



Royal College of
General Practitioners

Fit for the Future

Retaining the GP workforce



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Introduction

General practice is in crisis. This can be boiled down to the fundamental problem that demand for the service is outstripping supply. There is simply too much work to be done for the staff available.

GPs are working hard to meet growing demand, but this is not sustainable. In 2021, general practice in England carried out almost 370 million consultations, up 18.5% from 2019. On average, as of July 2022, each GP looked after 2,247 patients - a 16% increase since 2015.¹ These trends of expanding workload are being felt by our members right across the UK.

The most impactful way to meet this growing demand is to expand the general practice workforce. This has become widely accepted, with explicit government workforce targets in place for England and Scotland,² yet these targets have not translated into real progress. To address this workforce crisis, action needs to be taken on two fronts: firstly, there needs to be a sustained increased inflow of doctors to the profession, with GP training capacity expanded. Secondly, more GPs need to be supported to remain working in general practice for longer.

Significant progress has been made in expanding GP training in recent years, with the number of acceptances to GP Specialty Training across the UK rising from 3,182 in 2015 to 4,610 in 2021, and with fill rates now over 97% across all four nations.³ However, GP training takes a minimum of three years to complete. In the meantime, experienced clinicians,

faced with unmanageable workload, are reducing their contracted clinical hours, or leaving the profession altogether. This means that we must train and retain even more GPs to reach the workforce targets we desperately need. As part of an overarching retention strategy, we need to make the day job more doable so that GPs can focus on delivering high-quality patient care.

Our 2022 survey of RCGP members found that 39% of the GP workforce across the UK are seriously considering leaving the profession within the next five years. This could translate to over 22,000 GPs leaving the workforce across all four nations. Pressures will continue to intensify for those still in practice, creating a vicious cycle whereby increasing numbers of GPs continue to leave the workforce due to insurmountable pressures. Urgent action is needed to break this cycle, supporting today's GPs to stay in practice, while we continue to train tomorrow's GPs.

This paper draws together existing GP workforce data, data from RCGP surveys of GPs, and insights from workshops with our members, including RCGP UK Council. We present a set of high-level recommendations for action by politicians and NHS leaders across the UK to tackle the GP retention crisis.

Our key recommendations are:

- **A comprehensive review of existing retention initiatives backed by an investment of £150 million per year in England and commensurate amounts in the devolved nations.**
 - ▶ Develop local retention initiatives so that every GP can access tailored support to stay in the profession for longer.
 - ▶ Ensure funding is available in every locality for GPs to access a national retention scheme for those at highest risk of leaving the profession.
- **Evaluate and improve induction and career support programmes for early career GPs.**
- **Build capacity at network or system level to introduce increased flexibility and new opportunities across local areas.**
- **Take action to improve GP workload, in particular to support the delivery of relationship-based care.**
- **Expand multidisciplinary teams in general practice and invest in support for integration and supervision of new roles.**
- **Publish improved workforce data across the UK, in order to inform better workforce planning.**
- **Develop impactful communications for patients which demonstrate the role of the GP and help to explain what a patient can expect from their practice, including seeing different members of the team.**



The scale of the GP retention crisis

GP workforce data

While there is variation across the UK, GP workforce data shows concerning trends across the four nations:

- In England, the number of FTE fully qualified GPs fell from 29,364 to 27,507 between September 2015 and July 2022, a decrease of 6.3% of the GP workforce. In terms of headcount in the same time frame, the number of qualified GPs has slightly increased from 36,082 to 36,729.⁴
- In Scotland, the headcount of fully qualified GPs increased from 4,434 to 4,579 between September 2015 and 2021, an increase of 3.3%.⁵ However, estimates of the fully qualified FTE workforce (based on a biennial survey) show that numbers have not risen, standing at 3,604 in August 2015 and 3,613 in August 2019.⁶
- In Wales, there was a headcount of 2,403 fully qualified GPs in March 2022, compared to 2,656 in September 2015, a 9.5% decrease. From December 2021, Wales have also published FTE data; there were 1,570 fully qualified GPs in March 2022.⁷
- In Northern Ireland, GP headcount has decreased by 7.4% in the past four years; there were 1,421 fully qualified GPs in April 2022 compared to 1,323 in March 2018. No FTE data is available.⁸

Data coverage is highly variable across the four nations, with data on the FTE workforce only available for England and Wales. There is also a serious paucity of data relating to the out of hours (OOH) GP workforce across the UK. There is a Primary Care Out of Hours Survey released in Scotland; however, the most recent publication is from 2019.⁹ This reported that there were 329.6 FTE OOH GPs in 2019, which suggests that there is an extra 10% of the FTE GP workforce working in OOH in Scotland.

Recent analysis by the Health Foundation on GP workforce data in England reinforces the need to act urgently to reduce the number of

GPs leaving the profession. Their estimates - modelled on the Government's target to recruit 6,000 GPs between 2019 and 2024 - found a shortfall of 4,200 fully qualified, permanent FTE GPs as of 2021/22, but this could rise to 8,800 by 2030/21 if the current policy approach and general trends stay the same.¹⁰ However, in their pessimistic scenario, which is based on greater numbers continuing to leave the workforce, a lack of policy focus, and a lack of integration of ARRS roles, this figure rises to 18,900. This highlights that radically boosting retention is critical to improving workforce numbers in order to meet patient need.

The imbalance between working hours and contracted hours

A trend over recent years is that GPs are reducing their number of contracted hours in clinical practice, but for the most part, they are working more hours than they are contracted for.

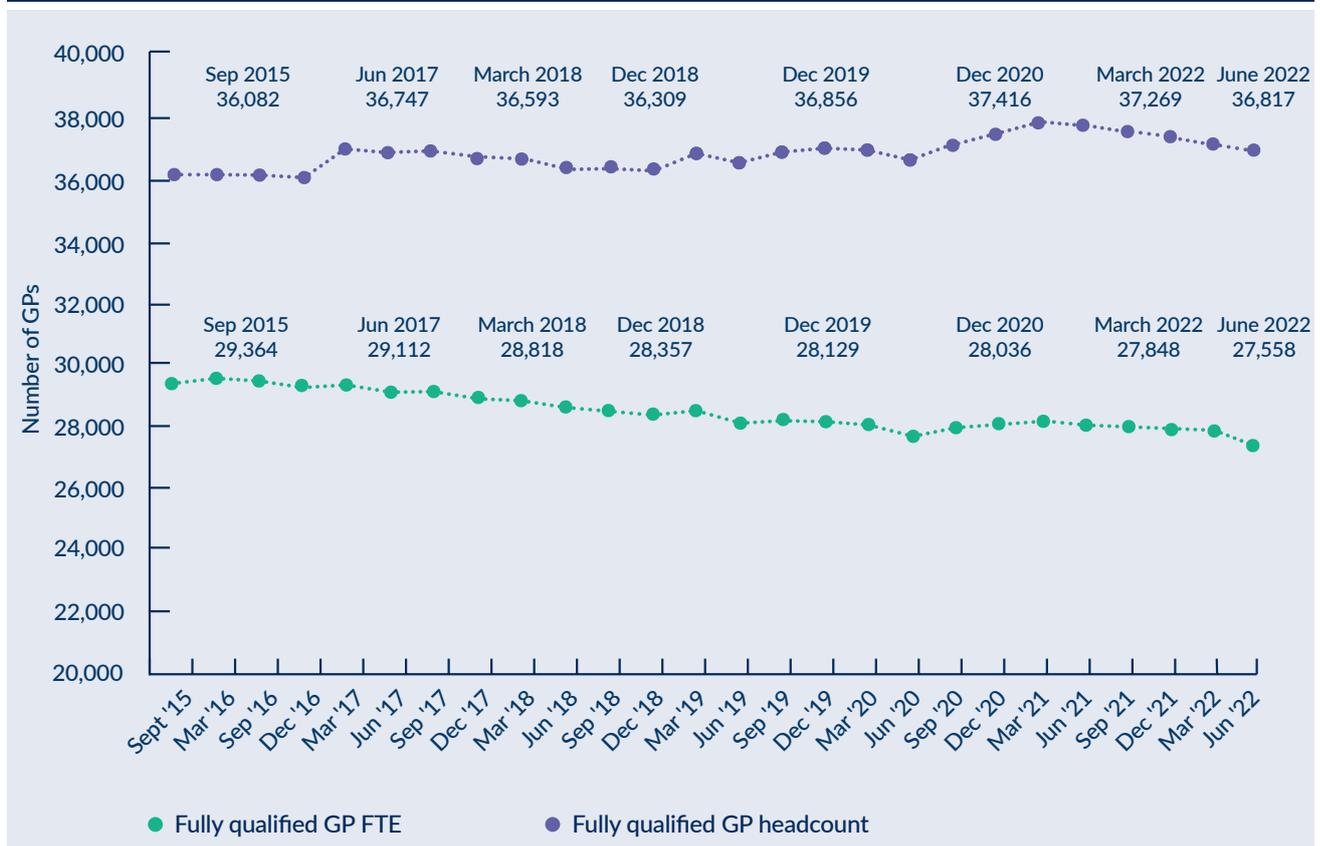
The 2021 GP Worklife Survey found that GPs on average work 6.3 sessions a week. A GP session is defined as 4 hours and 10 minutes, meaning that a 6.3 session contract should equate to 26.25 hours.¹¹ However, the survey found that GPs were actually working 12.2 hours longer on average, meaning they were working 38.4 hours per week.

Similarly, respondents to the 2022 RCGP Tracking Survey for England, on average, reported being contracted for 28.4 hours per week in general practice, but actually working 39.5 hours per week, with 20% working at least 50-hour weeks. Moreover, 84% of UK members reported working

more than their contracted hours at least most days. This highlights that, in reality, many GPs are working more than full-time despite having part-time contracts. In contrast to clinicians in secondary care specialties, most GPs do not typically have protected time in their contracts for administrative work, professional development, or teaching. This suggests that efforts to boost the workforce by driving up participation rates alone are unlikely to be effective or sustainable for most GPs.

Since 2015, the headcount of fully qualified GPs has increased slightly, but this has not translated into an increase in the FTE workforce, as shown in the graph below. Individual GPs are contracted for, on average, fewer hours now than in the past, but as outlined above, 'less than full time' (LTFT) contracts often translate into full-time hours due to the increasing workload that GPs are facing.

Figure 1: GP workforce numbers



Data from NHS Digital, General Practice Workforce (June 2022).

NHS Digital GP workforce data shows that the average participation rate among fully qualified GPs in England has fallen from 0.82 in September 2015 to 0.75 in July 2022. This decrease in participation rate is equivalent to losing around

8.75% of the workforce, more than offsetting the headcount growth seen in England. As the table below shows, participation rates for fully qualified GPs have fallen across almost every age cohort in recent years.

Table 1: Fully qualified GP workforce participation rates in England, 2015 - 2022

Age band	Participation rate September 2015	Participation rate July 2022	Change in headcount 2015-2022	Change in FTE 2015-2022
Under 30	0.71	0.74	-358	-302
30-34	0.75	0.68	-519	-675
35-39	0.75	0.67	809	106
40-44	0.77	0.70	967	298
45-49	0.81	0.73	992	475
50-54	0.84	0.76	-657	-909
55-59	0.83	0.78	201	-46
60-64	0.75	0.74	543	400
65 and over	0.68	0.73	124	77
All GPs	0.82	0.75	2,033	-575

Data from NHS Digital, General Practice Workforce (September 2015, July 2022). Excluding individuals with an age recorded as 'unknown'.

This data highlights how misleading the use of headcount is when analysing the growth of the GP workforce: whilst this data suggests that the number of GPs has grown by over 2,000, the change in FTE reveals that decreasing participation rates have led to the equivalent of 575 less GPs in England. It is important that FTE figures are taken as the standard as this is what impacts patient care. However, it should equally be noted that

the data above is only able to capture contracted hours, rather than hours worked, and so does not fully reflect the extent of GP workload.

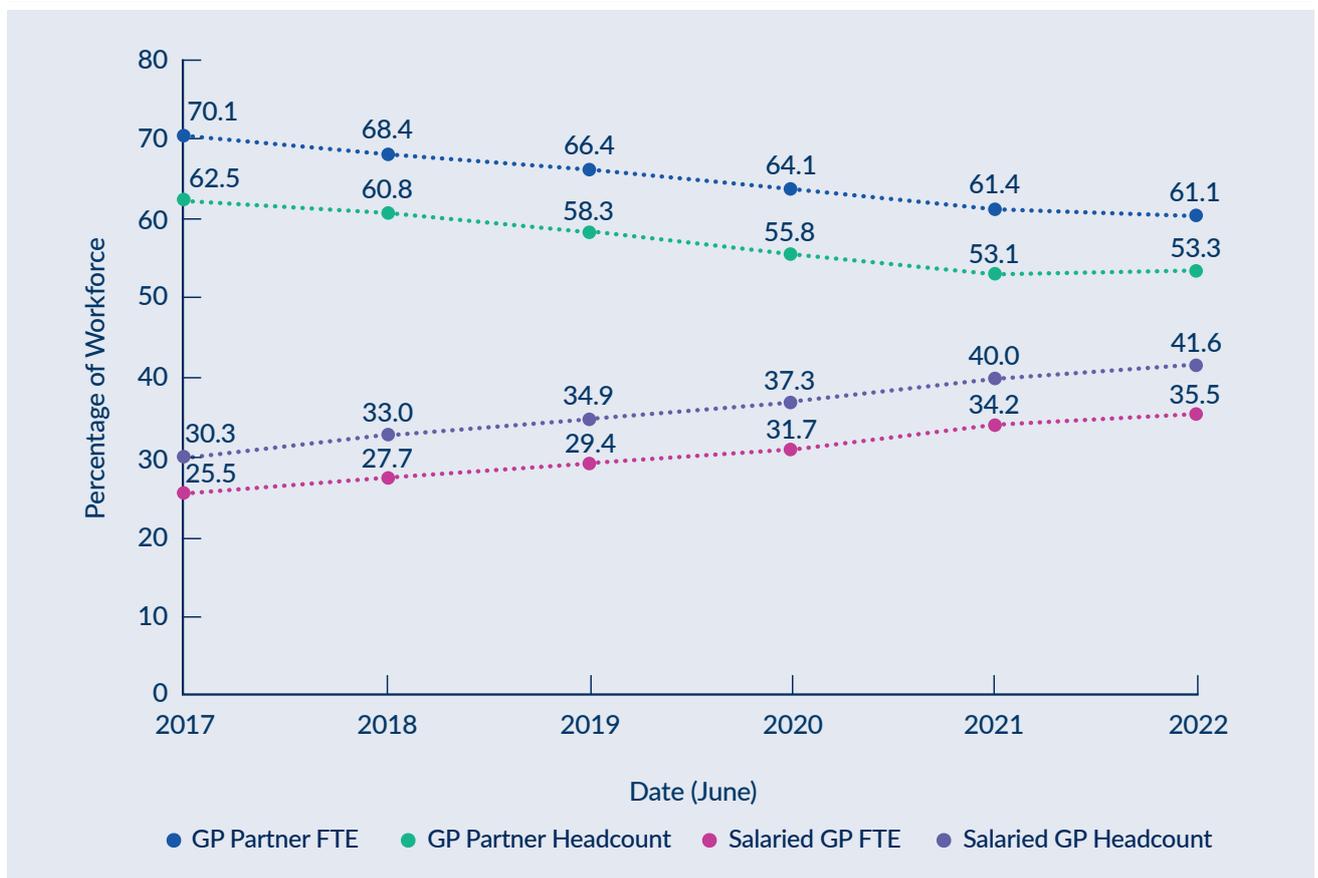


Fewer GP Partners

The move towards working fewer contracted sessions has happened in tandem with a shift away from partnership roles, which have the highest average participation rates, towards salaried roles with lower average participation rates. In June 2017, GP FTE partners represented 70.1% of the workforce in England, whereas by June 2022 this had dropped to 61.1%. Over the same time frame, the percentage of salaried FTE GPs has risen from 25.5% to 35.5%. The

graph below highlights that GP partners are more likely to work longer hours. Figures from June 2022 show that partners make up 53% of the headcount but their FTE contribution stands at a disproportionate 61%, meaning that many partners work more than full time. The decline in the uptake of partnership is hence having a negative impact on the FTE GP workforce.

Figure 2: Partners and Salaried GPs as a proportion of the Fully Qualified GP Workforce, June 2017-2022



Data from NHS Digital, General Practice Workforce (June 2022).

GPs may be increasingly choosing salaried roles because of the lower contracted hours, or because they find other elements of partnership unattractive. The RCGP 2022 tracking survey revealed that 56% of respondents disagree that being a partner is an attractive role in general practice. The 2019 GP partnership review found

that one of the key reasons why GPs were choosing not to join partnerships was due to the increasing level of personal risk, as partners are personally liable for the practice, which could lead to unprecedented indemnity costs or staff and premise costs.¹²

Numbers of GPs leaving the workforce

While some GPs have reduced their contracted hours, a significant number leave the workforce altogether, which exacerbates the workload issues for those remaining. Concerningly, high numbers of GPs report intending to leave the profession over the next few years, right across the UK (Table 2).

Table 2: Percentage of GPs likely or very likely to leave the profession over various timeframes

Nation	One year	Two years	Five years
England	10%	19%	42%
Scotland	9%	14%	36%
Wales	7%	10%	33%
Northern Ireland	6%	11%	29%

Data from RCGP Tracking Survey (April 2022, Unpublished).

Leaver and joiner data is currently limited, making it difficult to track the movement of GPs in and out of the workforce. However, the available data suggests some concerning trends.

Figure 3 shows the average number of GP leavers over the past six years. For both men and women, GPs in the 55-59 and 60-64 age cohorts are leaving at particularly high rates. These cohorts account for around 25% of all partners. However, this data also reveals that large numbers of female GPs in the 30-34, 35-39 and 40-44 age cohorts are leaving the workforce.

These groups may be leaving due to childcare or general caring responsibilities and therefore may not be planning to leave the GP workforce permanently, and scope exists to devise specific interventions to support this key part of the workforce to remain or return. Small marginal gains in retention for female GPs in these earlier career cohorts could potentially have a significant impact on the overall workforce.

Figure 3: Average GP leaver numbers, 2016-2022



Data from NHS Digital, General Practice Workforce, GP Joiner and Leaver Tables (March 2022).

It is important to note that leaver rates were lower among cohorts under 50 in the year 2020/21 than in previous years. However, this most likely reflects the impact of the COVID-19

pandemic, rather than a longer-term shift in the trend, with GPs temporarily postponing their departure from the profession to support the pandemic response.



What drives poor retention?

Each GP who leaves the workforce does so for a unique set of reasons, reflecting their own circumstances, experiences, and preferences. Retention support must therefore be tailored to individual needs. Nonetheless, certain factors will be common across different individuals and groups of GPs. Identifying these factors will enable the development of effective retention strategies at national, regional, and local levels.

Common factors

The GMC's Completing the Picture report, with survey responses from over 13,000 doctors from across the UK,¹³ reveals the most common reasons for stopping practice cited by GPs and other specialties. Burnout and stress were the second most common factors and significantly higher than other specialties. The 2022 RCGP Tracking Survey found that 23% of GPs across the UK were so stressed that they felt they

couldn't cope most days or every day, and a further 22% felt this way once or twice a week. When almost half of the GP workforce is feeling such an intense amount of stress on a weekly basis, it is no wonder that increasing numbers are planning on leaving the specialty.

Reason	GP percentage	Other specialty percentage
Retirement	56%	31%
Burnout/work-related stress	43%	22%
Dissatisfaction with role/place of work/NHS culture	37%	36%
Worry about errors/medico-legal risk	24%	10%
Regulation	17%	12%
Financial reasons (e.g., don't need to work, moved to a better paid job)	17%	19%
Desire to move abroad	14%	18%
Family reason (other than caring)	12%	24%
Pension concerns	11%	10%
Disability, illness, physical health	10%	5%

Similar themes were cited during an RCGP workshop with GPs. Key reasons for leaving or considering leaving included clinical and administrative workload, work-life balance, lack of job satisfaction, and health and wellbeing. However, it was noted that many of these factors are inextricably linked, for example

unmanageable workload is likely to impact work-life balance and wellbeing. GPs emphasised that career models and partnerships need to be more flexible, to give clinicians control over their work and enable them to balance their working lives with their personal lives.

Retirement and pensions

For GPs in their later careers, GP pension issues appear to be a particular driver of poor retention. Across all four nations, retirement was the most common reason provided by GPs who reported intention to leave the profession in the 2022 Tracking Survey (England 34%, Scotland 63%, Wales 56%, Northern Ireland 56%).¹⁴ Interestingly, this reason was far more common amongst GPs in the devolved nations, implying that the pensions issue could be more acute here.

Small fluctuations in earnings can have significant tax implications for GPs, due to the functioning of the annual and lifetime allowances. This is particularly problematic for partners, who cannot manage tax liabilities by adjusting working hours in year. Moreover, normal pension age for most GPs approaching retirement is set at 60 and it may be financially preferable to retire rather than working reduced hours. Data from the NHS Pension Scheme shows that 55% of GPs claiming their pension for the first time in 2019/20 did so through voluntary early retirement.¹⁵

Family and caring responsibilities

Women GPs in their 30s and 40s make up a considerable proportion of the workforce in general practice, yet women still face systemic barriers. The recent review of the gender pay gap in medicine found that general practice has one of the largest disparities, even after adjusting for hours worked.¹⁶ A key reason for this is likely to be that women continue to provide most unpaid care in their personal lives.¹⁷ While GP careers may offer a better work-life balance than some other medical

specialties, women may nonetheless find it harder to remain in the workforce, particularly when they have young children to care for. 53% of GPs in England do not think they are able to work flexibly in a way that allows them to meet personal needs such as family commitments or working fewer hours without retiring.¹⁸ GPs aged 35-39 and 40-44 in England are significantly more likely to be on the national GP retention scheme than other age groups, and women make up the large majority of these groups.¹⁹

Protected characteristics and discrimination

While specific data on the retention of most groups with protected characteristics for the GP workforce is not available, it is widely recognised that individual and systemic discrimination has a significant impact on people's working lives in the UK, and it is likely that this also affects retention in general practice.

It is well understood that Black, Asian, and Minority Ethnic (BAME) doctors in the UK are subject to both individual and systemic racism. A recent survey found that between 40% and 70% of BAME GPs had been the subject of racism in their professional lives, and over 10% of BAME GPs reported that their choice of working pattern had been affected by racism.²⁰ Nationally, BAME GPs are more likely to work in disadvantaged areas, where workload pressures are greater and the risk of burnout is higher.²¹

A similar picture emerges when considering the experiences of Lesbian, Gay, Bisexual and Trans (LGBT) GPs. A 2016 survey found that 12% of lesbian, gay or bisexual doctors had experienced at least one form of harassment or abuse at work and suggested that significant changes were needed to make workplaces welcoming to LGBT staff.²² The GMC's Completing the Picture report found that, of the doctors who left in the past three years, disabled doctors make up a higher proportion than their relative size on the register (10.6% vs. 5.9%).²³ The BMA report, Disability in the medical profession, suggested workplace cultures (such as around presenteeism) may be more challenging for GPs with long-term health problems or disabilities.²⁴

Working location and inequality

As well as personal factors, contextual factors impact on individual retention. Deprived areas typically have the greatest clinical need yet often have the lowest proportion of GPs in comparison to the population, and receive relatively low financial resources, meaning that the inverse care law continues to hold true across the UK.²⁵ Consequentially, GPs operating in these areas are likely to be under greater pressure than their

colleagues elsewhere in the country, meaning they are more likely to leave the workforce. Recent research has found that, between 2007 and 2019, practices in the most deprived areas had a greater risk of high turnover than practices elsewhere.²⁶ Similarly, rural areas tend to have higher numbers of patients per GP.²⁷ This increases pressure on current clinicians, further undermining retention.

Current retention programmes

As the GP retention crisis has come increasingly into focus over the last few years, a range of programmes have been put in place to try to support the retention of GPs at different career stages.

As well as specific programmes aimed at those already seriously considering leaving the workforce, such as the National GP Retention Scheme in England or the GP Retainer Scheme in Scotland, there are other initiatives which support retention more broadly. While some of these programmes have other specific aims

(e.g., reducing attrition at points of transition, encouraging partnerships, supporting rural general practice etc.), it is helpful to think of these as interlocking programmes designed to make general practice careers more attractive and sustainable. A summary of the initiatives currently in place is included in Appendix A.

Evaluating national GP retention schemes

The range of support available to GPs is highly variable across the four nations, with significant gaps at different career stages. All four nations operate a variation of a national scheme for GPs offering a limited number of sessions for those needing both flexibility and some form of additional support. The most recent data for each nation reported:

- **England** - 613 GPs retainers, across 42 Integrated Care Boards (ICBs) and 106 sub-ICBs (sub-ICBs are areas which were previously broken down as Clinical Commissioning Groups); 21 sub-ICBs do not currently report supporting any retainers, whilst one ICB has never reported supporting retainers on the scheme.²⁸
- **Scotland** - 64 retainers across 10 health boards; four health boards do not support any retainers (it is unclear whether this total includes GPs on the Stay In Practice Scheme (SIPS)).²⁹
- **Wales** - 26 Retainers across five health boards; two health boards do not support any retainers.³⁰
- **Northern Ireland** - 26 Retainers.³¹

While these wide-ranging support programmes are valuable, they are limited in scope and scale. In England, for example, RCGP has heard from our members who cannot get onto the scheme or have been refused access, although they feel they are eligible. Since ringfenced funding ended, some local areas have reported that they believe the scheme is too expensive and therefore they won't support it.

The national retention schemes in the devolved nations have had no formal evaluation and the England scheme has not been formally evaluated since 2016. Feedback the RCGP has received from the Wales scheme has highlighted that the national scheme is useful for those who have lost their confidence as a result of being away from the profession, for example due to illness or family reasons. Anecdotal evidence of the Scotland schemes suggests that they have not been well received, with low uptake. The GP Stay in Practice scheme (SIPS) requires those on the scheme to move practice, which could act as a deterrent to those whom the scheme could benefit. Moving to a new practice also reduces long-term continuity and could make it more difficult to undertake development and training.

Evaluating local GP retention initiatives schemes

In 2018, NHSE set up seven sites in areas with particular retention problems, known as GP Retention Intensive Support Sites (GPRISS), in order to formally test and evaluate local interventions.

The 2019 evaluation commissioned by NHS England and Improvement received mostly positive feedback about the scheme and analysis of workforce data during the scheme found that these sites had better changes in GP FTEs compared to the rest of England. Overall, 60% of GPs who responded to the survey about the scheme agreed that the combined impact of GPRISS interventions improved their job satisfaction. Most of the positive feedback was received from GPs in their first five years of practice, those working in larger practices, and those who received interventions aimed at individual, practice, and system levels. By focusing interventions at three levels, the schemes aimed to improve the work environment, reduce workload pressures, and encourage a positive work culture, alongside mentoring and educational initiatives. However, evaluations found there was unmet need for additional resources within practices and for managing patient expectations. This suggested there was potential to build on the positive outcomes of these schemes to have a greater impact.

Following the evaluation, funding was made available to set up local GP retention initiatives across England. In 2021/22, £12 million was made available for local retention schemes - this equated to approximately £9,600 per Primary Care Network, far below what is needed to enable practices to support GPs. Across the country, local schemes are highly variable and, in some areas, have struggled to get off the ground. These schemes are dependent on the time and resources available to the practice and the local system, which are limited. Anecdotally, some practices report simply not having the time or space to set up a local retention scheme.



Evaluating wider retention initiatives

As well as the national GP retention schemes, there are a range of wider initiatives designed to support retention more broadly, including some aimed at GPs at various stages of their career or who want more flexible working (see Appendix A). Many of these retention efforts have not been formally evaluated for their effectiveness, meaning we don't know how useful they are on a larger scale. However, RCGP has received some feedback and reviewed analysis of several of the retention initiatives.

Anecdotal feedback to RCGP from GPs who have been on the New to Practice Fellowship scheme in England has been mixed. Many have appreciated the additional support that a structured programme provides, but experiences have been variable across different areas. For example, the focus of the programme in one area has been on clinical education rather than leadership and confidence-building, and there has been a severe lack of in-person sessions, limiting any networking opportunities to allow those on the scheme to feel more integrated in their Primary Care Network. Although the lack of in-person sessions could be a consequence of the pandemic, this suggests that more needs to be done to listen to what people on the scheme actually want and to ensure that there are no disparities in the offerings between regions.

A key gap in current schemes is around support for career transitions, particularly for mid and later career GPs. These GPs may not need or want to work reduced hours, but might benefit from additional mentoring and support, which could be made accessible following annual appraisals. This could provide an opportunity to undertake career planning, as well as to signpost to specialist services. Currently, Northern Ireland's mentoring scheme appears to partially fill this need. England's local GP retention funding may also be used for this, but this is not effectively incentivised or monitored at a national level.

Another crucial challenge is around flexibility and control over work hours. As set out above, 'part-time' working does not necessarily translate into shorter working hours, and the current workload pressures appear to make it hard for GPs to reliably control when they work. For this reason, many GPs appear to be turning to the various GP retention schemes or leaving altogether. However, these programmes are not designed or financed to operate on a large scale.

More work also needs to be done to increase awareness of the retention initiatives available in each nation. Feedback from the RCGP 2022 GP survey found that in England, 11% of GPs were unaware of the national GP retention scheme and a quarter of GPs were unaware of the new to practice fellowship scheme.



Recommendations

Solving the issue of GP retention is not simple; a holistic, multi-faceted approach is necessary. At its core, GP retention is about making the profession more sustainable and enjoyable so that existing and future GPs want to remain in the speciality for the entirety of their careers. To achieve this, we call for action to make general practice a more sustainable and appealing career choice. Our recommendations for governments across the UK are:

1

A comprehensive review of existing retention initiatives, backed by an investment of £150 million per year in England and commensurate amounts in the devolved nations

We need a new and improved GP retention strategy, backed by a £150 million annual GP retention fund in England to support the development of the current schemes. Greater investment in retention initiatives is also needed right across the UK. Wider efforts to improve the working lives of GPs are essential, but in the short to medium term, investment in revamped retention initiatives will have an important impact. The benefits of these retention initiatives outweigh the cost of losing GPs, both in terms of having to train new staff to fill gaps and the impact that losing these experienced staff would have on patient care.



1a

Develop local retention initiatives so that every GP can access tailored support to stay in the profession for longer

There needs to be a review, revamp and expansion of current initiatives 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), additional funding should be provided for wider retention efforts.

These local initiatives should aim to improve the work environment, reduce workload pressures, and encourage a positive workplace culture. There are several examples of these programmes already working well. However, one size will not fit all, and it will be important that each local area is supported to tailor efforts to the specific needs of the locality and the individuals they are trying to retain. This personalisation would also need to be applied to GPs at various career stages, for example a greater focus on mentoring and leadership training for recently qualified GPs. Whilst such a scheme would initially focus on GPs, we need to recognise the importance of retaining all types of roles within general practice and not leave the wider team behind in these offerings. These programmes could draw on other schemes that have looked at the life of a GP as a whole, such as the 'train, work, live' programme in Wales.

To aid the delivery of these programmes, there should be dedicated regional support and coordination to get these programmes off the ground. Initiatives in under-doctored areas should receive additional funding to tackle the inverse care law. A major limiting factor during the pandemic has been the lack of headspace and time for GPs and practice leadership to develop and implement initiatives.



1b

Ensure funding is available in every locality for GPs to access a national retention scheme for those at highest risk of leaving the profession

As set out above, there are a number of areas of the UK which are currently not supporting any GPs on the national retention schemes. With almost four out of ten GPs planning to quit in the next five years, it is impossible to believe that this is because no GPs are contemplating leaving in those areas.

It is important that every local area has sufficient funding for a dedicated retention scheme for those at highest risk of leaving the workforce, particularly those with caring or other responsibilities. We do not expect this scheme to provide support to a large group of GPs, but for a certain group of GPs this scheme will be essential to help them remain in the workforce over the next few years.

As these schemes are designed for GPs who otherwise would no longer be able to remain in the workforce, it is important that they work around the needs of those on the scheme rather than the other way around. The SIP scheme in Scotland, for example, should be evaluated to determine whether it is actually necessary for GPs to move practice in order to receive support.



2

Evaluate and improve induction and career support programmes for early career GPs

The data above shows that we are losing GPs at all stages of their careers. GPs often report feeling clinically competent but not fully confident to enter the workforce after three years of GP training - two years of which are now spent within general practice in England and Wales and only 18 months in Northern Ireland and Scotland. RCGP has long set out the need for extended GP training to at least four years, as well as more time being spent in general practice during training.

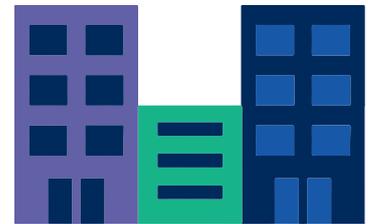
One action to support GPs as they transition into the workforce is through creating structured programmes for GPs' first few years of practice. The General Practice Fellowship programme in England, launched in 2019, has not yet been formally evaluated. An evaluation of the scheme, and similar schemes across the UK, should be carried out rapidly to ascertain whether further funding or support is needed to support implementation of the programmes.



3

Build capacity at network or system level to introduce increased flexibility and new opportunities across local areas

Wider steps should be taken to embed flexibility and control within all GP careers, not just for those on retention schemes. This could include providing more support to networks or groups of practices to enable new approaches to rostering and supporting job shares. Implementing job plans that are flexible and suit the needs of individual GPs will make general practice more viable and ensure that people maintain a good work-life balance. It is important that, across all four nations, GPs are given protected learning time in their contracts like that of other medical specialties, to give them adequate time to develop their knowledge and skillsets. By providing protected, funded time for professional development or time to come together to develop as a team and devise new approaches, services to meet the needs of patients will also be improved. Greater support for portfolio working could aid retention by ensuring that individuals experience greater variety, build new skills, and create a better balance between clinical and non-clinical work.



4

Take action to improve GP workload, in particular to support the delivery of relationship-based care

Relationship-based care, in which GPs develop rapport and trust with patients, offers significant benefits for patients in terms of improved experience and better health outcomes. Creating an environment within which GPs can deliver effective relationship-based care could help to aid retention because there are clear links between relationship-based care and job satisfaction. Many GPs tell us that they enjoy being able to build relationships with their patients rather than solely delivering transactional, episodic care.

To support GPs in delivering relationship-based care, and improve job satisfaction more widely, it will be critical to tackle workforce and workload challenges. There needs to be a greater focus on reducing bureaucracy and unnecessary workload for GPs as well as ensuring effective administrative interfaces between different providers. Additionally, the Quality and Outcomes Framework (QOF) in England and Northern Ireland and the Quality Assurance and Improvement Framework (QAIF) in Wales should be reviewed. Changes are required to move away from current systems which encourage tick-box focus and red tape, to ones that encourage GPs to focus on those who need care most. Quality improvement approaches that promote the fostering of outcomes-focused relationship-based care should be the focus, rather than linking payments to discrete processes and tasks.



5

Expand multidisciplinary teams in general practice and invest in support for integration and supervision of new roles

Increasing the number of non-GP staff in general practice who can help to reduce some of the workload pressures on GPs remains an important goal. However, current recruitment programmes fail to address issues around integrating these new members of staff and the knock-on effects on existing staff, such as increasing supervision costs for GPs and others.

In England, changes need to be made to the Additional Roles Reimbursement Scheme (ARRS). Recent research by the Kings Fund has demonstrated some of the challenges with the roll-out. Further work is needed to be done to ensure that the integration of team members across Primary Care Networks has a positive impact on workload.³² Changes to the programme should include greater flexibility in the roles that can be recruited, as well as greater emphasis on the use of roles to support 'core' general practice activity.



6

Publish improved workforce data across the UK, in order to inform better workforce planning.

There needs to be enhanced collection and publication of comparable UK-wide workforce data and the roll-out of a national staff survey for general practice, to enable a better understanding of how the GP workforce is changing across the UK. This should include FTE figures for all four nations, total hours worked rather than just contracted, and more accurate leaver data. Only through having an in-depth understanding of the make-up of the GP and primary care workforce and hours worked can we begin to implement targeted solutions and schemes.

Following this, we call for the establishment of realistic targets for the expansion of the fully qualified FTE GP workforce, including interim targets, against which progress should be regularly reported. These targets will ensure that we continue to recruit and retain enough GPs so that both patient care and GP wellbeing are never compromised.



7

Develop impactful communications for patients which demonstrate the role of the GP and help to explain what a patient can expect from their practice, including seeing different members of the team

The unjust criticisms that GPs have experienced in the media over the past year and increased instances of abuse in surgeries, have contributed towards the demoralisation of the workforce. Many of these issues stem in part from a lack of clear communications to patients about the changing nature of general practice, including the introduction of online access points and the introduction of new patient-facing staff - both of which have been a clear direction of travel set by government for several years.

A new campaign needs to be launched by the NHS to directly communicate to the public the different ways in which they can seek healthcare, including alternative services, as well as explaining the various multidisciplinary roles in primary care.³³ Work needs to be carried out by government to alert the public of the intense pressures that general practice is under, rather than making GPs try to do more work with fewer resources.



Conclusion

General practice is the part of the health service which delivers the majority of care for patients and which acts as the point of access for hospital services. To protect the health of the nation and ensure patient safety, it is imperative that more GPs remain in the profession, alongside increasing the number of GPs joining the workforce. This can be achieved through making general practice a more sustainable and satisfying career choice where GPs feel supported and their workload is manageable, as well as investing in dedicated and comprehensive retention efforts across the UK.

Improving the retention of our GP workforce is central to keeping general practice afloat in the short term and making it a sustainable and enjoyable career for current and future GPs in the long term. Without this, ever-increasing pressure will be placed on current GPs and other healthcare professionals, right across the system, forcing the NHS, which is already struggling, to the brink of collapse.



Appendix A

Current retention programmes in the UK:

England

The **National GP Retention Scheme**³⁴ is open to GPs at risk of leaving the profession because of personal reasons, approaching retirement, or needing additional flexibility and support. It is comprised of a one to four session per week contract (annualised), with additional funding to the retainer (£1,000 - £4,000) to cover additional training costs and the practice (£4,000 - £16,000), plus protected time for mentoring and educational supervision. Individuals can be on the scheme for up to five years and may undertake out of hours work.

The **New to Practice Fellowship**³⁵ is a 24-month programme, designed to support newly qualified GPs in practice. It is open to salaried GPs and GP partners (as well as GP nurses) within the first 12 months of qualification (or up to 18 months for parental leave, sick leave etc). The programme includes backfill for one session per week of CPD (pro-rata), a £3,000 training grant, and a range of educational and professional support, including induction, mentoring, peer support, non-clinical learning and development, and rotational portfolio working across Primary Care Networks (PCNs).

New to Partnership Payments³⁶ are open to any GP becoming a partner for the first time and offer a one off “golden handshake” of £20,000 plus on costs (pro-rata), and a £3,000 training bursary, designed to encourage the uptake of partnerships.

The **Supporting Mentors Scheme**³⁷ is offered to GPs who want to become professional mentors. They receive funded training leading to a recognised mentoring qualification, plus reimbursement to deliver one session a week of mentoring.

Primary Care Flexible Staff Pools³⁸ are targeted at local GPs wanting to work flexibly; they are billed as a compromise between the flexibility of a locum role, and the stability of a salaried post. ICSs can receive funding of up to £120,000 to develop locum pools to increase capacity in general practice.

The **Local GP Retention Fund**³⁹ provides funding to systems to deliver local programmes supporting GPs at points of transition, and new ways of working flexibly. There was £12 million available for 2021/22. It is unclear whether further funding will be available in future years.

These programmes are complemented by programmes designed to support GP health and wellbeing, including through NHS Practitioner Health (self-referral support for GPs with mental health problems or addiction) and NHS Our People (access to coaching, confidential support and health and wellbeing apps).⁴⁰

Scotland

The GP Retainer Scheme⁴¹ is open to GPs who have caring responsibilities which prevent them from committing to a more substantive post but would want to return to such a post at the end of the scheme (not those retiring or who need flexibility due to long-term conditions/disability). The scheme offers up to 14 hours per week in GP practice and up to two sessions per week in a relevant external setting, as well as weekly mentoring, up to four sessions of study leave per year, and wider support for CPD. GPs can remain on scheme for up to five years.

The GP Stay in Practice Scheme⁴² is a three-year programme, of two to six sessions per week, open to mid and late career GPs needing a reduced workload or administrative burden. GPs normally move to a different practice to ensure recognition of the new role and receive two hours mentoring per month, and study leave of one session per year for each weekly session, plus two further sessions for appraisal and revalidation. Funding of £1,500 per year is given to the SIPS GP, and £77 per session to the practice. There is a requirement for a ten-year gap in participation between the Retainer Scheme and SIPS.

GP Fellowships⁴³ include a range of rural, health inequality and medical education fellowships, split between education and service delivery.

Wales

The GP Retainer Scheme⁴⁴ is open to GPs at risk of leaving the profession, and offers one to four sessions per week, with additional support for mentoring and CPD. Individuals can be on the scheme for up to five years and receive a professional expenses supplement of £1,000 - £4,000 (depending on sessional commitment).

Additionally, the Train Work Live scheme, operated by Health Education and Improvement Wales to incentivise training in rural areas, provides £10,000 to trainees who continue to practice in the area they trained for at one year after qualification.⁴⁵

Northern Ireland

The GP Retention Scheme⁴⁶ is a three-year programme, with a four session per week contract, plus one out of hours session per month. It also provides one hour per week of protected time for mentoring. Funding of £60 per session is given to the practice, and a £300 payment to the GP on completion of appraisal. It is open to up to 25 GPs in need of additional support to remain in practice and currently, 21 of the 25 spaces on the scheme are filled.

The Northern Ireland GP Mentoring Scheme⁴⁷ is open to all fully qualified GPs on the performers list in Northern Ireland and provides up to five sessions of mentoring, to address issues such as workplace problems, team relationships and work-life balance.

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