
- Are leadership, supervision and improvement activities adequately recognised?
- Do our working patterns provide sufficient time for safe patient care and professional development?
- Which aspects of our model are strengthening sustainability and which may be undermining it?

The aim is not to create anxiety or bureaucracy, but to support more open conversations about what modern general practice requires and how that work can be organised sustainably.

Understanding your current working pattern

Before deciding what needs to change, practices may find it helpful to understand how work is currently being undertaken.

In many practices, the visible timetable tells only part of the story. Appointment books may be clear and measurable, while supervision, leadership, problem-solving, workflow management and follow-up activity occur in less visible ways. Much of the work that sustains safe care will therefore be absent from formal schedules despite occupying significant time and attention.

A useful first step may be a short period of structured reflection or time mapping. This need not be complex. Practices might simply review a typical week and consider:

- How much time is spent in direct patient care?
- How much time is spent on indirect clinical work?
- Which activities regularly occur outside scheduled sessions?
- Where are interruptions most common?
- Which responsibilities are concentrated on a small number of individuals?
- Which tasks have no clearly identified owner?

The **BMA's GP Diary app** which is available to BMA members is a straightforward way to carry out this time mapping. Even a relatively simple exercise can reveal hidden workload, duplicated effort, recurrent bottlenecks and responsibilities that have gradually become normalised without ever being formally acknowledged.

Practices may also find it helpful to consider who carries the cognitive load of the organisation. Every practice contains individuals who monitor risk, notice emerging problems, remember unfinished tasks and ensure that issues are followed through when ownership is unclear. These functions are often essential to safety and continuity but rarely appear in formal job plans or timetables.

Understanding the current reality is not an end in itself. It provides a foundation for deciding what changes are needed and where effort is most likely to deliver benefit.

Making change in a manageable way

Recognising the need for change is often easier than implementing it.

Most practices must continue delivering care while adapting to pressure, which means large-scale redesign can feel difficult or risky. For that reason, sustainable change is often most successful when approached incrementally.

Rather than attempting wholesale transformation, practices may benefit from testing small changes, learning from experience and gradually refining their approach. This allows changes to be adapted to local circumstances and reduces the risk of unintended consequences.

Sustainable models rarely emerge fully formed. More often they develop through a series of small adjustments that gradually improve how work is organised and supported.

TURAS provide practical tools to support quality improvement that practice may find useful and are available [here](#).

Using small tests of change

One practical approach is to use simple improvement methods such as Plan-Do-Study-Act (PDSA) cycles.

In its simplest form, this involves:

1. Identifying a specific problem or pressure point.
2. Agreeing a small change to test.
3. Predicting what effect the change is expected to have.
4. Testing the change for a defined period.
5. Reviewing the outcome.
6. Deciding whether to adopt, adapt or abandon the change.

The value of this approach is that it allows practices to learn from real-world experience within their own setting rather than committing immediately to large-scale change.

Suitable areas for testing may include:

- Protecting dedicated time for indirect clinical work.
- Clarifying supervision arrangements.
- Making leadership or management time more visible.
- Creating document-management or workflow sessions.
- Redesigning meeting structures.
- Reviewing allocation of incoming correspondence.
- Improving ownership of recurring tasks.
- Reducing interruptions to managerial or supervisory work.

The objective is not to identify a universally correct solution. Different practices will require different approaches. What matters is creating space to test ideas safely and evaluate whether they improve sustainability.

Reviewing change

When reviewing a test of change, practices may wish to consider both quantitative and qualitative measures.

Possible quantitative measures include:

- Appointment availability.
- Workflow backlogs.
- Results-processing times.
- Session overruns.
- Continuity measures.
- Time worked beyond planned sessions.

Equally important are qualitative indicators such as:

- Whether clinicians feel less rushed.
- Whether supervision feels more manageable.
- Whether workload is perceived as equal.
- Whether staff wellbeing has improved.
- Whether professional satisfaction has changed.

Practices may also wish to consider balancing measures to ensure improvements in one area do not create problems elsewhere. For example, a change that increases capacity may inadvertently reduce continuity, while a reduction in administrative burden for one group may transfer pressure to another.

Sustainable models depend on professional judgement as well as metrics. The experiences of staff and patients remain important sources of evidence.

Embedding change over time

When a change proves beneficial, the next challenge is ensuring that it becomes part of routine practice rather than an informal exception.

Successful changes are more likely to endure when they are visible, understood and explicitly supported by the wider team. This will often involve adjusting rotas, clarifying responsibilities, documenting agreed arrangements or reviewing partnership expectations.

Without this step, improvements can gradually erode as pressures increase and old patterns re-emerge.

Practices may also benefit from sharing learning through clusters, Local Medical Committees and professional networks. Hearing how others have approached similar challenges can provide reassurance, generate ideas and reduce the sense that individual practices must solve sustainability challenges alone.

Meaningful cultural change rarely occurs through a single intervention. More often it develops through a series of deliberate, incremental improvements that gradually create safer, fairer and more sustainable ways of working.

Worked examples

The examples below are illustrative only. They are not intended to define the right approach for any practice, but to demonstrate how the principles described in this guidance might be applied in different settings.

Example 1: Reducing invisible work in an urban practice

A larger urban practice has concluded that the greatest threat to sustainability is not the number of consultations being delivered, but the accumulation of work surrounding them. Results management, prescribing queries, workflow, supervision and clinical correspondence are all consuming significant amounts of unrecognised time outside of contracted hours.

Rather than redesigning the entire service, the partners might begin by making one indirect-clinical-care session available within the weekly rota. They may also clarify ownership of incoming workflow and review how supervisory responsibilities are distributed across the team.

After a trial period, the practice assesses whether backlogs have reduced and whether clinicians are working less frequently beyond planned hours. If successful, the changes become part of the routine working model and inform wider discussions about workload distribution.

Example 2: Building resilience in a rural or remote practice

A rural, island or remote practice faces different challenges. Clinical scope in this instance is broader, workforce recruitment more difficult and access to wider system support more limited.

In this context, sustainability may depend less on increasing capacity and more on protecting organisational resilience. A practice uses this guidance and determines that key responsibilities are concentrated in too few individuals, that urgent work regularly disrupts planned activity, and that business and governance functions are receiving insufficient attention.

The resulting changes may be relatively modest. Making responsibilities more explicit, protecting time for essential non-clinical work and developing clearer contingency arrangements may nevertheless reduce organisational fragility and improve resilience over time.

Example 3: Using new investment to reshape GP time

As additional investment becomes available, practices may wish to consider how new resources can support sustainability rather than only increasing activity.

A practice might choose to use additional capacity to make leadership, supervision or quality-improvement time protected within GP working patterns. Others focus on reducing dependence on work undertaken beyond scheduled hours by building in sufficient time for non patient-facing work in work patterns.

The key question is not simply whether a practice can do more, but whether it can organise the whole job more honestly and sustainably. In many cases, investing in protected time for leadership, supervision and development will improve patient care just as effectively as increasing appointment capacity alone.

Example 4: Realising BMA safe workload limits

GPs in a practice are routinely providing more than the BMA and European recommended safe limit of 25 clinical contacts per day. While this limit can vary with the complexity of cases dealt with, clinical workload pressures in this practice are risking burnout in the GPs. With the help of their Practice Manager, GPs change the appointment system to ensure daily appointments per GP do not exceed this, by balancing the types of appointments and ensure all work is listed on the appointment screen. They may utilise the new workforce funding to employ additional GP hours to ensure increasing practice capacity also means that individual workloads are now sustainable, creating longer term stability within the team.

Conclusion

General practice remains one of the NHS's greatest strengths. It delivers comprehensive, relationship-based care close to home, manages complexity, coordinates services and provides continuity across the patient journey. Its contribution to the sustainability of the wider healthcare system is substantial and increasingly important.

Sustaining those benefits however, requires a more complete understanding of the work involved. Consultations remain central to the role, but they represent only part of what modern general practice requires. Safe and effective care also depends on indirect clinical work, supervision, leadership, governance, quality improvement and professional development.

Sustainability begins with recognising that reality. When the full scope of GP work is brought within formal working patterns, practices are better able to organise time sustainably, reduce reliance on invisible labour and develop models that are safer for patients and more sustainable for clinicians.

The guidance is not intended as a blueprint. Practices across Scotland face different challenges and will therefore need to develop different solutions. What matters is that practices have the confidence and permission to examine how work is organised, identify areas of strain and make deliberate changes where needed.

Boards, policymakers and system leaders also have an important role. Sustainable general practice cannot be secured through appointment capacity alone. It depends on creating the conditions in which continuity, clinical responsibility, supervision, leadership and improvement can all be sustained as part of normal professional life.

The opportunity now is not simply to manage pressure, but to build a stronger future. By recognising the whole GP role and supporting working patterns that reflect the realities of modern practice, Scotland can strengthen the partnership model, improve workforce sustainability and preserve the relationship-based care that remains at the heart of general practice.

This guidance should therefore be read as a statement of professional reality: Sustainable general practice depends on recognising the whole job, not just the parts that are easiest to count.

Further reading on continuity of care

Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH.

Continuity of care with doctors: a matter of life and death? A systematic review of continuity of care and mortality.

BMJ Open. 2018;8(6):e021161.

DOI: 10.1136/bmjopen-2017-021161

Link: [BMJ Open article \[bmjopen.bmj.com\]](https://bmjopen.bmj.com)

Baker R, Freeman GK, Haggerty JL, Bankart MJ, Nockels KH.

Primary medical care continuity and patient mortality: a systematic review.

British Journal of General Practice. 2020;70(698):e600-e611.

DOI: 10.3399/bjgp20X712289

Link: [BJGP article \[bjgp.org\]](https://bjgp.org)

Engström SG, André M, Arvidsson E, Östgren CJ, Troein M, Borgquist L.

Personal GP continuity improves healthcare outcomes in primary care populations: a systematic review.

British Journal of General Practice. 2025;75(757):e518-e525.

DOI: 10.3399/BJGP.2024.0568

Link: [BJGP article \[bjgp.org\]](https://bjgp.org)

Fox MN, Dickson JM, Burch P, Hind D, Hawksworth O.

Delivering relational continuity of care in UK general practice: a scoping review.

BJGP Open. 2024;8(2):BJGPO.2024.0041.

DOI: 10.3399/BJGPO.2024.0041

Link: [BJGP Open article \[bjgpopen.org\]](https://bjgpopen.org)

Royal College of General Practitioners.

Continuity in Modern General Practice.

London: RCGP; 2023.

The Health Foundation.

Continuity of care: why it matters and how it can be measured.

London: The Health Foundation; 2024.

Appendix: Practical prompts for practices

Reflective prompts for partnership or practice discussion

Practices may find it helpful to use the following prompts when discussing sustainability:

- Which parts of our work are currently visible in the rota and which are largely hidden?
- Which tasks regularly spill into lunch breaks, evenings or days off?
- Are indirect clinical care, supervision, managerial work and professional development being protected in any meaningful way?
- Does our current model depend on particular individuals carrying a disproportionate amount of cognitive load, responsibility or risk?
- Are there parts of the role that are essential to the functioning of the practice but are not openly recognised in how time is planned?
- Have we reviewed whether our current arrangements still reflect the reality of the work we now do?

A simple self-review checklist

- We have a shared understanding of the full range of GP work in our practice.
- We recognise indirect clinical care, supervision and business management as legitimate work.
- We can identify where work is currently hidden or reliant on goodwill.
- We have considered whether key responsibilities are fairly distributed.
- We protect some time for development, reflection and improvement.
- We are able to test change on a small scale before making it routine.
- We review whether changes improve sustainability without creating new risks elsewhere.

A simple PDSA framework for practices

Plan:

Identify one pressure point or one part of the working pattern that feels unsustainable. Agree one small change to test, decide how long to test it for, and make a simple prediction about what you expect to improve.

Do:

Test the change on a small scale. Keep it manageable and avoid trying to redesign multiple parts of the system at once.

Study:

Review what happened. Consider both formal indicators, such as backlog, waiting time, continuity or overrun, and informal indicators, such as whether clinicians felt less rushed or whether the change seemed fairer and more workable.

Act:

Decide whether to adopt the change, adapt it and test again, or stop. If the change helped, make it visible in the normal working pattern so that it is not lost when pressure rises again.