Royal College of General Practitioners (RCGP) organisational response to the Department of Health & Social Care's 10 Year Workforce Plan - call for evidence

November 2025

About RCGP

We are the professional membership body for GPs in the UK. Our purpose is to encourage, foster and maintain the highest possible standards in general medical practice. We support GPs through all stages of their career, from medical students considering general practice, through to training, qualified years and retirement.

The first part of our response to the call for evidence, 'Recommendations for the 10 Year Workforce Plan' (pp 1-11), sets out our recommendations for the plan using the results from three surveys we carried out this year[1] and analysis of relevant NHS datasets. The second part of our response, 'Call for evidence response' (pp. 12-18), was prepared with input from our GP networks including members of our Clinical Adviser Network. The role of the clinical adviser is to share their expert generalist voice, ensuring that it is heard across the UK policy landscape and is reflected in the future of general practice.

RCGP Recommendations for the 10 Year Workforce Plan

1. Background

Following the publication of the NHS Long Term Workforce Plan (LTWP) in June 2023, the RCGP welcomed its aims to double undergraduate medical school places by 2031/32 and increase GP training places. However, we expressed concern over the plan's lack of detail and ambition regarding GP retention and overall capacity – both in terms of trainer availability to deliver an expansion of specialist training and physical infrastructure to house more registrars and qualified GPs. We were also concerned that the plan did not project meeting the previous Government's commitment to recruit 6,000 additional fully qualified GPs until well after 2026/27, despite the original target date being 2024/25.

Our reservations deepened in light of the National Audit Office (NAO)'s independent assessment of the modelling underlying the LTWP in March 2024.[2] Our evidence submitted to the UK Parliament's Public Accounts Committee (PAC)'s inquiry into the LTWP modelling highlighted these concerns.[3] It was disappointing that the inquiry was not completed following the General Election, despite joint calls from the RCGP and other health bodies for

it to be reopened. This means that concerns about the plan's assumptions, particularly around GP retention and workforce distribution (for example, GP growth was projected at just 4% versus 49% for hospital consultants by 2036/37), have not been properly addressed.

As such, we welcome the commitment to publish a new 10 Year Workforce Plan (10YWP) with a stronger focus on shifting care into the community and addressing weaknesses in previous modelling. We look forward to engaging in the development of this new plan. Our key data on the general practice workforce and recommendations for the plan are outlined below. While we recognise that some of our recommendations may fall beyond the 10YWP's direct remit, acknowledging and addressing these issues will be critical to ensuring the plan's success.

2. Workforce modelling and training numbers

The RCGP welcomed the commitment of the 2023 LTWP to increase the number of GP training places, given the urgent need to strengthen primary care capacity. However, the LTWP's projections did not show a corresponding rise in the number of fully qualified GPs. While the overall number of doctors working in primary care was projected to grow significantly over the modelled period, the increase in fully qualified GPs was minimal, at around 4% by 2036/37. The assumptions underpinning this gap were not clear. We also want to see the training place target reached earlier than 2031/32.

Competition ratios for GP training have risen sharply; according to the recently published Medical Training Review, the number of applicants per post has nearly doubled, from 1.4 in 2015 to 2.7 in 2023.[4] This trend reflects growing interest in joining the profession but also highlights the need to ensure sufficient training capacity.

RCGP recommendations for workforce modelling and training numbers for the 10YWP:

- Provide transparency on workforce modelling, including assumptions relating to GP retention, working hours and role mix, to ensure projections are credible and accountable.
- Accelerate the planned expansion of GP training places set out in the 2023 LTWP, reaching 6,000 places earlier than the current 2031/32 target.

3. Infrastructure and resources for GP training

There was minimal detail in the 2023 LTWP on how NHS England planned to address capacity issues, including physical and trainer capacity, or on the costs associated with tackling these issues. To accommodate the much-needed increase in GP training places, it is vital that funding is provided for training practices to ensure there is sufficient physical space as well as

GP trainer capacity. In May 2023, the RCGP published a report on infrastructure in general practice, which highlighted the inadequacy of general practice premises and digital infrastructure, including limited physical space, inadequate capacity to host multidisciplinary teams or receive new registrars, deficient IT infrastructure and poor building energy efficiency. Our 2023 Infrastructure survey found that 84% of general practice staff said a lack of physical space limited their practice's ability to take on GP registrars or other learners. 73% of staff said their practice had little or no capacity to increase training places without additional funding. These problems have not diminished in the intervening years:

> Our 2025 survey of around 500 practice managers found that almost three quarters of respondents (74%) agreed that a lack of physical space was preventing their practice from recruiting more GPs.

> Our 2025 GP Voice survey of over 2,000 GPs found that 30% of practising GPs considered their practice building unfit for purpose.

RCGP recommendations for infrastructure and resources for the 10YWP:

- Invest in upgrading general practice premises to provide adequate space for patients, GP registrars and expanded teams. This must anticipate the move towards neighbourhood hubs and integrated care, ensuring shared facilities are fit for purpose while maintaining the capacity of individual practices to train and deliver care effectively.
- Expand training capacity, including by increasing the number of GP trainers to meet future demand.

4. Recruitment

As we train more GPs, in order to grow the workforce and meet patient need, it is essential that practices have the funding to employ them. As of 31 October, the RCGP has made 3,655 recommendations for registrars who will CCT this year and we project this will reach over 4,000 by the end of the year, indicating that the number of CCTs awarded in 2025 will remain high (see Figure 1 for numbers in recent years).

Year	2019	2020	2021	2022	2023	2024
CCTs during year	2,861	2,866	3,213	3,248	3,718	4,090

Figure 1, RCGP CCT figures

In our 2025 practice manager survey:

- 61% of respondents agreed that they needed to expand their GP workforce to meet patient needs, but 92% of these said that a lack of funding was an obstacle to recruiting more GPs.
- 47% reported no change in GP vacancies when comparing 2024/25 with 2023/24; 30% reported an increase and 18% reported a decrease. This is unlikely to be sufficient to match the increase in GPs qualifying.
- 34% reported an increase in applications per GP vacancy when comparing 2024/25 with 2023/24; 33% reported no change and 20% reported a decrease.

Despite ongoing concerns about GP shortages, many qualified GPs report difficulty finding suitable roles. Over the last year, we have heard growing concerns around GPs struggling to find suitable vacancies. Our 2025 GP Voice survey indicates that GPs are willing and able to take on more hours but are held back by a lack of suitable roles, especially ones that do not require relocating. It is essential that GPs are supported to move into underserved or hard-to-recruit areas, for example, through the reintroduction of a targeted enhanced recruitment scheme or a similar initiative.

In our 2025 GP Voice survey:

- 40% of GPs had looked for a job in the past year, and 67% of these GPs had found it difficult to find an appropriate vacancy.
    - 79% said they couldn't find a GP role in the area they wanted to work in
    - 46% said they couldn't find a GP role that was flexible enough to meet their needs
    - 5% said they couldn't find a GP role anywhere in the UK.
- The number of vacancies (open for 3 months or more) reached an all-time low, with only 9% of GPs saying their practice had a vacancy this year, compared to 21% last year and 38% the year before.

ST3 GP Registrars (GPs in their final year of training) had particular concerns:

- The vast majority of ST3 GP Registrar respondents – 89% – felt that there were not enough suitable GP jobs available in the area in which they wanted to work.
- Two thirds said they struggled to find appropriate opportunities anywhere in the UK, and 86% expressed concern about whether they would be able to secure a GP role at all.
- When asked about their future options, just under half (46%) said they were considering extending their training simply to remain employed.
- Nearly two thirds (62%) said they might look for work abroad, while the same proportion reported that they were thinking about taking on a role outside general practice altogether.
- Of those who have been unable to find work (79 ST3 GPs), 70% said that there are not enough suitable jobs anywhere in the country, and 65% are considering leaving the UK to find work.

International Medical Graduates (IMGs), who account for over 40% of GP registrars, often face barriers when seeking roles after qualification – particularly in finding practices that offer visa sponsorship. Figure 2 shows the proportion of IMG registrars in recent years compared to those who graduated in the UK.

	Aug-25		Aug-24		Aug-23	
	Count	**%**	**Count**	**%**	**Count**	**%**
UK graduates	2,324	53.6%	2,200	53.4%	1,868	47.0%
International medical graduates	2,013	46.4%	1,918	46.6%	2,104	53.0%
Total	**4,337**		**4,118**		**3,972**	

Figure 2, RCGP registrar intake figures

Our 2025 survey of general practice managers revealed that only 29% of practices currently offer visa sponsorship. In September 2025, we wrote to the Home Secretary to highlight these challenges.

A survey conducted jointly by the RCGP and BMA GP registrar groups in July 2025 of 521 GPs and registrars who either needed or had recently secured a visa to work in the UK further highlighted the challenges faced by these doctors:

- 71% of respondents said they had found it difficult or very difficult to find a job that would sponsor a visa.
- 62% of these said that if their difficulty linked to visa problems with finding a GP job continued, they would plan (or would have planned) to leave the UK and work as a GP elsewhere.

Our 2025 GP Voice survey found that almost half (46%) of the respondents who needed a visa sponsor to work as a GP in the UK said they had found it difficult to gain visa sponsorship to work in general practice.

Additional Roles Reimbursement Scheme (ARRS)

While recognising the progress in GP recruitment via the Additional Roles Reimbursement Scheme (ARRS), the RCGP has raised concerns regarding the scheme, including that GPs recruited under it often do not have a fixed practice or clinical setting, that the eligibility criteria are too narrow and that pay scales generally fall below the model GP contract.

NHS England data shows that 2,068 GPs were recruited through ARRS between 1 October 2024 and 30 June 2025, based on claims submitted by practices and approved by Integrated Care Boards (ICBs).[5] However, this is a headcount figure – including part-time staff – rather than a measure of actual contracted time. Full-time equivalent (FTE) data for the same period shows only 957 FTE posts were filled. It is important that reporting always clearly distinguishes between headcount and FTE to avoid overstating the additional GP capacity.

While we have highlighted the need for improvements to the GP roles in ARRS, ultimately, **we must see sufficient core funding for practices to recruit.** This is key to ensuring that there are enough roles for GPs across the country; that GP to patient ratios can be reduced to safe levels; and that patients can promptly access the care they need.

The ARRS has expanded the primary care workforce by more than 34,000 new posts altogether, including pharmacists, physiotherapists, paramedics and link workers, generating over 50 million additional appointments. The RCGP has consistently been supportive of multidisciplinary team working in general practice, highlighting the potential benefits as well as the continued role for the expert generalist skills of GPs in leading these teams. However, integration of new roles has not always been smooth, and it is critical that they are not considered through the lens of substitution. Studies show limited improvements in satisfaction and outcomes, with ongoing challenges around supervision, governance and scope of practice[6] [7].

Some of our members report particularly significant shortages in mental health, learning disability and neurodivergence services, driven by heavy workloads, service gaps and limited training capacity. It is necessary to strengthen primary care training, supervision and resources, as GPs are increasingly managing patients who would previously have been seen by psychiatric services – including those at risk of acute and long-term harm.

The success of the new roles via ARRS depends on robust clinical supervision and clear integration within general practice teams. GPs remain central for diagnostic reasoning, co-ordination and relational care, and workforce planning should strengthen rather than dilute this expertise.

RCGP recommendations for recruitment of GPs in the new 10YWP:

- Set out how many additional FTE GPs are needed to meet patient demand and publish annual progress updates.
- Provide, via the next GP contract, a significant rise in ring-fenced funding to enable practices to employ the number of practice-based GPs that they need to care for their patients.
- Reinstate the national visa matching service to support IMGs in securing practice sponsorship for their employment as a GP post-training.
- Address the need to support GPs to move to underserved or hard-to-recruit areas through the reintroduction of a targeted enhanced recruitment scheme or similar.
- Implement any of the following to support IMG GPs to remain in the workforce:
    - Offer IMGs the opportunity to apply for indefinite leave to remain in the UK on successful completion of GP specialty training.
    - Create an overarching umbrella body to act as sponsors for all IMGs (this could be NHS England).
    - Promote the inclusion of IMG GPs within the 'earned settlement' route described in the Government's 'Restoring control over the immigration system: white paper'.[8]
- Ensure there is clarity and transparency in data regarding recruitment of the primary care workforce through the ARRS, particularly in differentiating between the number of salaried GPs employed on part-time or full-time contracted hours.

5. Retention

Improved GP retention is fundamental for the stability and effectiveness of healthcare services in England. It is critical that the lack of focus on GP retention in the 2023 LTWP is addressed in the new plan. Issues around GP retention are explored further in the RCGP's 2024 report, 'Retention: Looking after the GPs of today to safeguard the workforce of tomorrow'.

> General practice faces acute retention issues, with our 2025 GP Voice survey revealing that almost a third of GPs (31%) say they are unlikely to still be working in general practice in five years' time.
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> Aside from retirement, the two main factors behind GPs saying they are unlikely to remain in general practice are that they find it too stressful (44%) and that they would like to find a better work/life balance (40%).

Evidence suggests that targeted interventions can improve GP retention. NHSE's 2023 unpublished evaluation of GP retention schemes found that 79% of those who were on a retention scheme said their scheme had supported them to keep working as a GP. However, since this study, two national schemes have been closed,[9] with responsibility devolved to Integrated Care Systems with no ring-fenced funding allocated. It is particularly concerning that the New to Practice Fellowship programme was closed, as 80% of participants said that the scheme had supported them to remain as a GP at a time when one in five GPs under the age of 30 had left the profession within a 12-month period.[10]

> The importance of retention (and returner) schemes is corroborated by our 2025 GP Voice survey: Of the respondents who had received support or funding for a retention/returner scheme, 66% said that this had made it more likely that they continued to work as a GP.

RCGP recommendations for retention of GPs in the new 10YWP:

- Develop a National Retention Strategy for general practice with increased and ring-fenced funding for GP retention efforts.
- Reinstate national oversight for the New to Practice Fellowship and Supporting Mentors schemes and ensure consistent, protected funding for all GP retention programmes across ICBs.
- Provide targeted support for mid- and late-career GPs, including workload reduction options and retention incentives.
- Ensure the Return to Practice programme, which helps experienced GPs who have taken career breaks to re-enter general practice, continues with sufficient funding.

6. Workload

Key drivers of the GP workforce crisis include workload pressures and burnout. GPs, out of all doctors, are most likely to struggle with their workload (44% compared with 29% of all doctors) and to describe themselves as dissatisfied (46% compared with 33% of all doctors), with 19% of GPs at a high risk of burnout.[11]

As of August 2025, GP practices in England were responsible for approximately 63.8 million patients – an increase of approximately 6.9 million compared to September 2015. Consequently, the average number of patients cared for by each fully qualified FTE GP has risen to 2,247, representing a 16% increase (309 additional patients per GP) since September 2015.[12]

Recent research into hidden and unnecessary workload commissioned by the RCGP (publication forthcoming) found that this workload has significant impacts on core/clinical time as well as a resulting need for GPs to undertake work in unpaid time, with adverse consequences for wellbeing, job satisfaction and retention. Excessive administrative burden is a contributing factor to this hidden workload.

For GPs, the demands of mandatory training add to already significant workload pressures. According to our GP Voice survey 2024, 57% of members reported not having enough time to undertake training or CPD alongside their clinical work. In this context, mandatory modules often feel like an additional burden, diverting time away from more relevant, self-directed professional development aligned with adult learning principles. Streamlining mandatory training requirements would help reduce unnecessary workload, freeing up time for patient care and supporting safer, more effective practice.

In our 2025 GP Voice survey:

- 58% of respondents who described themselves as unlikely to continue working in general practice said a reduction in their administrative workload would be likely to keep them working in general practice for longer.
- GP registrars were notably likely to report unmanageable stress at least once a week (38%).
- Nearly three quarters (73%) of GPs agreed that patient safety was being compromised by excessive workload.
- 69% of GPs agreed that a further reduction in the number of indicators in the Quality and Outcomes Framework (QOF) would help improve their workload.

RCGP recommendations to prevent GP burnout for the new 10YWP:

- Expand flexible and portfolio working opportunities for GPs, supported by contractual levers that make them viable for practices.
- Ensure comprehensive mental and occupational health support is readily available to all GPs.
- Ensure GPs have fully funded protected time for CPD, and trainer and mentorship roles, so professional development does not add to workload pressures.
- Review remaining QOF indicators and processes to reduce administrative burden on GPs.

7. Multidisciplinary teams (MDT)

The RCGP recognises and continues to advocate for the expansion of the multidisciplinary teams working in the community as crucial to meeting the increasingly complex needs of the patient population. We welcomed the stated intention for the 10YWP to follow on from the 10 Year Health Plan (10YHP) and set out how the workforce required to meet ambitions around neighbourhood health services can be delivered.

It will be critical for the 10YWP to consider the wider primary care MDT and how it works together. In addition to GP shortages, there are significant workforce shortages across the wider primary healthcare team. District nurses and health visitors are in particularly short supply,[13] yet both professions are vital to the success of neighbourhood team working.

Following the 10YHP and the 10YWP, comprehensive guidance will be needed on the development of the multidisciplinary and multi-stakeholder working necessary to support implementation of neighbourhood health services.

> According to the 2025 GP Voice survey, the main concerns of GPs from England about the implementation of 'neighbourhood health services' were a lack of GPs and further increase to the GP workload (68%); a lack of clarity on funding allocation in general practice to implement and deliver neighbourhood health services (65%); a lack of clarity on the role of GPs (65%); and a lack of clarity on how these services would be implemented (64%).
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> 94% of GPs said they believe it is important for GPs to be involved in making commissioning decisions about healthcare services.

RCGP recommendations on the MDT for the new 10YWP:

- Support the need for clear guidance on the implementation of Neighbourhood Health Services, which factors in multidisciplinary working across general practice. GPs must play a key role in shaping this guidance, and will need protected time to do so.
- Increase the recruitment of district nurses and health visitors in primary care to support the implementation of neighbourhood health services.

Call for evidence response

This section responds to the areas set out in the 10YWP call for evidence. While the RCGP is not responsible for the delivery of care, many of our members are actively engaged in implementing new and innovative ways of working. As set out above, the responses below are based on feedback received from RCGP clinical advisers and broader membership intelligence.

Section 1: the 3 shifts

Digital initiatives improving patient care

The RCGP supports the use of digital innovation where it demonstrably improves patient outcomes. A recent example shared with us is the development of digital therapeutics for insomnia, offering NICE-approved cognitive behavioural therapy as a first-line treatment.

However, members have fed back to us that it is important to critically evaluate techno-optimism that may be driven by commercial interests. We have heard examples of local pilots reporting impressive results that are not replicated when evaluated independently. This evaluation should apply to all new digital initiatives and should consider the benefits to patients as well as the implications for GP workload. To avoid any new approaches having unintended consequences such as worsening problems of access to general practice, they should be implemented in a staged way alongside careful evaluation.[14] Technology should enhance, not undermine, continuity and relational care; these are the foundations of safe and effective general practice. Regarding therapeutics, there needs to be a suitable 'bar' set for what counts as an effective digital therapeutic. NICE endorsement based on evidence of the effectiveness and safety of the digital therapeutic would be an appropriate 'bar' along with robust negotiation on cost.

Artificial intelligence (AI) tools also offer the potential to ease administrative and documentation burdens – a critical goal at a time when many GPs are overstretched and under-resourced. Some clinicians report that AI scribes can free them to focus more fully on patient conversations rather than notetaking, improving their focus and quality of interaction. However, as with other examples of digital innovation, potential benefits must be weighed against risks and require robust evaluation of cost-effectiveness, clinical safety and patient experience.

Risks of AI tools include bias and the perpetuation of inequalities.[15] When the data used to train AI models fail to accurately reflect the diversity of the population, certain patient groups may be underrepresented, potentially reinforcing existing inequalities and leading to unequal

treatment or outcomes. We hear reports of AI scribes struggling with accent recognition and failing to accurately transcribe consultations with people who have particular accents.

Legal responsibility for AI errors remains unclear. Clinicians may be held liable even where faults originate from AI tools, many of which renounce responsibility. Education and training on AI must be embedded across medical education and CPD, with real-world application and regular updates.

Shifting care from hospital to community

General practice is the medical backbone of primary care, combining medical generalism, continuity, and trusted relationships with patients and communities. When adequately resourced, this model consistently delivers better outcomes and greater efficiency. A 2025 systematic review found that GP continuity reduced patient mortality by 10-15%, hospital admissions by up to 15%, and emergency department visits by up to 20%.[16] Continuity of care is central to prevention and long-term wellbeing. Smaller, GP-led practices are associated with better patient access, experience and satisfaction.[17] [18] Furthermore, for every £1 invested in primary care, there is an estimated £14 return to the wider economy.[19]

Despite these clear benefits, in previous years, the ambition to shift care from hospitals to the community has not been accompanied by a matching shift in funding. Our members tell us that this has left GPs feeling that general practice has been expected to absorb increasing workloads without the transfer of resources necessary to deliver safe and effective care. If more care is to be provided in the community, investment and workforce allocation must follow.

The shift from hospital to community must also include consideration of ways of working between primary and secondary care. While guidelines exist to support fair and effective collaboration between secondary and primary care, members report that these are often overlooked by secondary care with work being transferred from secondary to primary care without resource. Guidance on interface working, including the RCGP's Interface Working Guidance, offers an example of how collaboration can be done well. This should be supported and promoted at a national and local level.

Increasing flexibility

We have heard concerns from members that inconsistent application of the Performers List (PL) regulations could create barriers to effectively shifting care from hospitals into the community. In particular, GPs working in 'interface' roles – those bridging primary and secondary care – may encounter difficulties if Responsible Officers interpret the PL regulations too rigidly.

For example, we have heard from a GP who had developed a special interest in cardiology, and worked with local cardiologists to develop a community-based cardiology clinic. This GP later stopped offering undifferentiated care and gradually wound down their general practice sessions. Once they were doing the cardiology clinics only, they were told they could no longer stay on the PL. The acute trust that employed medical cardiologists did not agree to appraise/revalidate this doctor. The doctor retired earlier than planned due to the complexity of the situation. This example highlights the need for clearer, shared understanding between primary and secondary care about where such doctors 'sit' within the system, particularly regarding appraisal, revalidation and responsibility under the PL framework.

The recently published systematic review, 'General practitioner workforce sustainability to maximise effective and equitable patient care: a realist review'[20] emphasises that workforce sustainability is not only about increasing the number of GPs, but also about improving how work is organised and experienced; prioritising meaningful conversations between GPs, colleagues and patients, making continuity the default, and creating opportunities for peer support, mentoring and shared reflection.

Section 2: modelling assumptions

Demand and capacity

Demand for healthcare can be understood as dynamic rather than fixed and to be influenced by the availability and organisation of services. In a resource-limited NHS, it is essential to balance accessibility with sustainability, ensuring that service redesign improves patient flow and equity without creating unmanageable pressures on the workforce. Clear communication with the public about what is feasible, safe and deliverable within current resources is vital to maintain trust and protect the quality of care.

Need for ongoing evaluation

It is essential that workforce planning for the NHS is grounded in transparency, accuracy and continuous evaluation. The assumptions underpinning workforce models, such as projected demand, productivity, skill mix and anticipated impact of service redesign, should be clearly published and open to scrutiny. Transparent reporting builds confidence among clinicians, policymakers and the public, and helps ensure that planning decisions are evidence-based rather than aspirational.

Given the pace of change in healthcare delivery, workforce plans must also incorporate ongoing evaluation. Needs will evolve as technology, population health and models of care shift, and the workforce strategy must be able to adapt accordingly. This requires a system for regular review of workforce data, performance against assumptions and responsiveness to new evidence.

Workforce intelligence

A further priority is investment in robust, real-time workforce intelligence. At present, data on the number, distribution and deployment of clinicians, particularly within general practice and community services, remain incomplete or lagging. Accurate, timely information on who is working where, in what roles, and under what capacity constraints is fundamental for effective planning. Without a reliable baseline, even the most sophisticated models risk being detached from operational reality. Strengthening the infrastructure for workforce data and transparency will enable better forecasting, fairer resource allocation, and more sustainable workforce policy across the NHS.

Skill for modern general practice

It is important that modelling assumptions used to underpin the 10YWP are evidence-based and consider both the numbers of staff needed to meet current and future demand and the skill sets required for delivering modern NHS care. RCGP members have highlighted recent research literature which provides insight into training needs and capacity issues within general practice:

- The longitudinal qualitative study of 12 UK general practices (2021-23), 'After the disruptive innovation: How remote and digital services were embedded, blended and abandoned in UK general practice'[21] examines how remote and digital services were embedded, adapted or abandoned. It identifies variation in digital maturity, implications for access, continuity, safety, equity, workforce and training. The authors propose that staff (clinical and non-clinical) require new capabilities in remote-digital care (for example, triage, remote consultation modalities, ethics/governance, digital inclusion) and suggest that a competency framework is needed to support training and workforce development.

- The study, 'Training needs for staff providing remote services in general practice'[22] suggests that training for remote services works best when it is embedded within team-based workflows (including clinical, care-navigation/front-desk, IT/admin staff) and uses scenario-based formats rather than purely didactic lectures. High workload and understaffing are significant barriers to effective training, so allocating protected time and aligning training with real-world workflows is important. The authors emphasise the need for guidance on when to use phone, video, messaging or face-to-face consultations, and for safe escalation pathways.

- Academic GP capacity is a pinch-point. The article, 'Building capacity in the academic general practice research workforce',[23] highlights a long-standing shortfall in the

academic primary care workforce just as policy demands better evaluation of service redesign and digital change. Priorities include protected academic time, clearer career pathways, mentorship and stable funding to grow clinician-researchers. Without academic capacity, the system struggles to produce independent, generalisable evidence on what workforce or digital models actually work, risking policy driven by anecdotes or vendor claims.

Section 3: productivity gains from wider 10 Year Health Plan implementation

Benefits of continuity of care

As outlined above, there are clear productivity benefits of GP continuity for the whole of the NHS and there is extensive evidence that continuity of care reduces morbidity and mortality.[24] RCGP members have highlighted that papers such as 'What makes general practice work',[25] provide evidence that continuity of care is a core driver of the effectiveness, efficiency and sustainability of general practice. For workforce planning, this may mean that models should go beyond simply counting posts and appointments as measures of productivity; embedding assumptions about relationship continuity, team stability, retention of GPs and integration of multidisciplinary roles into continuity-preserving workflows. Failing to do so may risk a workforce capable of access but not continuity, which, according to the research, undermines outcomes and increases downstream demand.

Translating these principles into practice in the context of modern, team-based general practice, requires rethinking how continuity is delivered. It is important that relational continuity between patients and all members of the primary care team is safeguarded, and that patients are able to build trust with the different members of the team. Continuity increasingly depends on consistent and accessible patient records, supported by stable, team-based models. An example shared with us is the 'Living Well' partnership in Southampton, which delivers 'group continuity' through small multidisciplinary teams, ensuring that patients are known by a core group of clinicians.

Data driven evaluation and improvement

Productivity is also dependent on the ability of services to understand their populations and to continually innovate to meet patient needs. An example shared with us is the Tower Hamlets managed practice network study,[26] which illustrates how academically informed, data-driven collaboration in general practice can deliver measurable improvements in population health when supported by adequate workforce capacity and protected time. Partnering with the Clinical Effectiveness Group at Queen Mary University of London, local practices achieved major gains in cardiovascular outcomes by combining real-time data analytics, peer learning and continuous quality improvement. Crucially, this success relied on

clinicians and managers having protected time for audit, education and collaborative review, activities often squeezed out by routine workload. The findings highlight that embedding academic general practice within service delivery provides the research expertise, analytical infrastructure and evaluative capacity needed to translate innovation into safe, effective care. Future workforce planning must therefore fund not only clinical headcount but also the time and capability for reflection, training and evidence generation, ensuring that service redesign in community settings is grounded in robust science and sustainable practice.

Section 4: culture and values

At a time of growing complexity in patient needs, multimorbidity and system navigation, it is vital that workforce planning and commissioning explicitly recognise and value the unique skills that general practitioners bring to the health system. GPs combine diagnostic breadth, continuity, co-ordination and person-centred care – skills that are essential for managing uncertainty, integrating care across multiple conditions and supporting patients over time. These capabilities cannot be replicated simply by increasing task-specific roles or expanding access alone; they are the foundation of safe, efficient and compassionate primary care.

It is important to note the specific context within which general practice operates. Small teams can be destabilised by the long-term sickness or retirement of just one or two GPs. Members have expressed concerns that previous attempts to address this fragility through practice mergers have not delivered genuine economies of scale or greater stability. Many practices experience cycles of stability and strain, showing how precarious the current system can be. Sustaining general practice therefore requires long-term, reliable investment that values continuity and resilience rather than short-term initiatives. It also requires consideration of appropriate occupational support as well as HR and change management support, which is often much less available for general practice as compared to large trusts, for example.

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[1] - Our GP Voice survey (publication forthcoming) is an annual UK survey of RCGP members that aims to gather GP views to inform RCGP's policy activities. Savanta was commissioned to deliver the 2025 survey. 2,316 RCGP members responded.
- Our Practice manager survey (publication forthcoming) was an online survey of UK practice managers delivered to gather practice-level information on GP vacancies and recruitment, and visa sponsorship. 493 responses were received.
- The GP visa survey (unpublished) was an online survey that was promoted to international GPs and GP registrars who require a visa to work in the UK, which covered questions relating to experiences with visas and employment. 521 responses were received.

[2] National Audit Office (2024), NHS England's modelling for the Long Term Workforce Plan

[3] UK Parliament (2024), Written evidence submitted by The Royal College of General Practitioners

[4] NHS England (2025), The Medical Training Review: Phase 1 diagnostic report

[5] NHS England, Primary Care Workforce Recruited through the Additional Roles Reimbursement Scheme (ARRS)
[6] C. Penfold et al (2024), British Journal of General Practice, Additional Roles Reimbursement Scheme uptake, patient satisfaction, and QOF achievement: an ecological study from 2020-2023
[7] DHSC (2025), Independent review of the physician associate and anaesthesia associate roles: final report
[8] UK Government (2025), Restoring control over the immigration system: white paper
[9] Pulse (2024), NHS England to end two GP retention schemes
[10] Pulse (2023), One in five GPs under 30 quit the profession last year
[11] GMC (2025), The state of medical education and practice in the UK, Workplace experiences 2025 (pp. 12, 26, 27)
[12] NHS England, General Practice Workforce Statistics
[13] Nuffield Trust (2025), The lamentable decline of district nurses in the NHS in England
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