Written evidence submitted by The Royal College of General Practitioners

Introduction:

1. The Royal College of General Practitioners (RCGP) appreciates the opportunity to contribute to the Public Accounts Committee's (PAC) inquiry into NHS England's modelling for the Long-Term Workforce Plan (LTWP). As the professional home for GPs, representing over 55,000 family doctors, the RCGP are deeply invested in ensuring the sustainability and effectiveness of workforce planning within the NHS, particularly for primary care.

2. The RCGP acknowledges and welcomes the first-of-its-kind approach to projecting long-term health workforce needs, including the doubling of undergraduate medical school places to 15,000 by 2031, and the expansion of GP training places by 50% to 6,000 per annum by 2031.

3. However, as highlighted in the NAO report, the LTWP does not appear to get the balance right between expansion of primary and secondary care and did not sufficiently consider the capacity constraints or costs associated with this level of expansion, which requires significant capital investment.

Questions we are keen to have answered

- Why does the LTWP plan to only increase the number of fully qualified GPs by 4% (27,800 to 28,900 FTE) between 2021 and 2036, compared to a 49% growth in hospital consultants?
- With plans to only retain an extra 0 to 700 GPs by 2031/32, why is the LTWP not more ambitious on retention in general practice?
- What plans does the NHS have to tackle the bottlenecks blocking the expansion of training in general practice, including the lack of infrastructure and trainers needed to meet the rapid expansion in training places?
- Will the Government commit to allowing IMG (International Medical Graduate) trainee GPs to have permanent residence in the UK on qualifying rather than having to extend their Tier 2 visas?
- What modelling has the NHSE carried out to assess the impact on patient safety and quality of care of its plans to rely less on fully qualified GPs and more on other members of the primary care team?

Models underpinning the LTWP and the lack of ambition for general practice

4. In the introduction to the 2016 GP Forward View Sir Simon Stephens was in a reflective mood saying "So if anyone ten years ago had said: "Here's what the NHS should now do - cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs", they'd have been laughed out of court[1]. But looking back over a decade, that's exactly what's happened." With this in mind, NHSE committed to increase the number of GPs by 5,000 which was later increased to 6,000 at the 2019 election.

5. On GP numbers the GP Forward View plan was a failure. According to the Nuffield Trust's analysis of NHS workforce data, the number of fully qualified FTE GPs has declined by around 2,000 while the number of hospital specialists has increased by 28%, since the release of the GP Forward View plan in April 2016.[2]

6. The modelling in the new NHS Long Term Workforce Plan (LTWP) suggests that NHS England has failed to learn any of the lessons of the past. There is similar rhetoric about moving care from hospitals with the plan outlining intentions to "grow the number and proportion of NHS staff working in mental health, primary and community care to enable the service ambition to deliver more preventative and proactive care across the NHS". This matches similar language in the 2022 Plan for Patients where the Government said they were prioritising primary care.[3]

7. **The RCGP are concerned that despite plans to move care from hospitals to the community, the NHS is only planning to increase the number of fully qualified GPs by 4%, compared to a 49% increase in the consultant workforce.** In 2016 Sir Simon said you would be laughed out of court for suggesting the number of hospital doctors should increase three times faster than GPs. In 2024 the Government is suggesting the number of hospital doctors should increase by 24 times more than the predicted increase in GPs. (26800 rise in hospital doctors compared to 1100 increase in GPs).

8. Currently, around a third of all fully qualified doctors are GPs. By 2036 at the end of the LTWP this will have fallen to just a quarter of doctors being GPs.

9. The NAO calculations that fully qualified GP numbers will rise by 4% do not at first seem to match up with the LTWP plans to increase GP trainee numbers by 50% per year. It would be helpful if NHSE was able to explain why increases in trainee numbers do not lead to a significant rise in fully qualified GPs in later years.

10. The RCGP believe that delivery of health and care services embedded within the community environment enables patients' faster access to a wider range of services and support services, and supports continuity of care with a holistic approach.[4] However, in order to effectively and safely deliver these services and take on the shifting workload from secondary care, general practice and primary care needs significant investment, which has yet to be met.

11. The LTWP says that their modelling for patient demand in general practice "was calculated using demographic data assuming we need to restore the qualified GP-to-patient ratio observed in September 2015".

12. According to NHS England data, the number of patients per fully qualified full-time-equivalent (FTE) GP as of September 2016 was 1,963, compared to 2,295 patients per fully qualified full-time-equivalent (FTE) GP in March 2024. This means that on average, each GP is currently responsible for 332 more patients than what the modelling suggests is appropriate. In addition to growing patient lists, GPs across the UK are delivering more appointments, whilst managing risk and increasingly complex healthcare needs of local communities, related to factors such as ageing populations and rising rates of multiple conditions.[5]

13. It is however, unclear why NHSE chose matching numbers from September 2015 as the target for the GP-to-patient ratio when in 2016 the Government decided that there was not enough GPs to meet patient need and set a target to expand the number of GPs by 5,000.

14. As the NAO highlights, the LTWP plans a significant move away from patients being seen by fully qualified GPs, with knock-on effects for patient care, which we expand on below.

15. While the LTWP correctly says that the RCGP was “engaged in forming the NHS Long Term Workforce Plan” (Annex A), the extent of engagement was quite limited, and we were not consulted on the use of this measure to determine actual patient demand.

16. Looking beyond the modelling and critique of demand ratios, the RCGP stress the ongoing and unprecedented demands on GPs, trainers, and their teams at the front line.

17. Our tracking surveys suggest that 47% of practices feel their GP trainers don’t have enough time to train, and 84% of practices said a lack of physical space limits their practice’s ability to take on GP trainees or other learners.

Retention

18. One of the reasons that the LTWP fails to adequately expand the GP workforce is that it is not ambitious enough on retention.

19. The modelling predicts that they will only increase the number of GPs that they will be able to retain by between 0 and 700 GPs by 2031/32 (p123 Table 123). Whilst there are sustained high numbers in UK GP training, this is not enough to plug the gap of GPs reducing their clinical hours or leaving the workforce altogether, nor does it address the lag time taken for these trainees to enter the workforce or the limited resources critical for their placement & training.

20. Significant action is required to retain more GPs in the short-medium term to tackle this vicious cycle, so we can improve working conditions and ultimately patient care.

21. The 2023 RCGP Member Tracking Survey found that 37% of GPs plan to leave the profession in the next five years. This reflects a trend that we are already seeing, with 2,403 GPs leaving the profession in 2022, including one in five GPs under the age of 30.[6]

22. Recent analysis from the British Medical Association (BMA) estimates the financial cost to the public purse for the loss of medical practitioners, termed the 'cost of attrition'. This report conservatively estimates the financial cost to the public purse to replace a single full-time, fully qualified GP with six years’ experience at a minimum of £295,000.[7] This figure emphasises the need for careful and considered workforce planning, alongside investment in retention, to ensure public funds are being appropriately and sustainably invested.

23. A key driver of the GP retention crisis is burnout, with UK GPs experiencing the highest stress and lowest job satisfaction compared to GPs in 9 other high-income countries.[8] The GMC have recommended that one of the priorities for the NHS should be “efforts to resolve the persistent issues in workloads and other indicators of burnout that GPs report”.[9]

24. This recommendation follows GMC data from 2023 that:[10]

- Over half of GPs (55%) were categorised as struggling with their workload, compared with 38% of all doctors.

- 45% of GPs reported experiencing compromised patient safety or care, and 62% found it difficult to provide sufficient patient care each week.

- General practitioners (GPs) reported more high-intensity days (78%) than other doctors and fewer low-intensity days (3%)

25. These findings are synonymous with results from our RCGP Member Tracking Survey (2023) that:[11]

- Only 47% of GPs said they are likely to still be working in five years.
- 37% of all GPs said they are **unlikely** to still be working in general practice in five years, including 30% of GPs under the age of 35, 47% of GP partners, and 28% of registrars.
- The proportion of GPs who are unlikely to still be working in five years has significantly increased since before the pandemic, from 21% in 2019 to 37% in 2023.

26. The failure to prioritise GP retention can already be seen with the recent cuts to programmes designed to aid GP retention. With the NHSE recently announcing the end of national funding for the General Practice New to Practice Fellowship and the Supporting Mentors schemes.

27. It is particularly concerning that the NHS England General Practice New to Practice Fellowship and the Supporting Mentors schemes are being closed to new applicants. These schemes have been shown to play a vital role in supporting early-career GPs to remain in the profession, with the NHS's own evaluation finding that over 80% of those surveyed who had been on the scheme said the Fellowship scheme supported them to remain as a GP.

28. NHSE have said that they will devolve responsibilities for this important role to ICSs but we have not yet heard how they will ensure that funding is to be protected and committed to retention, once at a local level.

29. Flexibility for ICBs to tailor retention programmes to their local areas and the demographics of their leavers may be a positive step, but this will only be possible if there is sufficient funding and prioritisation in the system for GP retention schemes. Uncertainty exists around the proposed re-prioritisation of ICB funding, as it has been suggested that funding currently available for local retention initiatives has been flagged by NHSE for ICB budget clawbacks to compensate for significant financial challenges created by industrial action in 2023/24.[12]

Expansion of training places

30. The Long-Term Workforce plan is more ambitious on GP trainee recruitment than it is on retention. The plan aims to go from 4,000 training places in 2022 to 6,000 in 2031 (page 40 table 2). GPs are the only speciality highlighted in the report so at first it seemed that they were being prioritised. It is however concerning that by 2023 the ratio of GP training places to medical school places will fall significantly, so what first appeared to be prioritisation in fact turns out to be the opposite.

31. The LTWP also states that NHSE wants trainee GPs to spend more of their time in primary care settings in future.

32. Both the LTWP and NAO reports acknowledge the "need for investment in the primary care estate which could be a constraint with such a large expansion in training".[13] Our survey found that 84% of general practice staff said a lack of physical space limits their practice's ability to take on GP trainees or other learners.[14] The LTWP and the NAO both recognise this as a significant issue but so far we are yet to see a commitment to funding the much needed expansion.

33. The process of expanding GP estate can take several years, so it is worrying that there has been no announcement yet of additional funds to invest in primary care infrastructure. The LTWP's aim to expand the GP workforce will likely fail, unless urgent action is taken to ensure there is

sufficient and appropriate infrastructure. We recommend that future updates of the LTWP include capital investment in scope so that they are considered simultaneously.

34. We also need to significantly increase the number of trainers. Our survey found that 47% of general practice staff said their practice has a shortage of educators/supervisors limiting their capacity to take on GP trainees or other learners.[15] The current cohort of trainers will not simply manage to take on more trainees with the GMC predicting that the greater pressure and demand on trainer workloads, will be detrimental to trainers' wellbeing, patient safety and care, and the quality of training that trainees receive.[16]

Funding

35. Since the LTWP was published DHSC announced the core practice contract financial uplift for general practice of just 1.9%.[17] This amounts to a real terms funding cut when compared to CPI inflation and will make it even harder for GPs to deliver the care our patients need at a time when general practice is already in crisis. This figure is due to be adjusted once the Review Body on Doctors' and Dentists' Remuneration (DDRB) reports and it is vital that the final settlement takes into account the need to expand general practice.

36. This is sadly part of an ongoing trend of neglecting primary care, with the Government's own figures showing the proportion of Integrated Care Board direct commissioning spend on primary medical care has fallen to 8.4% in 2023/24 - a smaller share than in any of the previous eight years.[18]

37. There is a particular problem with funding for practices in deprived communities, which face a greater burden of health inequalities. Practices in the poorest areas have 14.4% more patients per fully qualified GP compared to wealthy areas,[19] but receive 7% less funding after accounting for the additional needs of the population.[20] DHSC need to review all general practice funding streams to channel more spending to the areas of greatest need, alongside an increased investment across general practice.

Reliance on international doctors

38. The LTWP modelling assumes a reduction in reliance on international doctors and according to the NAO, no international doctors are to be recruited from the mid-2030s. This is going to be particularly challenging for general practice because of the currently high proportion of GP trainees who are International Medical School Graduates (IMGs).

39. The RCGP acknowledges the vital contributions of IMGs to general practice and the broader NHS. The RCGP wish to highlight that IMGs face unique challenges, including adapting to new medicolegal frameworks, training systems, and cultural differences, which can affect their performance and career progression. The RCGP supports initiatives that facilitate the integration of IMGs into the NHS, ensuring they are valued and receive the necessary support to deliver high-quality care.

40. Around 45% of all GP trainees are IMGs[21] and we need to do everything we can to support them. If the Government does take steps to restrict the recruitment of international doctors, general practice will be particularly hit hard. The RCGP is concerned that unrealistic plans to completely end international recruitment will mean that the NHS fails to prioritise supporting the IMGs we currently have and those that we will continue to recruit.

41. For example, IMGs must be guaranteed permanent residence in the UK on qualifying rather than having to extend their Tier 2 visas. We otherwise risk making working as a GP in the UK a less attractive option and losing the benefit of the investment that has been put into their training.

42. It is also concerning that NHSE no longer have a member of staff whose role it is to support practices in organising visas for IMGs, leaving this for ICBs to cover locally or for IMGs to personally navigate with the Home Office.

General practice and workforce substitution

43. As the NAO report highlights there is a significant shift being planned in how care in general practice is going to be delivered. With a smaller proportion of patients being seen by fully qualified GPs and more being seen by trainees and Specialty and Associate Specialist (SAS) and Locally Employed (LE) doctors. Non-GP doctors (SAS and locally employed doctors) do not and cannot replace the vital roles of GPs, both as expert generalists and as leaders of their multi-disciplinary teams, and increasing numbers of these other professions in primary care cannot be used as an alternative to investment into recruiting and retaining the GP workforce.

44. The RCGP has been carrying out some scoping work into the potential role of doctors who are not GPs working in general practice. This comes following the publication of the GMC report which recommended SAS Doctors to work in general practice and changes to the 2024/45 NHS England GP contract which will embed the COVID-19 Performers List flexibilities and enable SAS doctors to be employed by practices and PCNs.[22, 23]

45. In April 2023, we wrote a public letter to NHS England expressing some questions and concerns we had regarding the role, as well as setting out some redlines which we believe must be in place if this role were to be introduced.[24]

46. The College has identified some principles for this role, which have been agreed by our Council:

- The GP role, as the expert medical generalist, should remain protected, with this role having its own separate, limited scope of practice.
- Efforts to expand the GP workforce should not be undermined as a result of the introduction of the role.
- This role should contribute to maintaining and improving the standards of patient care.
- This role should be fully integrated within the primary care team.
- This role should be seen as a career in its own right, with opportunities for progression.
- Furthermore, the redlines that we have set out for this role are that:
- These doctors must be supervised by a qualified GP and must be given a thorough induction to general practice.
- These doctors cannot be seen as an alternative to addressing the urgent shortage of GPs and we cannot support counting them as contributing towards the Conservative Manifesto target of 6000 more doctors in general practice. There must be a clear distinction between this role and the role of the GP.

47. As the NHSE LTWP assumes a transfer of workload and substitution of fully qualified GPs, the RCGP advise the Committee to consider existing concerns regarding the role of Medical Associate Professionals (MAPs) within primary care and general practice settings.

48. In addition to the issues about other doctors working in general practice not being there to substitute for GPs, there is the increasingly debated issue of Physician Associates working in

general practice and the added supervision requirements for them as a dependent profession that cannot work independently.

49. The RCGP Council has set out our 'red lines' around PAs in general practice and the RCGP is currently in the process of consulting our members to help develop further work in this area.

50. RCGP formal position on PAs (red lines):
    a. PAs working in general practice must always work under the supervision of qualified GPs.
    b. PAs must be considered additional members of the team, rather than substitutes for GPs.
    c. PAs do not replace GPs or mitigate the need to urgently address the shortage of GPs.
    d. PAs must be regulated as soon as possible.
    e. Public awareness and understanding of the PA role must be improved.
    f. Training, induction and supervision of PAs within general practice must be properly designed and resourced.
    g. At a time of significant GP workforce challenges, funding allocations, resources and learning opportunities within general practice must be prioritised for the training and retention of GPs.
    h. The significant responsibility and skills required for supervision must be recognised and resourced, with GPs able to choose whether or not they are willing to undertake supervision of PAs. PAs should not be employed unless sufficient supervision can be provided.

51. It is concerning to see the NAO spell it out clearly that in their view fully qualified GPs are being replaced and that a greater proportion of patient care in general practice is going to be carried out by clinicians who are not fully qualified GPs.

Future NHS productivity

52. General practice can be seen as one of the most productive parts of the NHS. GPs and our teams delivered almost 32.5 million appointments in January 2024 – almost 5 million more than in January 2019, yet with 3% fewer fully qualified, full-time equivalent GPs. Furthermore, NHS Confederate research with Carnall Farrar shows that for every £1 invested in community or primary care, there is up to a £14 return back into the economy.[25]

53. As discussed above, the average number of patients per fully qualified GP continues to rise and is now 2,295 patients per fully qualified full-time-equivalent (FTE) GP in March 2024, meaning each GP is, on average, responsible for 332 more patients than they were in September 2016.

54. While this may appear efficient, it is also a demonstration of increased demands on general practice, with an ageing population and rising prevalence of multi-morbidity and complicated medical care requirements as a result. While we are still understanding the full implications this growing demand may have on the workforce and patient safety, we are aware of growing concerns that this demand is compromising continuity of care, which is closely associated with better clinical patient outcomes and experiences.[26]

55. Measuring appointment numbers is too crude a system to judge efficiency. As a patient being seen by lots of different members of the primary care team before being referred to a GP would appear more efficient than just being seen by one doctor, but can lead to fragmentation of care, inappropriately higher investigations and prescribing, all because the patient does not have one clinician who really knows them.

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