Royal College of General Practitioners

Tackling the GP workload crisis

From evidence to action on hidden and avoidable workload in general practice

April 2026

Executive summary

General practice is facing a workload crisis. As the cornerstone of the NHS, general practice is the first point of contact for most patients seeking medical care. GPs and their teams are responsible for delivering comprehensive primary health care to local communities and ensuring appropriate access to more specialised services, depending on clinical need. Despite chronic underfunding, unprecedented workload and workforce pressures and increasing numbers of patients experiencing complex and multiple conditions, GPs are working flat out to support their patients and communities, delivering more care than ever - with over 375 million general practice appointments in 2025 in England alone.[1] Yet excessive and unrecognised GP workload continues to threaten patient access to high-quality care.

82% of the public are concerned about pressures GP practices are under.[2]

This report reveals the scale of hidden and avoidable workload and sets out practical solutions to tackle GP workload to protect patient care and the GP workforce. In December 2025, the Royal College of General Practitioners (RCGP) published 'Uncovering the GP workload burden: A study of the drivers and costs of 'unnecessary' and hidden workload', conducted by Apollo Innovation and Here. This three-phased research project examined the complex nature, scale and impact of unnecessary and hidden workload across general practice in England, estimating the average equivalent cost of unnecessary workload at **£410 per GP per day**.[3] Tasks identified, ranging from repeated referrals due to administrative issues and excessive regulatory documentation to chasing information due to poorly integrated IT systems, were contributing to inefficiencies, reduced job satisfaction, stress and burnout, with significant implications for workforce retention and stability. Whilst indicative and based on a modest sample size, these conclusions highlight a substantial avoidable burden, representing a significant drain on clinical time and NHS resources, and strengthen the case for urgent system-wide improvements to reduce administrative demands and protect patient care.

Almost three quarters of GP's (73%) say patient safety is being compromised by excessive workload.[4]

Findings from this research amplify what we're hearing from GPs and patients. In our 2025 GP Voice Survey, GPs reported spending over a quarter of their time (25.3%) on administrative workload and/or bureaucracy that is related to clinical care but does not always improve patient care or outcomes.[5] NHS England reported in the Delivery Plan for Recovering Access to Primary Care that over 30% of GP time is spent on administrative tasks such as fit notes and certification,[6] taking a significant amount of their time away from other activities. Through our recent joint project with the Patients Association '"It shouldn't be this hard": Solving the NHS maze for patients and GPs', we heard directly from patients who have struggled to access their GP due to external bureaucratic pressures.[7]

Less than a third of GPs (29%) have time during appointments to build the patient relationships they need to deliver quality care.[8]

As Government plans to shift even more care into the community through the 10 Year Health Plan for England (10YHP), demands on general practice will only continue to rise. GPs and their teams are central to delivering a future-ready NHS and to making plans for a Neighbourhood Health Service a reality, but the Government and NHS England must urgently address significant workload issues and provide the funding uplift needed so practices can meet the needs of patients today while building the capacity required for tomorrow.

Informed by the latest research in this relatively understudied space, this report determines the tangible actions Government, NHS England and system leaders must take to tackle hidden, avoidable and unsustainable workload in general practice in England. While our recommendations focus on England due to the devolved nature of health policy, workload pressures are a UK-wide concern, and further work to understand and address challenges and opportunities across the devolved nations is also urgently needed.

Summary of recommendations

Summarised below, this report includes recommendations for the Department of Health and Social Care (DHSC), NHS England (NHSE), Integrated Care Boards (ICBs), the Care Quality Commission (CQC), the Medicines and Healthcare products Regulatory Agency (MHRA), and the National Institute for Health and Care Research (NIHR).

Improvements to system working and the primary and secondary care interface

1 **Publish and implement the Red Tape Challenge**
Publish the full findings and require implementation across providers, aligned with professional interface guidance, with clear accountability for reducing bureaucracy, improving collaboration and ensuring meaningful reduction in unnecessary workload.

2 **Improve provider communications and patient pathways**
Introduce contractual frameworks to ensure all health and care providers provide clear, timely, and accessible communications with patients about their care, including referrals, tests, and treatments.

3 **Co-design system and pathway reform with patients and GPs**
Ensure all national system and pathway redesign initiatives are co-designed with patients and GPs and are subject to ongoing evaluation of their impact on GP workload, patient experience, and system efficiency.

Recognising GP workload to guide fair resource allocation

4 **Commission further research on hidden workload**
Fund research to better quantify and understand hidden workload in general practice, including its drivers, variation, and impacts.

5 **Recognise hidden workload in commissioning and funding arrangements**
Ensure funding and contract design reflect the full scope of GP work, including indirect and system-compensating activity.

6 **Simplify and modernise regulatory and reporting requirements**
Streamline incentives such as QOF and other regulatory requirements to focus on high-value care and reduce administrative burden.

7 **Avoid oversimplified efficiency measures and support continuity**
Ensure policies and commissioning frameworks recognise the complexity of general practice and support continuity and relationship-based care.

8 **Tackle overdiagnosis and overmedicalisation**
Strengthen national and local guidance, public information, and practical tools that promote appropriate testing and screening to reduce low-value care and unnecessary demand.

9 **Address inequalities of health, workload and funding**
Align resources and workforce planning with need in deprived areas, including through reform of the Carr-Hill formula.

10 **Develop and implement a national framework for Operating Pressures Escalation Level (OPEL) for general practice**
Introduce a consistent national system to support practices during periods of exceptional demand and protect patient safety.

Improving digital infrastructure, IT systems, and interoperability

11 Invest in modern, interoperable IT systems
Improve digital infrastructure to enable seamless data sharing and reduce duplication.

12 Ensure digital systems reduce workload and are safe
Evaluate all digital developments for their impact on efficiency and workload, data protection, and patient safety.

13 Standardise and automate common administrative processes
Develop national tools and templates to reduce duplication and manual workload.

GP occupational and mental health support

14 Prioritise GP mental health and occupational support
Ensure accessible, confidential and sustained support for GPs across all career stages.

15 Embed wellbeing in workforce planning and retention strategies
Ensure workforce strategies prioritise sustainable working, retention, and job satisfaction.

The Government, NHS England, regulators and system partners need to take decisive action to address hidden and avoidable tasks and tackle the GP workload crisis, to safeguard the future sustainability of general practice.

Context

General practitioners are managing a significant and increasing volume of demand, inside and outside the consulting room. While much of general practice workload is essential to delivering safe, continuous and coordinated care for patients, many of these tasks are often unmeasured, unfunded and poorly understood across the wider system. In response to these concerns, the Royal College of General Practitioners (RCGP) commissioned a study to examine the nature, scale and impact of unnecessary and hidden workload in England, subsequently publishing the 'Uncovering the GP workload burden: A study of the drivers and costs of "unnecessary" and hidden workload' report in December 2025.[9]

Conducted by Apollo Innovation and Here, the study focused on understanding 'unnecessary' and 'hidden' tasks undertaken by GPs in England. The mixed-methods research combined a narrative literature review, qualitative interviews with GPs, and a time and motion study to reveal a complex and nuanced picture of unnecessary and hidden workload in general practice.[10] The three-phased inquiry found that a significant proportion of GP time is spent on tasks that are clinically peripheral, system-generated, or administrative in nature, often completed outside contracted hours and unaccounted for in workforce planning or funding frameworks. The findings highlighted the need for more systematic recognition, measurement, and resourcing of general practice workload. They also emphasised the importance of tackling root causes, such as poor interface working, fragmented digital systems, and regulatory complexity, while avoiding simplistic efficiency policies that risk shifting hidden workload back onto GPs.[11] Additionally, these insights corroborate the concerns we've heard from patients and GPs at the front line, through our annual GP Voice Survey and joint report with the Patients Association '"It shouldn't be this hard": Solving the NHS maze for patients and GPs'.[12]

Reducing administrative (58%) and clinical workload (43%) are reported by GPs as the interventions most likely to retain them in general practice for longer.[13]

"A lot of unnecessary GP appointment time is taken up with fielding referrals where other personnel or the patient themselves might have been able to facilitate that."[14]
– Patient workshop participant

The literature review identified excessive non-clinical and administrative burdens, fragmented system processes, and regulatory requirements as major drivers of hidden workload. These pressures were associated with reduced time for patient care, increased stress and burnout, and eroded professional autonomy. Recommended mitigations included delegating non-clinical tasks, simplifying external demands, improving digital infrastructure, and streamlining regulatory and compliance systems.[15]

During the RCGP study, GP interviews reinforced this complexity, describing blurred boundaries between necessary and unnecessary work. GPs described inefficient or inappropriate tasks as "pointless," "bureaucratic," or "not a GP's job", however they acknowledged that some tasks were inefficient yet supported continuity and relational care, or carried ethical significance. They gave examples such as form-filling for external agencies and secondary care follow-up, often undertaken out of moral duty, patient vulnerability or gaps in the wider system.[16]

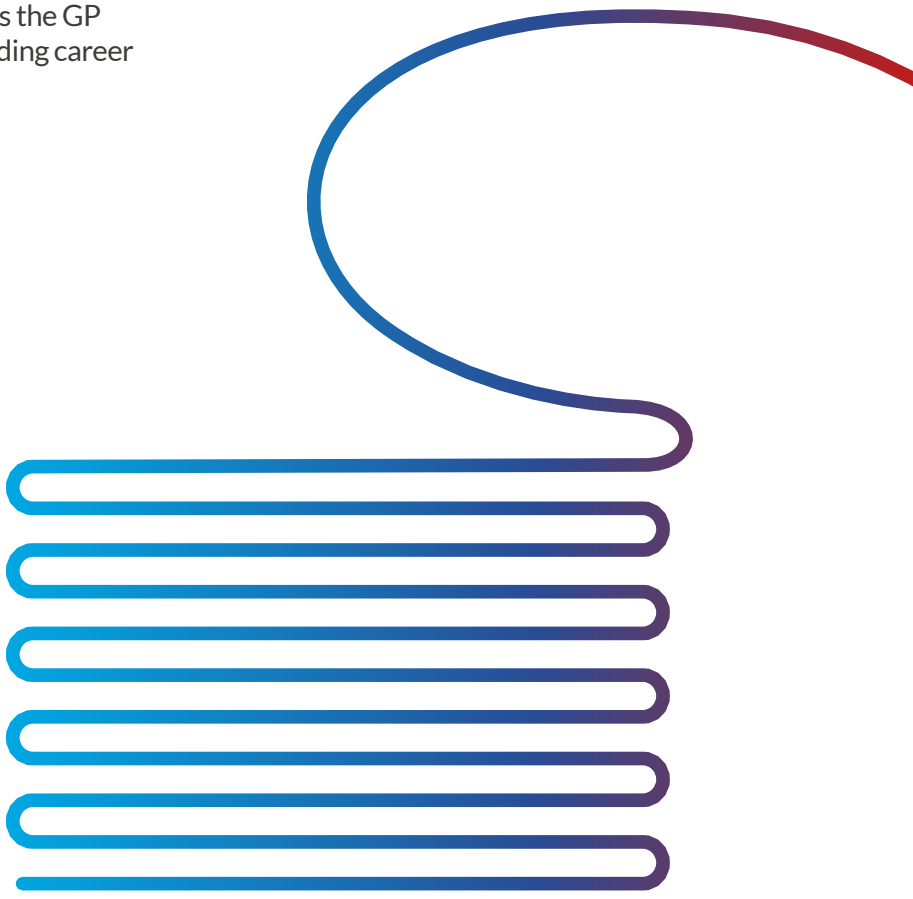
Finally, the time and motion phase of the study attempted to quantify this burden, estimating the overall average equivalent cost of unnecessary workload at £410 per GP per day in England (inclusive of on-costs such as use of premises). While indicative, further research is needed to validate these figures and better understand both the financial and emotional impacts. Importantly, much of this work occurs outside contracted hours and reducing this workload burden should not be assumed to translate directly into more appointment capacity.[17]

Overall, the findings demonstrate that hidden, unnecessary or avoidable workload is widespread and under-recognised across general practice in England.[18] GPs reported spending a significant proportion of their day on indirect care, reflecting the extent of work that supports patients but remains largely unseen. Workload intensity and resource demands were identified as key drivers of workforce retention problems, and practices in deprived areas were highlighted as facing greater hidden burdens. The study also found that digital infrastructure inefficiencies, including issues with access, quality and interoperability of IT systems, amplified workload pressures. Though based on a modest sample, this research strengthens the evidence base and highlights the urgent need for further research and targeted policy reform to ensure that all aspects of general practice work are visible, understood, and adequately resourced.

While this report focuses on addressing the systemic and administrative drivers of unnecessary and hidden workload in England, lasting improvement also depends on strengthening and retaining the GP workforce. The RCGP has published recommendations on these specific areas in our '10 Year Health Plan Recommendations' and GP Retention report 'Looking after the GPs of today to safeguard the workforce of tomorrow'.[19, 20] Experiences of workload challenges are diverse across the GP profession, influenced by factors including career stage and working environment.

Our 2025 'GP Partnership Principles' paper highlights the benefits and importance of the independent contractor model for patients, GPs, and the NHS; and how workload and bureaucratic pressures associated with GP partnership can dissuade new partners and contribute to a cycle of rising workload for those who remain.[21] Inextricably linked with GP workload and workforce challenges, our newly published joint report with the Patients Association 'Solving the NHS maze' calls for collaborative action to address the "overwhelming" administrative and procedural barriers patients face when seeking care in the NHS.[22]

> "The system can feel like a maze. It's full of pathways, departments, referrals, and rules that aren't always clear."[23]
> – Patient workshop participant



Key themes and recommendations

Using the insights from the 2025 RCGP study into hidden and unnecessary GP workload 'Uncovering the GP workload burden', alongside wider evidence and analysis, we have developed targeted recommendations for policymakers and system leaders in England to tackle the GP workload crisis and safeguard the future sustainability of general practice.

I. Improvements to system working and the primary and secondary care interface

Poor system working and challenges at the interface between primary and secondary care are a key source of hidden workload and one of the most remediable drivers of inefficiency in the NHS. Within the time and motion phase of our GP workload research, 91% of GPs reported spending time navigating referral processes, with the average equivalent cost of this activity estimated at £94 per GP per day.[24] The majority of GP participants reported spending 25–30 minutes per day completing tasks relating to a referral or follow-up activities, including manual data entry of non-integrated forms, re-issuing prescriptions and re-sending referrals, including those which had been lost, bounced-back or rejected because of inconsistent and 'clunky' pathways. These activities were found to be driven by ambiguity and system fragmentation, characterised by poorly defined processes, duplicated roles and responsibilities, and a perceived moral responsibility and expectation for GPs to safety net and compensate for gaps or failures elsewhere in the system. Much of this work may be considered displaced demand, where work is shifted into general practice from other sectors, and failure demand, arising when services fail to meet patient needs at first contact. However, a significant proportion of hidden workload is unfunded yet essential for patient care and GPs should be appropriately recognised and resourced for these efforts.

Studies identified in the literature review highlighted that poor interface working, wider system inefficiencies, and duplication are persistent drivers of unnecessary workload, clinical error risk, burnout and workforce attrition.[25,26,27]

Wider research from the Primary care Academic CollaboraTive's (PACT) ongoing Hidden Workload Study, the General Medical Council's (GMC) Workplace Experiences Report, and Barnard et al.'s ethnographic research supported these findings, identifying that hidden workload is pervasive, with GPs spending a substantial proportion of their working day on indirect care.[28,29,30]

> Over 80% of GPs say improved guidance to support GPs and their teams navigate diagnostic and referral processes could improve their workload.[31]

Our 2025 RCGP GP Voice Survey contributed additional weight to these conclusions with 96% of GPs stating that requiring specialists to refer patients directly to other specialists (onward referral) where appropriate, rather than requiring GPs to re-refer, would improve workload.[32] Clearer patient pathways are also needed between general practice, community services, and the voluntary sector to reduce duplication and delays.

The Government's Red Tape Challenge in England (2024-25) recognised the importance of GP workload and the value of efficient and integrated working, and some proposed improvements have been published within the DHSC and NHSE Neighbourhood framework guidance for England.[33] However, its full findings and recommendations have still not been made publicly available. This lack of transparency risks undermining accountability and delaying implementation.

The Red Tape Challenge recommendations align with previously published guidance from the RCGP and BMA. Full and consistent implementation of established standards on clear expectations around roles, responsibility and workload distribution across the system, remains essential to reduce inappropriate workload transfer and support safe, coordinated patient care.

While initiatives such as the Red Tape Challenge and the Getting It Right First Time (GIRFT) 'Bridging the interface' programme have rightly focused on clarifying responsibilities and reducing inappropriate workload transfer between providers, less attention has been given to the role of patient-facing communication in generating avoidable demand. In practice, patients often visit their GP for clarification on investigations, referrals, or treatment decisions that have originated in or been managed in other areas of the health system, often due to unclear, delayed, or inaccessible communication from the originating provider. This fragmentation can create additional, avoidable workload for GPs, who are required to interpret, explain, and follow up on care they did not initiate, effectively acting as a safety net for failures elsewhere in the system. This pattern represents a form of system-generated demand that is not addressed solely through interface process improvements. Strengthening direct communication between providers and patients, alongside clear and accessible routes for patients to seek advice from the originating service and relevant responsible clinician(s) is essential to improving patients' experiences, tackling avoidable GP workload and improving system efficiency.

Our 'Solving the NHS maze' report, emphasised the importance of clear communication, patient understanding, and appropriate navigation of services.[34] Beyond this, the report and our recent workload research highlight the need for further development of bureaucracy-reducing measures co-designed with patients and GPs. These include standardised referral and discharge pathways, clearer roles and communication channels, interface liaison officers within each Trust, improved prescribing practices, and strengthening of the Discharge Medicines Service, as recommended in GIRFT guidance.[35,36] To be effective, national system and pathway redesign initiatives require ongoing GP and patient input at every stage, from design to delivery and evaluation.[37] Without this, reforms risk overlooking frontline realities and generating additional workload. Continuous evaluation using clear measures of workload, patient experience, and system efficiency is essential to refine implementation and avoid unintended consequences.

Recommendations

1 **Publish and implement the Red Tape Challenge**
DHSC and NHSE should publish the full findings and recommendations of the Red Tape Challenge in England and require implementation across providers, aligned with professional interface guidance. Providers should report annually on progress to ensure transparency, accountability, meaningful reduction in unnecessary workload, and improved collaboration.

2 **Improve provider communications and patient pathways**
DHSC, NHSE and ICBs should introduce new contractual requirements and support, to ensure all health and care providers deliver clear, timely, and accessible communication with patients about their care, including referrals, tests, and treatments. Patients must be supported with straightforward and accessible routes to information regarding their care.

3 **Co-design system and pathway reform with patients and GPs**
DHSC and NHSE should ensure all national system and pathway redesign initiatives are co-designed with GPs and patients and subject to ongoing evaluation of their impact on workload, patient experience, and system efficiency.

II. Recognising GP workload to guide fair resource allocation

The absence of mechanisms to record and measure hidden workload, whether unnecessary or essential, means a large proportion of GP activity remains unrecognised in funding, workforce planning, and performance frameworks, despite its direct impact on care quality, access and workforce capacity.

Our research identified recurring themes such as duplicative origins of activity and GPs being the 'safety net' for work that should be managed elsewhere, highlighting how system gaps and fragmentation translate directly into GP workload. These included clinical administration, supervision, safeguarding, care coordination, and activities such as Driver and Vehicle Licensing Agency (DVLA) forms. Although some tasks contributed positively to continuity and relationship-based care, most were time-intensive and required extensive record navigation.

System reforms must acknowledge the complexity of care delivered in general practice.[38] Further research is needed to better understand and quantify the hidden workload in modern general practice, across clinical and non-clinical activity, to support appropriate commissioning and resourcing. This work should include analysis of workload drivers across different practice settings, patient demographics, and deprivation levels to support more equitable resourcing. Development of commissioning arrangements must be undertaken in close collaboration with the RCGP, BMA and other relevant representative bodies to ensure that funding mechanisms reflect the realities of practice and avoid the creation of additional bureaucratic requirements.

The Quality and Outcomes Framework

Our commissioned research also highlighted the burden created by frameworks such as the Quality and Outcomes Framework (QOF), excessive paperwork, and compliance demands, which can divert time from core clinical care and erode professional autonomy.[39] The 2025 RCGP GP Voice Survey found that 69% of GPs believed a reduction in the number of QOF indicators would help improve their workload.[40]

In 2024, 70% of GPs thought streamlining the QOF reporting process through automation would help improve their workload.[41] Many GPs view QOF as overly rigid, box-ticking, and misaligned with the realities of modern practice. Last year, 2024/25 GP Contract changes made progress by retiring 32 QOF indicators (212 points) and reducing the total to 564 points for 2025/26.[42] Despite commitments to refine QOF by "streamlining by combining and simplifying existing measures", 2026/27 saw NHSE reduce the total number of indicators by just one, introducing two new obesity-related indicators and 18 additional QOF points.[43] Further simplification of the funding framework is needed.

Continuity of care

Access and continuity are often viewed as competing priorities, particularly in areas of high deprivation where demand pressures are greatest.[44] However, this is often a false dichotomy and with appropriate planning and resourcing, both can be achieved together. There is strong and growing evidence that continuity of care in general practice is linked to more appropriate use of services, including lower rates of unnecessary testing and prescribing, as well as greater overall efficiency and productivity.[45,46,47] The 2025 RCGP GP Voice Survey found that less than a third of GPs (29%) have time during appointments to build the patient relationships they need to deliver quality care.[48] Efficiency policies must recognise the complexity of general practice, where even seemingly routine presentations often require nuanced clinical judgment, coordination, and follow-up. Approaches that prioritise activity volume over continuity, such as simplistic access targets, may risk fragmenting care, increasing duplication, and driving further administrative burden. Policymakers and commissioners should therefore place continuity and relationship-based care at the heart of system design, ensuring that efforts to improve access and efficiency strengthen, rather than weaken, the GP–patient relationship.

Overmedicalisation

Overmedicalisation and overdiagnosis also significantly contribute to hidden and avoidable workload in general practice, generating follow-up tasks, patient enquiries, and considerable administrative burden with limited patient benefit.[49] RCGP resources, including clinical toolkits and courses on overdiagnosis and patient safety, provide valuable evidence and guidance on diagnostics, screening, and shared decision-making to minimise low-value care and assist in the delivery of safe and effective care to patients.[50,51] Concerns remain that commercial and non-evidence-based screening outside of NHS services create avoidable anxiety, unnecessary referrals and added pressure on already overstretched GPs. In 2019, the RCGP issued a position statement and joint letter with the BMA, advising that only screening approved by the UK National Screening Committee (UK NSC), National Institute for Health and Care Excellence (NICE), or equivalent devolved bodies should be offered, and this remains the College's position.[52,53]

Health inequalities

Hidden and undervalued workload is especially pronounced in areas of high deprivation, where GPs face greater patient demand and complexity, larger patient lists with higher patient to GP ratios, and around 9.8% less funding per needs-adjusted patient than in more affluent areas, making it harder to recruit and retain staff.[54,55] The outdated Carr-Hill formula fails to reflect the additional workload faced in these settings, leading to persistent underfunding and workforce shortages, further perpetuating the issue.[56] The Government's commitment to review the formula is therefore welcome and this should be prioritised to ensure fairer funding distribution in line with need. However, significant consultation and meaningful engagement with GPs and patients in this process will be required to ensure success, alongside an overall uplift in GP funding. This also needs to sit alongside urgent action in the forthcoming 10 Year Workforce Plan to address inequalities in workforce distribution and wider support for practices serving the most deprived communities. Our May 2024 report 'Breaking the inverse care law in UK general practice' identifies key recommendations to help reduce health inequalities.[57]

Operating Pressures Escalation Level (OPEL) framework

Consistent with the experiences of individual GPs, many practices are currently overwhelmed and struggling with workload. In our 2025 RCGP GP Voice Survey, almost three quarters of GP's (73%) had concerns that patient safety was being compromised by excessive workload.[58] Recently announced changes to the GP Contract for 2026/27 set out to guarantee same day appointments for clinically urgent issues and to require practices not to switch off online consult tools during core hours.[59] These shifts pose questions as to what practices should do if they are overwhelmed and unable to ensure patient safety, particularly as demand is only expected to increase with 10 Year Health Plan for England (10YHP) ambitions.

To combat this, the RCGP would like to see the development, piloting and evaluation of a national OPEL framework for general practice, applicable to online access and more broadly, to support consistent, transparent responses and support from ICBs during periods of exceptional demand. Some areas already have systems of this nature in place, such as the LMC-led General Practice Alert State (GPAS) initiative. This innovation converts anonymised practice data into an OPEL assessment which can be used by practices to reflect current pressures back to the rest of the system and to commissioners. However, this remains localised and the recently updated NHSE OPEL Framework 2025/26 does not explicitly mention any plans or support for a 'consistent and unified alert' system for primary care. A national general practice OPEL framework, co-produced with GPs and setting out clear triggers, defined alert levels and corresponding commissioner responsibilities would ensure appropriate support could be made available when demand exceeds capacity and poses risks to patient safety.

Recommendations

4 Commission further research on hidden workload

Relevant funders, including DHSC and the NIHR, should commission more research to quantify and characterise the scale, nature and costs of hidden workload in modern general practice, particularly the clinical and non-clinical activities that are essential yet currently unrecognised, and evaluate solutions. This should include evaluation of practical interventions to reduce avoidable workload and support appropriate resourcing to improve care quality, workforce sustainability, and efficiency.

5 Recognise hidden workload in commissioning and funding arrangements

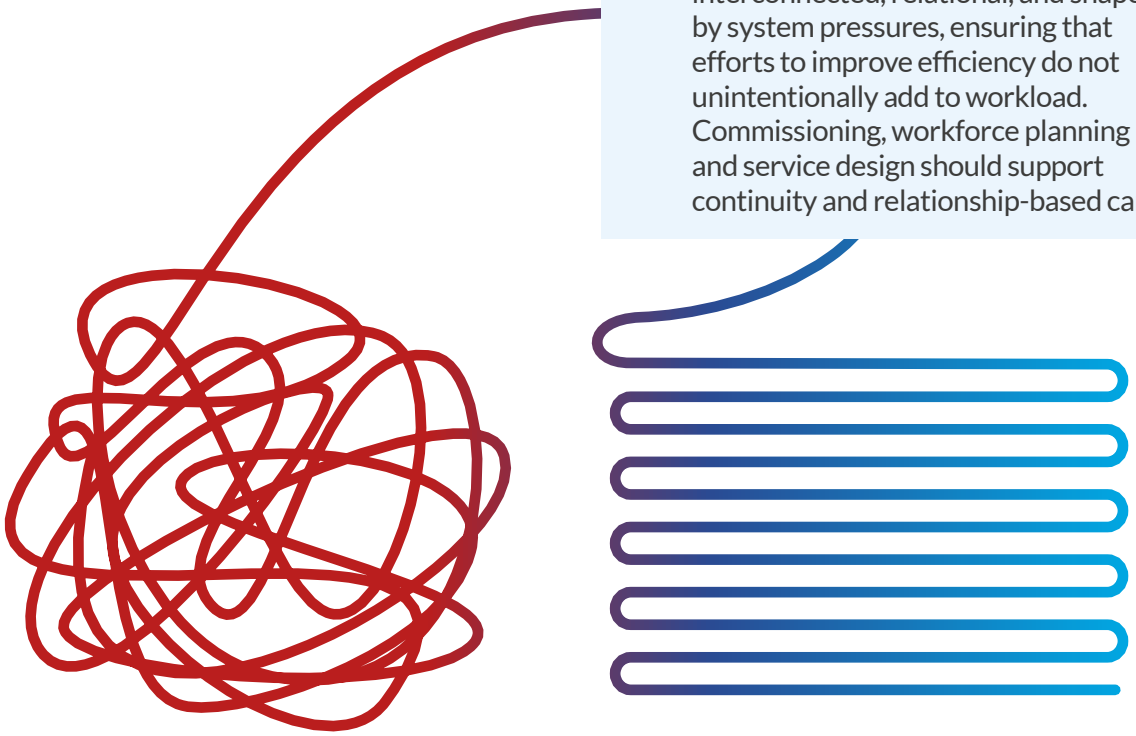
DHSC, NHSE and local commissioners should account for indirect and system-compensating work in resource allocation and contract design, guided in collaboration with the RCGP, BMA, and local GP representatives and informed by greater research. Funding and commissioning arrangements should reflect the full scope of GP activity, including hidden but essential work that supports safe, continuous, and coordinated care.

6 Simplify and modernise regulatory and reporting requirements

NHS bodies and regulators such as the Care Quality Commission (CQC), working with the RCGP, BMA and relevant local representatives, should simplify compliance, reporting and regulatory processes to focus on meaningful, high-value outcomes. We would like to see a significant reduction in the number, and bureaucracy, of incentivised indicators, such as QOF. Excessive and duplicative documentation, such as for QOF, CQC inspections and mandatory training, should be replaced with proportionate, outcome-focused approaches that prioritise quality of care, support professional development, and minimise bureaucratic compliance. Any new measurement or reporting tools must be proportionate, automated where possible, and not add to GP workload.

7 Avoid oversimplified efficiency targets and support continuity

Governmental and system healthcare reforms and planning should avoid arbitrary and oversimplified access targets and be grounded in an understanding of how GP work is interconnected, relational, and shaped by system pressures, ensuring that efforts to improve efficiency do not unintentionally add to workload. Commissioning, workforce planning and service design should support continuity and relationship-based care.



8 Tackle overdiagnosis and overmedicalisation

a) National and local commissioning frameworks should actively support high-value, evidence-based care, empowering clinicians to avoid unnecessary testing and intervention. This should be supported by stronger system-wide guidance, public information on appropriate testing and screening, and practical tools to reduce low-value care.

b) DHSC and NHSE should invest in system-wide technology to flag duplicated or potentially unhelpful investigations, alongside the introduction of clear, proportionate diagnostic guidelines, to help reduce avoidable workload and follow-up.

c) DHSC, NHSE and ICBs should ensure national and local policy discourages non-evidence-based screening and testing outside NHS pathways, which often create avoidable anxiety, unnecessary follow-up and additional administrative burden. Except in research settings, only screening approved by the UK National Screening Committee, NICE, or equivalent devolved bodies should be supported.

d) NHSE should support patients and GPs by providing additional public information on appropriate testing and screening.

9 Address inequalities of health, workload and funding

The Government should urgently review primary care resource allocations (including reforming the Carr-Hill funding formula) so that funding genuinely reflects the complexity and intensity of workload in general practice, especially in under-doctored and socioeconomically deprived areas. This review should involve co-design with patients and GPs and be guided by the principles of proportionate universalism, to ensure equitable funding distribution, and be jointly delivered alongside workforce planning to address health inequalities. Any reform must be supported by an overall uplift in funding and should be appropriately implemented in consultation and collaboration with the RCGP, BMA and local commissioning bodies.

10 Develop and implement a national framework for Operating Pressures Escalation Level (OPEL) for general practice

NHSE should co-produce a national general practice OPEL framework with relevant representative bodies including the RCGP and the BMA. This should set out clear triggers, defined alert levels and corresponding commissioner responsibilities. This consistent and unified national alert system should be developed, piloted and evaluated to enable consistent, transparent responses and support from ICBs during periods of exceptional demand.

III. Improving digital infrastructure, IT systems, and interoperability

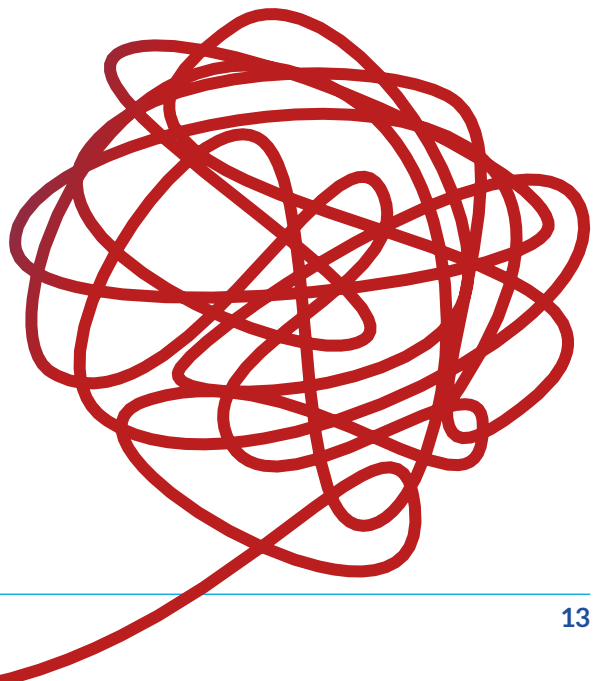
Improving the NHS' digital infrastructure, including GP IT systems, and interoperability between systems in different healthcare settings is a key priority to reduce unnecessary administrative workload and increase efficient care delivery.

Interviews within our research identified "clunky" and inconsistent IT systems, particularly for referrals and communication with secondary care, as major sources of unnecessary work. Frequent referral rejections, duplicate data entry, and manual form completion often required GPs to work beyond contracted hours. In the time and motion study, 27% of participants reported daily IT-related delays, and wider studies by Odebiyi (2021) and Croxson (2017) link poor digital integration to duplication and inefficiency.[60,61] In our 2025 RCGP GP Voice Survey, 91% of GPs said an improved digital interface between primary and secondary care could improve their workload, 81% thought the introduction of e-prescribing in secondary care would help improve their workload, and 73% believed the implementation of an integrated electronic shared patient record could help.[62] From the same survey, only 21% of GPs agreed that the ability of their system to exchange information with secondary care was fit for purpose or of an acceptable standard, with poor interface between existing IT systems and poor IT infrastructure to support communication channels cited as the top causes.

91% of GPs say an improved digital interface between primary and secondary care could improve their workload.[63]

Technology should support, not hinder, clinical work. Standardised e-templates and automation can streamline repetitive tasks such as referrals, diagnostic follow-ups, and form completion, reducing duplication and error. Digital systems must be intuitive, interoperable, and designed around clinical workflows across primary, secondary, and community care. The Government's 10YHP commits to record interoperability and greater use of the NHS App to enable more coordinated, personalised and predictive care.[64] The RCGP supports these ambitions in principle, provided they are underpinned by robust data protection, evidence and regular quality audits, and they result in genuine time savings and clinical safety advancements, rather than added bureaucracy.

The 10YHP also describes major ambitions for the use of artificial intelligence (AI) in healthcare settings, including its potential to reduce GP workload. The use of AI in general practice has already shown promising signs of its ability to improve GP workload, for example by reducing administrative tasks and documentation burdens through automation and Ambient Voice Technology (AVT).[65] However, feedback from GPs on the impact of AI tools has been mixed, and there are a range of actions required to enable its safe and effective roll-out. This includes development of a robust regulatory framework and national guidance, and robust evaluation of the potential benefits and risks of AI tools. Our recently published joint report with Nuffield Trust 'How are GPs using AI? Insights from the front line' sets out recommendations to policymakers to address the variation visible in the adoption of AI and to encourage its responsible use.[66]



Recommendations

11 Invest in modern, interoperable IT systems

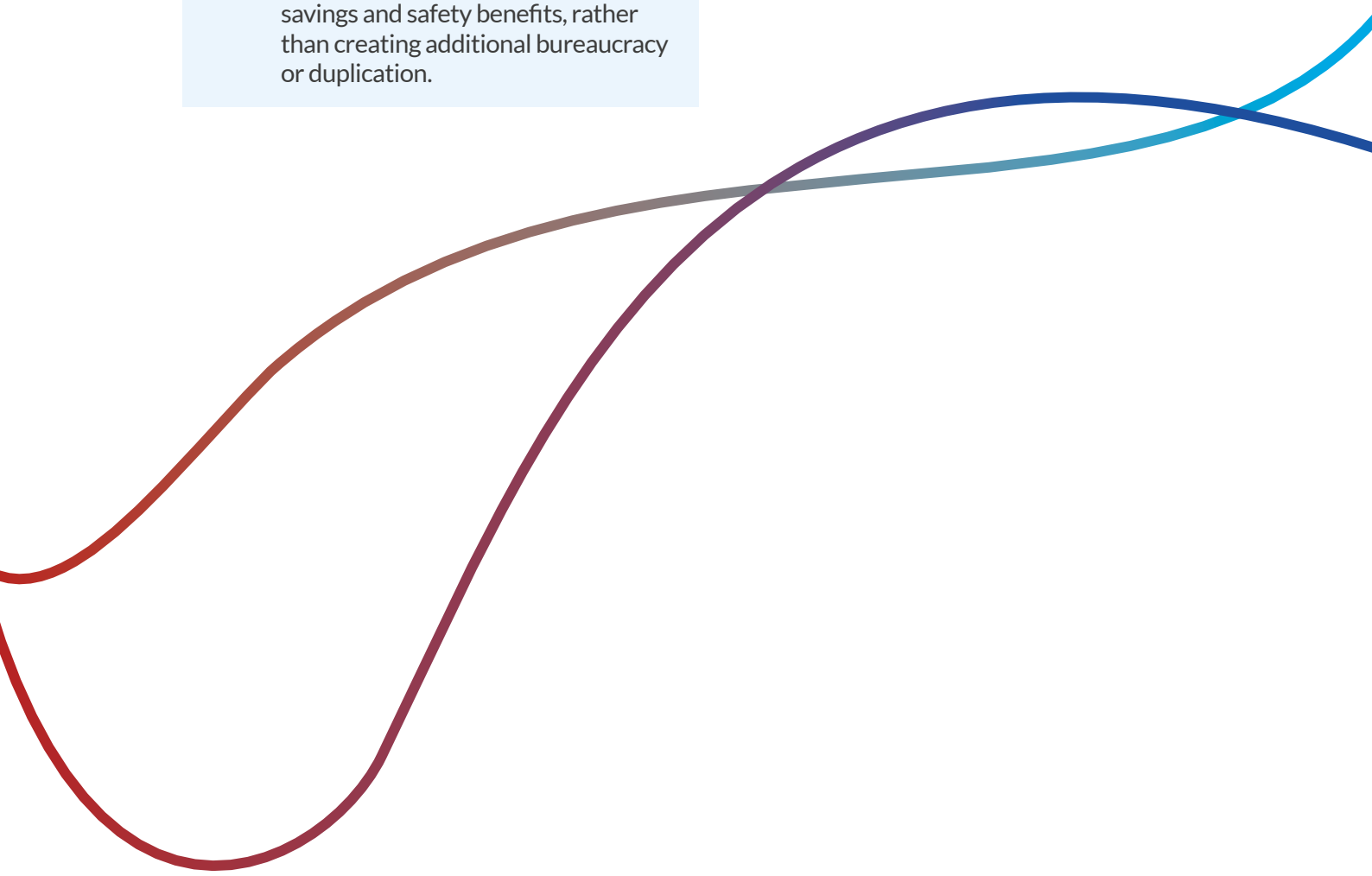
DHSC and NHSE should invest in up-to-date, interoperable digital systems that reduce duplication and support seamless data exchange across primary, secondary, community, and mental health services. Systems must be reliable, user-friendly, interoperable and integrated across care settings, and designed with patients and GPs.

12 Ensure digital systems reduce workload and are safe

DHSC, NHSE and the MHRA should ensure that all digital developments, including AI tools, are subject to evaluation of their impact on efficiency and workload, data protection, and patient safety, with findings used to inform commissioning and quality improvement. New digital tools should demonstrate genuine time savings and safety benefits, rather than creating additional bureaucracy or duplication.

13 Standardise and automate common administrative processes

DHSC and NHSE should work with the relevant professional bodies (including the RCGP) to develop national e-templates and automation tools for repetitive administrative tasks, such as referrals, DVLA or insurance forms, to minimise manual data entry, reduce rejection rates, and prevent duplication.



IV. GP occupational and mental health support

The RCGP's recent workload research suggests that GPs spend a large share of unpaid or personal time on hidden, avoidable or unnecessary tasks, which is driving burnout, moral injury, and intentions to leave the profession. This hidden effort means formal workforce metrics such as full-time equivalent (FTE) workforce data underestimate true working hours. Wider evidence links heavy administrative demands with poor job satisfaction, reduced autonomy, and declining care quality.[67,68,69] In our 2025 RCGP GP Voice Survey, GPs said that reducing administrative (58%) and clinical workload (43%) were the interventions most likely to retain them in general practice for longer.[70]

The GMC's Deep Dive on Managing Workloads report highlights physical and mental exhaustion experienced by GPs, with impacts on the wider workforce, training capacity and service continuity, as some reduce working hours in response to such pressures.[71] NHSE data from July 2021 to December 2024, shows that almost 15% of GPs leaving the workforce cited 'work–life balance' as their reason for resignation, with an average age of just 43, signifying a serious loss of mid-career experience.[72]

Efficiency gains from reducing unnecessary workload should not be assumed to directly create more appointment slots. Freed capacity must also protect time for workforce development and quality improvement. The Government's 10YHP for England proposed 'New Staff Treatment Hubs' to provide occupational health services for all NHS staff, which will be a positive step, but GPs, who remain the most pressurised medical group, need comprehensive, tailored, accessible mental health and occupational support.[73,74]

The RCGP therefore calls on the Government and NHSE to embed GP wellbeing and sustainable working conditions at the heart of workload and access reforms.

Recommendations

14 Prioritise GP mental health and occupational support

The Government and NHSE should prioritise comprehensive, confidential, and equitable mental health and occupational support, accessible for all GPs across every region and career stage, and guarantee ongoing funding for Practitioner Health services.

15 Embed wellbeing in workforce planning and retention strategies

Within the forthcoming 10 Year Workforce Plan for England, DHSC and NHSE should explicitly link GP wellbeing to workforce retention, incorporating measures that address burnout, improve job satisfaction, and provide targeted support for GPs at risk of leaving the profession. Workforce planning should recognise that sustainable working conditions, protected time, and professional fulfilment are essential to retention and high-quality care.

Conclusion

As general practice adapts and responds to the evolving needs of their communities, workforce expectations, and wider system transformation, there is a clear need to better understand and address workload issues to strengthen and protect sustainable and high-quality general practice at the core of the NHS.

Building on the findings of the RCGP's workload research, 'Uncovering the GP workload burden', this report presents targeted recommendations for policymakers in England to tackle the GP workload crisis and safeguard the future sustainability of general practice.

We will continue to work with Governments, NHS bodies, system partners and stakeholders across the UK to highlight and address workload challenges to improve the experiences of GPs so they can deliver the best possible care for their patients and improve the nation's health. Urgent action now will determine whether general practice can continue to deliver safe, high-quality care for patients in the years ahead.

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