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This evidence is based upon our knowledge of research evidence in this area, and the experience that some of us have had as GPs. We are responding specifically with respect to those commitments which pertain to General practice workforce, specifically the set of questions labelled '1' in the briefing document (focusing upon Planning for Workforce). We have included links to cited documents in the text below.

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1. PLANNING FOR THE WORKFORCE

Commitment: - Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs.
Including evidence on:

- ☐ ***Current levels of staffing***
- ☐ ***Whether workforce targets set for various staff groups has been met, including Government targets:***
  - ***6,000 more doctors in general practice (from the Conservative's 2019 Manifesto Commitments)***
  - ***26,000 more primary care professionals (from the Conservative's 2019 Manifesto Commitments)***

Questions:

A. Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?

1. Does the commitment have a deadline for implementation?

Both the commitment to 6000 more doctors in general practice and the commitment to 26,000 more primary care professionals had a deadline of 2024. There is a consensus that the commitment to 6000 more doctors is highly unlikely to be met (eg https://www.nuffieldtrust.org.uk/nhs-staffing-tracker/general-practice#general-practice). It is also the case that this commitment was lacking in specificity; for example, it is unclear if it refers to headcount of full time equivalent staff, and it is unclear whether it includes GPs in training as well as fully qualified staff.

Table 1. GP workforce statistics. December 2019 and March 2022[1]

	Dec-19	Mar-22	Change	%Change
HC				
All GPs	43,442	45,280	1,838	4%
All fully qualified	36,760	37,092	332	1%
FTE				
All GPs	34,519	35,988	1,470	4%
All fully qualified	28,129	27,769	-360	-1%

2. Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?

Whist there has been a small increase in the number of GPs entering the profession from training schemes, the increase in less than full time working means that overall availability of GPs has decreased (https://www.nuffieldtrust.org.uk/news-item/what-does-the-gp-workforce-look-like-now). The commitment to recruit 6000 more GPs was not accompanied by any specific implementation mechanisms, beyond an already existing scheme (started in 2016) to enhance recruitment in areas where it was difficult to recruit via an additional payment of £20,000 (https://www.england.nhs.uk/gp/the-best-place-to-work/starting-your-career/recruitment/), an increase in training places and a suggestion that more doctors would be recruited from overseas (https://www.bbc.co.uk/news/health-50351861). It is therefore not surprising that it is unlikely to be met by 2025. We are not aware on any specific research or evaluation addressing in any detail the question of why GP recruitment and retention has proved difficult to address. It is likely that the underlying cause of this failure is multi-factorial, and may include: a perception amongst newly qualified doctors that general practice may not be a satisfying career, possibly arising out of experiences at medical school (Spooner, Pearson et al. 2017); early career GPs feeling under-prepared for their new role (Spooner, Laverty et al. 2019); issues with pension taxes accelerating older GPs leaving the profession; publicity around workload pressures in general practice hindering recruitment; lack of specific targeted measures to address the policy; and ongoing pressure and work-related stress accelerating GPs' decisions to leave direct patient care.

The commitment to 26,000 more primary care professionals in general practice was associated with the establishment of Primary Care Networks (PCNs), with funding for these new post channelled to

[1] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-march-2022

these new groupings of GP practices (see our recent report for an explanation of PCNs and the associated policy framework). Whilst many such professionals have been employed (see section B below), many areas have struggled to recruit staff: in February 2022, halfway to the implementation deadline of 2024, less than half the intended 26,000 staff had been recruited (https://www.gponline.com/multi-billion-pound-pcn-recruitment-scheme-fails-meet-halfway-target/article/1740916), with the Chair of the Royal College of GPs commenting at the time:

> *''It's great to see that around 12,000 people recruited so far through the ARRS scheme, but these figures are further evidence that efforts need to be urgently stepped up to catch up and meet the target of 26,000 members of the wider general practice workforce by 2024".*

This is in part because PCNs are recruiting in a pool of staff which was not itself expanding. Thus, they are competing with other services. For example, ambulance Trusts have raised concerns about being unable to recruit sufficient staff due to an increase in recruitment in primary care. Furthermore, over the past year in particular there has been significant negative press coverage about services in general practice, with a media narrative that GPs were not offering appropriate services and were, in some way 'closed', with a negative impact on the rest of the NHS (for example: https://www.dailymail.co.uk/news/article-10139701/Sajid-Javid-says-lack-face-face-appointments-piling-pressure-Es.html). This is in spite of the fact that data shows a record number of appointments being delivered in primary care, with a significant proportion taking place face to face. The recent 11th National GP Worklife Survey found that 55% of respondents reported 'considerable' or 'high' pressure from adverse publicity in the media. Such coverage can be demoralising, with GPs' representative bodies expressing concern about the damaging effect on staff morale (https://www.theguardian.com/politics/2021/oct/14/whats-behind-sajid-javids-row-with-gps) with potential knock on effects on recruitment and retention. Importantly, the 11th National GP Worklife Survey found that in 2021 15.5% of GPs under the age of 50 reported a considerable/high intention to quit. It was figure was only 7.1% in 2008, suggesting a significant increase in GPs intending to leave the profession early. This is very important in considering future workforce planning.

One important mitigating approach would be to be flexible in the types of staff that can be recruited. Initially PCNs were restricted to a small number of different types of professionals, although the number of different roles included in the scheme has increased over time. The policy may have been more successful in meeting the target if this flexibility had been allowed from the outset (see, for example, a report from the King's Fund: https://www.kingsfund.org.uk/publications/integrating-additional-roles-into-primary-care-networks) (Baird, Lamming et al. 2022). Further mitigation would have included a comprehensive workforce plan that sought to project required workforce numbers across sectors in order to ensure that recruitment within one sector did not adversely affect other sectors, and additional bespoke training provision for staff transferring to primary care from secondary or other sectors would dhave been helpful.

3. To what extent has the Covid-19 response affected progress on targets?

Covid-19 has undoubtedly affected progress against these targets, although this is difficult to quantify. The requirement for NHS staff to deliver the Covid-19 vaccination programme may have impacted the availability of suitable staff. In addition, the pandemic disrupted medical student and GP speciality training; it is as yet unclear what impact these may have had on entry to the profession.

4. How has this commitment been interpreted in practice at local authority/care provider/trust level?

There is no local Trust involvement in the commitment to the employment of additional doctors. CCGs are responsible for commissioning local primary care services until July 2022 and therefore have had a role in supporting recruitment and retention of doctors. This responsibility is now passing to Integrated Care Systems (ICSs) and it is unclear how they will enact this role. The role of Health Education England is also changing, with its incorporation into MHS England. It is not currently clear how this will affect their activities.

In terms of PCN recruitment of additional types of primary care clinicians, local Clinical Commissioning Groups have had an important role in supporting PCNs (Hammond, Warwick-Giles et al. 2020, Warwick-Giles, Hammond et al. 2021). However, the merger of CCGs and their immanent disbandment (as a consequence of the recent Health and Care Act) has had a potentially negative impact on the support available (Checkland, Allen et al. 2021). In particular, the loss of local expertise and loss of a local support function has in the past been shown to have a negative impact on the support and oversight of primary care services (McDermott, Checkland et al. 2019), and it seems likely that the transfer of these responsibilities from CCGs to much larger Integrated Care Systems will reduce the local support on which PCNs have so far depended. There is currently little clarity as to how local service oversight and support will function at what is being called 'place' level, and it remains to be seen how PCNs will be supported to continue to employ new types of clinical workers in pursuit of the target.

B. Was the commitment effectively funded (or resourced)?

1. Were specific funding arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and where were they made?

With respect to the extra 6000 doctors in general practice, no specific additional funding was made available beyond an existing 'targeted enhanced recruitment scheme offering additional payments to GPs entering practice in deprived areas (https://www.england.nhs.uk/gp/the-best-place-to-work/starting-your-career/recruitment/). In particular, three has been no targeted investment in retention of the existing workforce

In addition, some funding was provided to Health Education England to support the development of early-career Fellowships for newly qualified GPs (https://www.hee.nhs.uk/our-work/gp-fellowships#:~:text=The%20HEE%20post%2DCCT%20fellowships,fellowship%20opportunities%20in%20your%20area). The aim of these is to increase the proportion of qualified GPs who enter the workforce by providing them with additional support, educational and other opportunities. It is intended that these additional opportunities will make a career in general practice more attractive and prevent qualified GPs from leaving the UK or deciding not to practice. Finally, there was an increase in the number of training places available in general practice. However, prior to this policy training schemes were rarely fully subscribed, reducing the likely impact of this change.

With respect to the additional clinical staff in primary care, funding is provided via an 'add on' contract which is in addition to the standard General Medical Services contract. The funding available to PCNs and the mechanisms by which it is calculated are set out in our recent paper: https://bjgp.org/content/71/710/422. (Hutchinson, Hammond et al. 2021).

2. What factors were considered when funding arrangements were being determined?

Funding for PCNs builds upon existing funding formulae, and is available to PCNs to claim. However, although exact figures can be difficult to find, it is clear that some PCNs have struggled to spend the money available to them. Our analysis of the funding approach taken suggests that it fails to adequately account for deprivation, with a risk that deprived practices will be further disadvantaged by the funding mechanisms chosen (https://bjgp.org/content/71/710/422).

3. Do healthcare and social care stakeholders view the funding as sufficient?

In the case of PCNs and the additional 26,000 staff, funding overall is less of an issue than the availability of qualified staff and the need to find space within the existing primary care estate for them to practice. The distribution of funding as noted above could be better adjusted to account for need.

4. Was any financial commitment a 'new' resource stream? If not, did reallocation of funds result in any unforeseen consequences/ undesirable 'work arounds' at local level?

Yes, the PCN funding was a new stream of funding. However, it is a funding stream which is tied to a highly specified contract as set out above, with particular difficulties experienced in the early stages when practices were restricted as to which roles they could recruit to (Baird, Lamming et al. 2022). Furthermore, the scheme did not take account of existing practice staff profiles, resulting in some PCNs which had been previously proactive in recruitment of a wide range of staff missing out on funding. It is possible that a more flexible scheme from the outset may have allowed more rapid recruitment and tailoring of workforce to local needs. It is also possible that, rather than allocating the money to groups of practices working together as PCNs, allocating additional funding directly to practices may have been a more flexible approach. This has worked in the past when, for example, direct reimbursement of salaries to practices rapidly increased the number of nurses employed (Bloor and Maynard 2003).

C. Did the commitment achieve a positive impact for patients and service users? (Indirectly through impacting workforce)

1. Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?
2. Will (or have) staff, patients or service users benefit(ted) directly, indirectly or both?
3. What category of staff, patients and service users have benefitted? And why?
4. Have some staff, patients and service users been adversely impacted by the commitment and its implementation?

We will answer these questions together.

It is difficult to draw conclusions about the impact of these policy commitments on patient outcomes, as there are many other factors at work.

With regard to the commitment to 6000 doctors in primary care, there is some weak evidence that improved access to primary care may be associated with reduced hospitalisations for what are called 'ambulatory care sensitive conditions' (i.e. conditions for which improved medical care should improve outcomes) (Gibson, Segal et al. 2013). Furthermore, there is increasing evidence that continuity of care is associated with improved outcomes (for example see: https://bjgp.org/content/72/715/e84.abstract) (Sandvik, Hetlevik et al. 2021), and some evidence

that continuity of care in England is declining: https://bjgp.org/content/71/707/e432.abstract (Tammes, Morris et al. 2021). It is therefore plausible that failing to meet the target of 6000 new doctors in general practice will result in poorer outcomes, and that meeting that target may contribute to at least preventing a decline in outcomes.

With regard to the commitment for 26,000 additional healthcare workers in primary care, our own work has shown that integrating such workers into primary care is not straightforward (Spooner, McDermott et al. 2022), requiring complex practice processes and with a significant need for GPs to undertake additional work in the training and supervision of the new workers. These findings were confirmed by research undertaken by the King's Fund cited above (Baird, Lamming et al. 2022). Our study of outcomes associated with different patterns of skillmix found the following associations:

> *Having additional GPs was associated with higher levels of satisfaction for the GPs themselves and for patients, whereas additional staff of other types had opposite associations with these outcomes. Having additional nurses and health associate professionals was associated with lower costs per prescription but more prescribing activity than having additional staff from the other two groups. Having more GPs was associated with higher costs per prescription and lower use of narrow-spectrum antibiotics compared with the other staff groups. Except for health associate professionals, greater staff numbers were associated with more hospital activity*. https://bjgp.org/content/72/718/e307.short (Gibson, Francetic et al. 2022)

Furthermore, fragmenting care amongst a wider group of professionals may, unless it is carefully handled, reduce continuity of care with associated negative outcomes.

In summary, the policy to employ 26,000 health care professionals in primary care is underpinned by an assumption that such workers will act as substitutes for GPs, as well as improving access to care overall. Evidence about the outcomes associated with the policy is necessarily incomplete and to some extent indirect. However, our recently completed study of skillmix change suggests that this assumption may be flawed. It would seem to be by no means certain that meeting this commitment will lead to improved outcomes, nor is it certain that it will relieve pressure on GPs. Moreover, the scheme brings with it significant complexities around regulation of professions (some staff roles such a Physician Associates are currently unregulated, and in others (eg Clinical Pharmacy) existing regulatory frameworks may been to be adjusted to take account of new responsibilities) and responsibility for clinical standards. Finally, we do not yet have good evidence about the impact of these significant changes on patient satisfaction, beyond the finding that a smaller number of GPs as a proportion of the overall workforce is associated with lower overall satisfaction.

D. Was it an appropriate commitment?

1. Was (or is) the commitment likely to achieve meaningful improvement for health and social care staff and/or the health and care system as a whole?
2. Is the commitment specific enough?
3. Has the commitment had unintended consequences?
4. Was the level of ambition as expressed by the commitment reasonable?
5. Is the target contained in the commitment an effective measure of policy success (if applicable)?
6. How has working to those commitments affected other aspects of care?

The commitment to an increased 6000 GPs in general practice was a policy which did not receive dedicated implementation support. It was also poorly defined, in that there was no clear statement of what types of doctors were included in the total, nor whether it referred to headcount or full-time

equivalent staff. An increase in training places for GPs occurred against a backdrop of unfilled training places, reducing any likely impact, and other measures were tangential in their approach. It could be argued that the commitment was too specific in numbers, whilst lacking specificity around the mechanisms by which it was intended to be achieved. A careful study of recruitment and retention of GPs is required in order to understand these issues better. In particular, it is important that we find more about:

- ☐ Why general practice is not a more attractive career choice, and what would make it more attractive
- ☐ Why some GPs are leaving the profession altogether, including those some way off retirement and those reaching the age at which they may take their pension (Odebiyi, Walker et al. 2022)
- ☐ Why some young GPs seem to prefer to work abroad

The commitment was not effectively implemented, and therefore did not have specific unintended consequences. However, this more recent commitment followed a similar commitment to 5000 new GPs by 2020 which was not met; it is possible that repeating such promises without implementing specific measures to address them may increase disillusion amongst members of the profession. The target was very ambitious, and this may have been a problem, as it is hard to see how it might be met. Improving working conditions within general practice to prevent an efflux of experienced professionals would seem to be an urgent priority.

The commitment to an additional 26,000 health care professionals in primary care was both specific and accompanied by a specific implementation approach, tied to a negotiated contract. This implementation mechanism has the merit of being relatively straightforward. However, the availability of relevant staff remains an issue, and, as we have discussed, funding could be more effectively targeted to address inequalities. The target is partially met, which suggests that the level of ambition was reasonable, although a more comprehensive workforce plan across the NHS addressing the availability of all types of staff would have been helpful. The full impact of the policy on quality and availability of care will take time to become clear, but early evidence suggests that, whilst increasing the variety of clinical staff available to provide care in general practice may be beneficial in some regards, it will not necessarily relieve pressure on GPs as intended and may have unintended negative consequences.

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