Written evidence submitted by Royal College of General Practitioners (EPW0059)

Note

As this response is on behalf of the Royal College of General Practitioners (RCGP), it will primarily focus on the government's target for 6,000 more doctors in general practice and 26,000 more primary care professionals and how any of the government's commitments outlined below apply to the GP workforce.

PLANNING FOR THE WORKFORCE

Government commitment under evaluation:

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

Including evidence on:

- 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)

Column 1: Is the commitment on track to be met?

- **6,000 more doctors in general practice**

The government is not on track to meet its commitment to ensure that general practice has the number of doctors it needs to deliver the levels of care they promised in their most recent manifesto. The Secretary of State for Health and Social Care Sajid Javid has himself confirmed this.[i]

The target was to increase the numbers of doctors in general practice by 6,000 between 2019 and 2024, but recent data from NHS Digital demonstrates that the number of FTE fully-qualified GPs employed in the NHS has actually decreased by 717 (-2.5%) since March 2019.[ii]

When the commitment was made it was unclear if it referred to fully-qualified GPs or whether it included trainees. It was also unclear if they were referring to a simple headcount of individual GPs or using full time equivalence. The RCGP generally review the numbers of FTE fully qualified GPs as a key metric, as changes to this number have the biggest impact on patient care.

It can be useful to consider the total number of FTE GPs, including trainees, as this helps to show how successful the system has been in training up the next generation of GPs. On this metric, the government would be doing slightly better with an increase of 1,462 (+4.2%) when compared to March 2019. Even if the 6,000 target does include trainees, at this rate the Government will not meet its target until 2031/32.

It is also worth remembering that GP trainees currently require 3 years training. During this training period they will gradually learn to take on more responsibilities and need significant oversite and support from qualified GPs. It is therefore deeply concerning that FTE fully-qualified GPs continues to decrease, whilst the demand for training increases.

Many GPs feel unable to work 'full-time' in clinical practice general practice, and many contribute to other important roles such as delivering research or system management roles. This means we need to train and retain even more GPs to reach the governments FTE workforce targets, and subsequently its related target for 50,000 additional appointments in general practice.

- **26,000 more primary care professionals**

According to NHSE, the government is on track to achieve its target of 26,000 more primary care professionals working in general practice. The latest figures we have seen show that there are 13,867 additional roles are in post since 2019, however we are awaiting new data which is expected over the next few weeks.

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?

We do not have enough GPs and other healthcare professionals to cope with the increasingly complex needs of a growing and ageing population. In 2022, 73% of surveyed GPs found it difficult to recruit a GP.[iii] In addition, 42% of surveyed GPs in England in 2021, have indicated plans to leave general practice within the next five years.[iv]

- **A lack of a detailed workforce plan**

There is not an adequate system for determining how many doctors, nurses, and allied health professionals we require to meet the long-term needs of the population.

To be able to adapt to changing workforce needs we need workforce plans that consider the short, medium and long term, which have been lacking in the past. A detailed plan must be developed and implemented to fill workforce shortages, with clear lines of accountability for delivery.

When the government committed to 6,000 additional GPs, they never set out a clear plan of how this was going to be achieved. For example, the government never stated how much of the 6,000 target would come from additional training and how much from improving retention. It would be helpful if the expert panel was able to determine if simple plans like this were made at the time and not published, or if no such plans were ever made.

- **Workload pressures, mental health, and burnout**

Workforce pressures within general practice combined with a growing and ageing population has led to mounting pressure on GP workload.

GPs and their teams are having to work harder to meet patient needs which will not be sustainable over the long-term and despite these efforts, some patients are still facing difficulties in accessing care. This pressure is becoming overwhelming, driving many GPs and other staff out of the workforce, and threatening to destabilise general practice. Too much of this unsustainable workload is due to unnecessary bureaucracy. The GP Worklife survey suggests about 9% of GP time is spent on non-clinical administrative tasks, and data from the RCGP Research and Surveillance Centre suggest that clinical administrative workload has gone up by 30% compared to pre pandemic levels.[v]

A survey conducted by the RCGP suggests that 65% of GPs have seen their mental wellbeing deteriorate significantly in the last year.[vi] A recent study has found that on average, GPs described that they were working at 'high intensity' for three quarters of the time and more than half of GPs (54%) are struggling with their workload - far higher than when compared to responses from other specialists (28%). It is therefore unsurprising that the same study found that 32% of GPs reported they are at high risk of burnout, which was the highest amongst all doctors (about twice as likely).[vii] In addition, new data from the BMA suggests more than half of GPs (51%) in Britain have lost staff over the last 5 years due to unmanageable workloads and 48% say GPs have left due to mental health issues or 'burnout'.[viii]

- **GP trainees vs GPs leaving the profession**

Although there has been a lift on the cap of medical school places and we have seen an increase in numbers of GP trainees in England - between 2015 to 2021, the number of doctors accepted to GP training programmes in England rose from 2,769 to 4,000 - this is still not enough to replace the number of GPs retiring.

A 2022 RCGP survey found that 42% of GPs expect to leave the profession within 5 years, which could mean the loss of over 15,000 GPs to the workforce. It is clear that the numbers of GPs planning to leave the profession is much higher than the numbers of trainees expected to enter the workforce which suggests that the government's target of 6,000 new doctors in general practice itself, is insufficient.

- **Visa's for IMGs**

International Medical Graduates (IMGs) are doctors who have completed medical degrees overseas and were responsible for 47% of new GP trainees in 2020/21. The NHS invests significant resources into training these doctors as GPs, both in terms of funding (GP training costs approximately £50,000 per student per year) and in terms of trainer time and expertise. In return, IMGs make invaluable contributions to the NHS. IMGs are especially likely to work in areas with fewer doctors overall, meaning they play a key role in levelling up healthcare across the UK. Unfortunately, current visa regulations mean these trainees face significant bureaucracy if they wish to remain in UK general practice after completing training, putting both their contributions and the NHS's investment at risk.

GP training consists of a three-year programme, during which time IMGs (whether on a tier 2 or Health and Care visa) are sponsored by their national training body, Health Education England. On completing training, these GPs are required to find an employing practice to act as a sponsor. This poses a significant administrative challenge for all parties. GPs can be left feeling undervalued or anxious about their future in the UK, while practices often do not have sponsorship licences in place, and struggle to secure licenses in the short time before visas expire. As a result, NHS England is left with a significant task to try to support newly qualified IMGs with finding appropriate employing practices who can sponsor visas. We understand that hundreds of GPs need this support each year, and this number is likely to grow as more EEA doctors who do not currently hold settled status begin to move into the workforce.

To address this problem, the RCGP has called on the government to ensure all IMGs are offered indefinite leave to remain in the UK on successful completion of GP specialty training.

- **Lack of investment for GP retention schemes/strategies**

With significant numbers of GPs planning to retire it is concerning that the retention programmes set up to encourage them to stay are piecemeal and underused. Around one in five CCGs are not reporting

helping a single GP through the NHSEI National GP Retention Scheme and other retention efforts, such as the fellowship programme for early career GPs, are also struggling to get off the ground. That's why we are calling on the government and NHSE to improve GP retention strategies and invest in high-quality professional development opportunities for GPs through local 'training hubs' and provide back-fill funding for their development time.

- **Lack of support for integrating the wider general practice workforce**

Although the numbers of ARRS roles in general practice are more positive than numbers of new GPs, a number of key issues remain in the roll-out of the programme, including a lack of flexibility in the roles and difficulty in integrating these roles effectively. In our recent survey over half of GPs (57%) said that their practice does not have access to the support and guidance to effectively integrate the new MDT roles.

If Primary Care Networks (PCNs) are not given the adequate support to incorporate these roles, greater pressure is placed on GPs due to the supervision required, and ARRS staff feel marginalised, which could lead to a retention issue further down the line.[ix] There are also concerns about the future of this funding post-2024.

- **Lack of space in GP surgeries**

According to an RCGP survey carried out in 2022, 74% of GPs said that their practice wasn't large enough to accommodate the expanding staff team. To address this problem, the RCGP has consistently called on the government and NHS England to invest £1 billion in order to make general practice premises fit for purpose, including sufficient space to accommodate training for GP trainees, expanded multidisciplinary teams, and deliver digitally-enabled remote care.[x]

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

Over the COVID-19 pandemic, the general practice workforce was forced to adapt to rapidly changing demands and a range of measures were put into place to support this in the short-term. This had both positive and negative consequences for the GP workforce.

A key aspect of the Covid-19 response which may have positively affected progress toward the government's target for 6,000 more GPs was the streamlined approach implemented during the pandemic to enable doctors to return to the workforce as quickly and as easily as possible. Overall, nearly 9,000 GPs received temporary registration from the GMC across the UK, though it is important to note that not all went on to apply to return to Medical Performers Lists (MPL), a requirement for any GP working in primary care services within the NHS.[xi] Of these GPs, at least 1,500 returners were reinstated to the National Performers List in England.[xii] Therefore, while some returners may not have wished to remain in the workforce longer-term, for example due to retirement plans, some GPs may have been persuaded to stay in practice, given a favourable working environment and conditions.[xiii]

Though some of the changes implemented as part of the COVID-19 response may have helped to progress the government's target for 6,000 more GPs, this progress is likely to be minimal when looking at the wider problem. The new ways of working implemented during the pandemic have put more pressure on GPs; they are managing more patients whilst continuing to get criticised in the media for not. This is affecting our GP workforce, with many more likely to quit because of burnout and mental health problems.

Does data show achievement against the target (if applicable)?

As shown above the data demonstrates that we are not on track to meet the target of 6,000 more doctors in general practice but may be on track to meet the target of 26,000 more primary care professionals.

Column 2: Was the commitment effectively funded (or resourced)?

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?

Funding for medical students

For many years, to save money, the Government has put a cap on UK medical schools on how many students they can train. This cap is significantly lower than the number of new doctors the NHS needs to meet patient needs. This has meant that 47% of new GP trainees in 2020/21 were International Medical Graduates.

In 2020 and 2021 the cap on medical schools was raised and we have a record number of students in medical schools.[xiv] The government need to ensure that there is funding set aside to train these future doctors when they graduate in shortage specialities such as general practice.

Funding for trainees

DHSC has made funding available for 4,000 GP training places and the most recent figures from Health Education England confirm they have all been filled. This is the highest number of GP trainees to enter the workforce since the government's 2019 manifesto was launched.

We have not yet had confirmation as to whether HEE has been provided with sufficient resources for these training places. We have also heard that it is becoming increasingly challenging for existing training capacity to be stretched to accommodate more trainees. It is crucial that the number of trainers and the relevant training infrastructure - which requires physical space for trainees within general practice - is expanded.

Funding for retention

While retention schemes will have an important impact, to truly hit the 6,000 target it is essential to improve the day to day working lives of GPs and convince them that their jobs are sustainable and manageable.

20 CGGs across England do not report supporting any GPs on the National GP Retention Scheme, and others report low numbers (as of March 2022). Given the numbers leaving the workforce it is unlikely that this is because not a single GP would have benefited from the scheme in those CCGs.

The RCGP has received feedback that some GPs felt they would struggle to get onto the scheme and therefore did not apply. Others told us that they had previously been refused access to a retention scheme, although they may be eligible. Some CCGs, who make the initial decision about whether to grant access to the scheme, have reported that the scheme is seen as too expensive to deliver. It is therefore important that every local area has sufficient funding for a dedicated retention scheme for those at high-risk of leaving the workforce, particularly those with caring or other responsibilities.

The scheme should also be reviewed regularly to make sure the right criteria for eligibility and subsequent support are in place. However, the National Scheme is designed for GPs who have specific needs and/or are at very high-risk of leaving the workforce, and therefore much wider retention initiatives should also be prioritised.

Although the current retention efforts have achieved some success in keeping GPs in the workforce, there needs to be a review, revamp and expansion of current schemes and approaches so that all GPs can be supported to remain in the workforce. Drawing on the successes of the GP Retention Intensive Support Sites (GPRISS) in England in 2019, additional funding should be provided for wider retention efforts. In 2021/22, just £12 million was allocated for these local programmes, which works out at approximately £9,600 per Primary Care Network (PCN), and there is limited regional support to help with delivery. Furthermore, it is unclear whether practices were easily able to access and spend this funding, as figures of actual spend are not yet available.

Funding for additional primary care staff

The Additional Roles Reimbursement Scheme (ARRS) was implemented in 2019 as part of the PCN Direct Enhanced Service and launched funding for 26,000 additional roles to join primary care and create multi-disciplinary teams. NHS England has reported that the government is on track to reaching its target.

We are seeing significant variation in whether PCNs have enough resources to recruit the roles needed. With 53% of our members surveyed saying that there is sufficient funding being provided through their PCN to enable recruitment of new MDT roles and 45% saying the funding is not sufficient.

This funding covers additional staff but does not include any funding for existing staff to manage the extra staff. This creates a danger that it will be hard to retain staff if they are not given support they need.

There are also concerns about the future of this funding as there are no long-term guarantees. If this funding ended it would be disastrous for many patients who are currently receiving support as a result of this scheme.

In addition, the recent Additional Roles Reimbursement Scheme (ARRS), did not take deprivation into account when allocating funding to pay for new roles. This means that GPs and their teams serving populations that are socio-economically deprived are being asked to do more work for less money, which makes it harder to recruit new team members and harder to retain staff already employed.

What factors were considered when funding arrangements were being determined?

It often seemed that funding decisions on GP training and retention were based on the budget HEE had available rather than the actual targets set by the Government.

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

Given most recent data from NHS Digital on GP numbers and the Secretary of State for Health and Social Care Sajid Javid himself declaring that the government is not on track to reach its target for 6,000 more doctors in general practice,[xv] it is clear that since the Conservative's 2019 Manifesto any funding for general practice was insufficient.

Though NHS England has announced that the government is on track to reach its target for 26,000 ARRS roles by 2024, it must be noted that this funding covers additional staff however does not include any funding for existing staff to manage the extra staff, and demonstrates that the funding allocated is insufficient. Feedback on the scheme's impact also suggests that often staff are spread too thinly across practices, which again suggests that funding for new staff is insufficient. There are also concerns that this funding will end, and questions about what happens if and when that does happen.

Column 3: Did the commitment achieve a positive impact for patients and service users? (Indirectly through impacting workforce)

Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?

As we have seen a fall in FTE qualified GPs since the commitment was made in 2019, any improvement in patient care is down to GPs working harder and smarter rather than the target. If we did hit the target then it would significantly improve patient care.

Over 30 million consultations were delivered in general practice in March 2022, and appointment levels are consistently exceeding pre-pandemic levels. This shows that on average GPs are seeing more patients, which puts pressure on the level of care they can deliver.

The expansion of different roles within general practice has helped to improve patient care. According to the national GP Patient Survey, 32% of appointments in general practice were carried out by someone other than a GP.

Column 4: Was it an appropriate commitment?

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?

If we did significantly expand the GP workforce, it would have significantly improved patient care. However, without a detailed workforce plan, a vague commitment was never going to make a difference.

Is the commitment specific enough?

The target number of 6,000 GPs is specific enough, however, government was not specific enough on how they were going to meet the target. It was not specified how much of the target was going to be met by increasing retention and how much was going to be met by increasing training places. It would be helpful to know if these calculations were done but not published or if they were not even considered, and if so, it would be useful for this data to be made available.

Was the level of ambition as expressed by the commitment reasonable?

Only when the Government carry out some proper workforce modelling will we know if the two targets were the right level of ambition. We have never seen a detailed long term plan that looks at likely future health needs with estimates of the numbers of staff that would be needed to meet them.

We believe a 6,000 increase in GPs was an achievable ask when compared to the overall growth in the number of doctors in the NHS over recent years, however we reiterate that government was not specific enough on how they were going to meet the target.

Is the target contained in the commitment an effective measure of policy success (if applicable)?

True policy success can only really be measured in improved patient care. Expanding the workforce in general practice would help deliver this care.

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[i] Health and Social Care Select Committee (2021). Q242 of oral evidence transcript from session with Health Secretary on clearing the backlog caused by the pandemic. Available at: https://committees.parliament.uk/oralevidence/2942/pdf/

[ii] NHS Digital (2022). Appointments in General Practice, March 2022. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/march-2022

[iii] Based on surveys of GPs in each nation of the UK in 2020. In field Feb–April 2020 (sample of 1183 GPs). Data representative of GPs who said they were involved in recruitment, excluding "don't knows"

[iv] RCGP (2021). Tracking Survey 2021 (Unpublished).

[v] RCGP and Oxford University Research and Surveillance Centre, https://orchid.phc.ox.ac.uk/index.php/rcgprscworkloadobservatory/

[vi] RCGP (2021). 2021 RCGP tracking survey, with 1284 GP responses. Not available online.

[vii] GMC (2021). The state of medical education and practice in the UK. Available at: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

[viii] BMA (2022). BMA Poll for Rebuild General Practice Campaign press release. Available at: https://drive.google.com/file/d/1LTIR1vUPu6NUzZMTaBaCq-h73eNN0KR_/view

[ix] The King's Fund (2022). Integrating additional roles into primary care networks. Available at: https://www.kingsfund.org.uk/sites/default/files/2022-02/Integrating%20additional%20roles%20in%20general%20practice%20report%28web%29.pdf

[x] RCGP (2021). General practice in crisis: an action plan for recovery. Available at: https://www.rcgp.org.uk/policy/general-practice-crisis-action-plan-recovery.aspx

[xi] 12 Unpublished data provided by General Medical Council. Data correct as of 28 May 2020. Derived from the RCGP report 'General Practice in the post-Covid world' published in July 2020.

[xii] Unpublished data provided by NHS England and Improvement. Data correct as of 26 May 2020. Comparable data unavailable in other nations of the UK at the time of writing. Derived from the RCGP report 'General Practice in the post-Covid world' published in July 2020.

[xiii] RCGP (2020). General Practice in the post-Covid world. Available at: https://www.rcgp.org.uk/policy/general-practice-post-covid.aspx

[xiv] Health and Social Care Select Committee (2021). Q242 of oral evidence transcript from session with Health Secretary on clearing the backlog caused by the pandemic. Available at: https://committees.parliament.uk/oralevidence/2942/pdf/

[xv] Health and Social Care Select Committee (2021). Q242 of oral evidence transcript from session with Health Secretary on clearing the backlog caused by the pandemic. Available at: https://committees.parliament.uk/oralevidence/2942/pdf/

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