Written evidence submitted by Dr Emma Hayward (EPW0002)

Introduction

I am answering the questions that relate to primary care and to undergraduate medical education. There are many documents containing evidence that pertains to the questions posed. I will make comments from my point of view as a GP and medical educator about lived experience of the commitments made by government and provide links to relevant documents and data.

I am giving evidence as a practising GP and clinical educator at Leicester Medical School. The views I express are my own and do not represent the views of the organisations I work for.

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Planning for the workforce

Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs.

Meeting workforce targets

This commitment has been undermined by recent votes in the House of Commons when Conservative MPs voted against independent estimates for the NHS workforce. This was hugely disappointing for those of us who work in the NHS. Without a robust and realistic plan it is very difficult to see how we can recover from our current situation. The House of Commons vote extinguished any hope I had of things improving in the short-medium term and made it much more likely that I will leave the profession in the near future.

Current levels of staffing/6,000 more doctors in General Practice

This commitment has not been met and indeed the number of Full Time Equivalent (FTE) GPs has fallen. Current levels of staffing in general practice are inadequate to meet increasing demand. Those who remain are less likely to become partners with the extra workload this entails. This is not because newly qualified GPs lack the dedication of previous generations. In a system where the demand on primary care is unlimited, the only way many GPs can see to protect themselves from burnout is to work as a locum or salaried doctor where the pressures relate only to clinical workload without additional responsibility for running a practice. Pre-pandemic levels of burnout amongst GPs were high, compared to other professions and have since increased. I have never worked with so many colleagues suffering the effects of burnout than I do now.

On a day-to-day basis the lack of GPs available puts increased pressure on those of us remaining. We are acutely aware that, despite working long days to see as many patients as possible, there are many people who are still unable to get an appointment. This is frustrating to us because we know some of the current pressure in Emergency Departments could be relieved if people were able to see a GP in a timely manner but this is just not possible. Once the day of consulting is over the paperwork to complete is overwhelming. If a practice is relying on locums who don't take on paperwork then all blood results, scanned hospital letters and tasks are divided among the remaining GPs. This takes hours each day and many colleagues complete it at home, working until late at night. Filing results and letters is not just an administrative task – there are clinical decisions to make based on results, and there are safety implications for this work being completed by tired doctors at the end of a long working day. Awareness of the pressure on other staff members means

that GPs are reluctant to take time off, even when they are unwell, because they don't want their colleagues to have even more additional work.

Plugging some of the gaps left by GP vacancies with allied health professionals has not been fully effective. Physician associates and Advanced Nurse Practitioners do not always work at the same speed as a fully qualified GP. They have limitations on the patients they can see, and also require supervision for complex cases – with the burden of risk falling on their supervising GP. In addition, removal of minor illnesses from the regular GP workload means that GP lists are now full of more complex cases which we are expected to manage in traditional ten minute appointments. This requires intense concentration as we manage complexity and uncertainty. There is no chance to catch up on time or to have a mental break with a more straightforward case later on the list. Booked lists inevitably over-run leading to frustration for the patients and denying the GP time to have proper rest breaks. In addition to working through their list of patients, GPs are often interrupted with queries from people they are supervising within the practice, adding to the cognitive load. In addition, ambulance crews seem under pressure not to convey people to hospital and often call GPs to corroborate findings and confirm their clinical decisions. This is not a service Primary Care is funded for and leads to safety concerns as it interrupts the other work they are doing.

Whilst Covid-19 has accelerated some of the pressure on the GP workforce, the issues were present (and flagged up to the Department of Health) long beforehand.

There is little that can be done at a local or regional level to recruit/retain more GPs as it is wider systems issues that are causing the problem, namely:

- Workload
- Adverse media coverage
- Punitive regulatory framework
- Pensions cap leading some to leave the workforce early

However, instead of government taking responsibility for these issues, the burden has been placed on individual GPs, practices and NHS England.

Was the commitment effectively funded/resourced?

From the point of view of a practising GP I have not been made aware of any resources or funding to achieve this aim. However, I am aware of government statements that increase the workload and expectations of General Practice and contribute directly to GPs leaving the profession.

Relevant papers:

https://bjgp.org/content/72/715/e148 (Identifying how GPs spend their time and the obstacles they face: a mixed-methods study)

https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice-data-analysis

https://bjgp.org/content/72/718/e307 (Primary care workforce composition and population, professional, and system outcomes: a retrospective cross-sectional analysis)

https://bjgp.org/content/72/718/206#ref-list-1 (GP workforce crisis: what can we do now?)

https://bjgp.org/content/72/718/204 (The workforce crisis in general practice)

https://www.pulsetoday.co.uk/news/workforce/new-data-claiming-gp-workforce-growth-disingenuous-gaslighting-says-bma/

https://www.pulsetoday.co.uk/news/workforce/gp-retention-is-in-long-term-decline-finds-major-study/

https://www.pulsetoday.co.uk/news/workforce/gps-twice-as-likely-to-report-burnout-as-reason-for-leaving-nhs-report-shows/

Increasing medical student numbers by 1,500/year

There has been an increase in medical student numbers but despite this, there are still insufficient UK graduates to meet the needs of the future NHS (https://www.medschools.ac.uk/media/2899/the-expansion-of-medical-student-numbers-in-the-united-kingdom-msc-position-paper-october-2021.pdf). It is not clear to me whether the 1,500 extra medical student places includes those allocated to overseas students and therefore whether all of the extra students will remain in the UK after graduation. Simply expanding medical student numbers will not benefit patients or the NHS if they do not remain in post. This article, by a final year medical student, summarises the issues well:

https://www.bmj.com/content/374/bmj.n1998/rr

It is appropriate to increase medical student numbers but this commitment did not go far enough, either in terms of numbers or in terms of addressing issues that would enable the NHS to retain the doctors it is training. Therefore, achieving this target alone cannot be an effective measure of policy success.

In order to enable to UK to reduce its reliance on medical staff from overseas there is a need for further investment in healthcare education. This needs to include funding for:

- University academic and administrative staff
- Expansion of teaching spaces (both university based and within hospitals and primary care)
- Financial support for all healthcare students undertaking placements in primary and community care where accommodation and transport are barriers to a successful placement.

Increasing primary care professionals

About 7 years ago at Leicester Medical School we rewrote our curriculum. Cognisant of workforce challenges we more than doubled our students' time in primary care, giving them opportunity to become an integrated part of the practice team. Initial feedback appeared to show that this approach was effective in changing student attitudes towards general practice and seeing it in a more positive light. Not every medical school has been able to do this.

The payment to practices who take medical students has improved over recent years but practical issues such as reimbursement for travel or accommodation to more remote practices must be addressed if we are to provide adequate placements. Tariffs for nursing and pharmacy student placements in primary care fall woefully short of the actual cost of delivering them and act as a disincentive to providers.

Once on placement, students need to receive high quality teaching from primary care professionals who have been trained to deliver it. In Leicester we have an large cohort of enthusiastic GP tutors but this is not true in every medical school. I believe we have this group because we have over many years developed a learning community and invested in their development as teachers which is now

paying dividends. However, the resources to maintain this area of faculty development are not guaranteed.

Nationally GPs are making difficult decisions about where to cut back on activity because of the overwhelming clinical pressures. We must invest in them as teachers or we will end up unable to educate future GPs.

If we get these things right we have the potential to provide meaningful GP placements for medical and allied health students. Expanding undergraduate education in primary and community care will not only enable us to increase the numbers of medical and allied health graduates but may also encourage these graduates to choose to work in non-hospital specialities**, but only if their experience is a positive one.**

Wellbeing at work

Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services.

This is a laudable aim but does not acknowledge the role of the working environment in creating the problems in the first place. There is an emphasis elsewhere in the Conservative manifesto about prevention of illness but this does not seem to have been applied to the NHS workforce.

Was the commitment met/is it on track to be met?

There is no deadline for implementation and "quicker access" has not been defined. Given that NHS waiting lists for outpatients are now stretching to years, "quicker" could still mean significant waiting times.

The Practitioner Health service is an example of an excellent service that provides specialist help for doctors who are unwell. However, they deal only with the "tip of the iceberg" – doctors who are so unwell they feel compelled to seek help. Whilst other professions e.g. therapists, who support people in distress have regular, mandatory supervision sessions, there is no such support for GPs who regularly hear stories of mental distress, domestic violence and other trauma from their patients. Managing patients' distress and bearing individual responsibility for their wellbeing whilst managing multiple other work pressures is enormously stressful for all GPs. Expanding Practitioner Health and exploring ways to proactively improve GP wellbeing (rather than waiting for them to self-declare their need for help) would be a positive step to achieving this commitment.

Other factors increasing stress and ill-health amongst the NHS workforce which have yet to be addressed by government include:

Fear. A 2018 survey (https://www.bma.org.uk/media/2035/bma-caring-supportive-collaborative-survey-report-sept-2018.pdf) showed that 45% of doctors are often fearful of making a medical error and that 55% said that they were more fearful than five years previously. At that time 89% stated that one of the main reasons for making errors was pressure or lack of capacity in the workplace, with 93% stating that system pressures have a negative impact on their ability to provide safe care. Given that this survey data was collected before the Covid-19 pandemic and that pressures on the NHS are now even more acute, I suspect that this issue has worsened considerably.

Apart from the moral injury that results from working in a system that does not support them to provide the best care for their patients, **doctors also fear being held to account for systems failings beyond their control** (see survey above, section 2.1). This is not unfounded. It was seen in the case

of Dr Bawa-Garba but also more recently in the case of Dr Yeh (https://www.mpts-uk.org/-/media/mpts-rod-files/dr-peter-yeh-17-feb-22.pdf).

It is simply not fair for individual doctors to be left with responsibility for delivering perfect outcomes in a far from perfect system. The stress of knowing that on any working day we could be involved in a case that leads to loss of our livelihood, or even our liberty, is a major factor contributing to doctors leaving the profession. If the GMC was only allowed to sanction doctors where it can be **proved** that no systems errors contributed to the complaint against them this would be more reassuring to the profession and alleviate some of our anxieties**.** The GMC should also be held to account for the length of time it takes to bring an investigation to its conclusion. The case of Dr Yeh took 4 years from the date of the alleged incident. Subjecting doctors to prolonged and stressful fitness to practice procedures is harmful to them personally and to the profession more generally.

Workload. I have worked in the NHS for nearly 20 years and as a GP for nearly 16 years. The workload has risen, and continues to rise, inexorably. It feels unmanageable, because it is. Going to work each day knowing that you will be unable to meet the demand or to achieve the best for your patients is terribly demoralising. A study in 2018 concluded: *The existing literature has identified increasing workloads, time pressures, long hours and bureaucratic demands as key causes of work-related stress/distress among GPs.[5 11–13 27 28] Participants in this study also highlighted sources of stress associated with the fear of making mistakes, inspections, complaints and inquests, as well as the pressures associated with the revalidation and the appraisal process—the latter regarded as unhelpful, time consuming and of little value.[29] The emotional component of work in general practice and its impact on GP well-being is supported by previous evidence highlighting the impact of the emotional demands of working with patients and exposure to suffering.[5]* (Riley R, Spiers J, Buszewicz M, et al What are the sources of stress and distress for general practitioners working in England? A qualitative study BMJ Open 2018;8:e017361. doi: 10.1136/bmjopen-2017-017361)

However, instead of acknowledging the pressures on the workforce, the government continues to raise expectations among the public about what can be achieved (https://practiceindex.co.uk/gp/blog/news-practices-ordered-to-undertake-50-million-more-appointments/).

Steps that government could take include:

- Acknowledging that excessive workload and high expectations increases stress amongst healthcare workers and that this results in people leaving the workforce
- Immediately addressing the retention issue by changing the pension regulations which act as a disincentive to continuing work
- Being realistic with the public about the capacity of Primary Care to deliver safe care and managing expectations
- Publically challenging unreasonable or negative portrayals of primary care in the media

Relevant papers:

https://bjgp.org/content/bjgp/66/643/e128.full.pdf (Lost to the NHS: a mixed methods study of why GPs leave practice early in England)

https://www.bma.org.uk/media/2035/bma-caring-supportive-collaborative-survey-report-sept-2018.pdf

https://bmjopen.bmj.com/content/8/1/e017361 (What are the sources of stress and distress for general practitioners working in England? A qualitative study)

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