RCGP submission to the Autumn Budget 2025

October 2025

Summary

Recent public polling revealed that patients' top priority for the NHS is access to GPs. Increasing demand coupled with inadequate funding has left GPs grappling with unmanageable workloads and time pressures. Patients pay the price for squeezed budgets and staff shortages, reducing access to timely, safe care. General practice can deliver worldclass care but, not without the right resources. Without sufficient investment, patient care will erode.

General practice is one of the most financially efficient parts of the NHS, and investment in primary care leads to better health outcomes. While we welcome plans to shift care into the community, the proportion of NHS funding for general practice remains insufficient. There must be a sustained funding shift to general practice, rather than stretch an already strained service. The Government can achieve this by committing to a Primary Care Investment Standard, with the Secretary of State and ICBs reporting to it annually. The 10 Year Workforce Plan and the implementation of the 10 Year Health Plan are key opportunities to match political ambitions with the right fiscal backing.

GP practices were not excluded from the increase in Employer NICs. Practices therefore are facing significant additional costs, undermining patient care. 83% of practice managers cited NI as a barrier to recruiting the GPs they need.[1] Proposed further tax changes, including extending employer NICs to partnerships, would exacerbate pressures and hamper practices' abilities to operate. Mitigations and clear exemptions for GP partnerships must be introduced.

Submission text

The pressures facing general practice

1. The RCGP's 2025 survey of 2,316 members highlights how the pressures on general practice are compromising the standard of care that patients receive. 73% of practicing GPs say that patient safety is being compromised by their excessive workloads.[2] Furthermore, almost six in ten (58%) GPs report that they don't have enough time to adequately assess and treat patients during appointments, and 57% feel they don't have enough time during appointments to build the relationships with patients they need to deliver quality care.[3]

2. Recent UK-wide polling by the Health Foundation/Ipsos found that GP access (39%) sits above improving A&E waiting times (34%) and reducing the number of staff leaving the NHS by improving working conditions (29%) is amongst the public's biggest priorities.[4]

3. Access to GP services has consistently topped the public's priorities over the last year of the survey. And there is increasing public concern about the pressures GPs are under - 82% of the public (the highest recorded) are concerned about the level of pressure that GP practices are facing (up from 78% in May 2024 and 73% in May 2022).[5] The biggest challenges people believe their GP practice is facing are there not being enough doctors (41%), followed by the pressures from an ageing population (29%) and due to a lack of funding (27%).[6]

4. Without sufficient funding access for patients will be impeded, patient experience will be poorer, and staff will continue to leave the GP workforce. This is a real threat to patient safety, and the implementation of neighbourhood health services. However, given the proper support and investment, GPs could be enabled to work with patients to support the implementation of the 10 Year Health Plan, including delivering more care in the community and identifying illness earlier and properly embedding

prevention in the community – all of which would alleviate pressures across the health service and build the healthy society needed for a healthy economy.

General Practice: Value for Money

5. Despite the current challenges general practice faces, it has proved to be one of the most financially efficient parts of the NHS. This was recognised by the Darzi review, which described general practice as demonstrating the "best financial discipline in the NHS family".[7] Investing in primary care leads to better health outcomes and delivers value for money to the NHS, the economy and society as a whole. For every additional £1 invested in primary care, research has shown that at least £14 is delivered in productivity across the local community.[8] General practice is delivering 50 million more appointments a year than in 2019 but there are simply not enough GPs to meet patients' needs. The average fully qualified GP now cares for 16% more patients than in 2015 (2,257 patients per GP).

6. The NHS Confederation and Carnall Farrar's analysis from 2023 showed that increasing primary and community care spend relative to need can reduce non-elective admissions by up to 15% and ambulance conveyances by up to 10%.[9] They found that systems could make a 31% return on investment in primary and community care, which could make investment self-financing. This indicates that a well-funded general practice service is a sound investment in the health of the nation, and our NHS.

7. However, despite multiple governments pledging to shift patient care out of hospitals and into the community, there has not been a sufficiently sustained and substantial transfer of NHS funding to general practice.

8. Despite acknowledgement by the previous government that more than 90% of a patient's direct experience of the NHS being through primary care and GP practices, currently less than 10% of the NHS budget in England is spent on primary care[10] and core funding for general practice has fallen as a share of NHS funding.[11] According to the BMA, the core GP contract in 2024/25 accounted for only 6% of the NHS budget (excluding PCN DES).[12]

9. The RCGP therefore welcomes the Government's acknowledgment of the importance of primary and community care services and its stated commitment in the 10 Year Health Plan to shift the proportion of NHS funding out of hospital care. This would help enable more integrated care in local communities to diagnose and treat problems earlier and keep patients out of hospital, with more and better services tailored to the needs of patients. The 2025/26 GP funding settlement was a step in the right direction to begin increasing the share of total NHS resources going to general practice. However, more fiscal support will be needed and, it is worth noting that some of this increase has been eroded by changes to the minimum wage and increases to employer National Insurance contributions.

10. If the Government is to successfully deliver this shift, then the ambition must be matched with the necessary resources. To ensure resources continue to increase for general practice, the College recommends the Government replicates the Mental Health Investment Standard. For Primary Care this new standard would require central Government and Integrated Care Boards to increase spending on general practice and primary care year on year. As part of this, the Secretary of State should report annually to Parliament on the proportion of NHS spending in general practice and primary care, as is currently required for mental health spending. Similarly, each ICB would be required to report this proportion annually and held to account for ensuring this increases year on year.

GP Partnerships (National Insurance)

11. While the public sector and the rest of the NHS were protected from the April 2025 increases to Employer's National Insurance (NI) contributions, GP practices, which deliver NHS services but are mostly run as small businesses, were not. Despite the increase in funding for general practice announced

in December 2024, we remain concerned about the ongoing impact the NI increase is having on practices and ultimately patient care. GP practices often operate with tight margins and many already struggle to afford the staff they need, so they are unlikely to be able to absorb additional costs.

12. When asked about practices' ability to recruit more GPs, 83% of respondents to RCGP's survey of practice managers cited NI as a key factor in preventing practices from recruiting more GPs.[13] Due to the growing financial strain on general practice, practices are having to divert vital funding from recruiting the workforce they need, so that they are able to meet the NI increase, with patients ultimately paying the price as they experience poorer access to care.

13. Rumoured further increases to the tax system proposed by the Centre of Analysis of Taxation (or Centax), including imposing employer NICs on partnerships, risk exacerbating this crisis. As Centax point out in their report, GP practices would be affected more than any other type of partnership, with 96% of partnerships liable to pay extra in 'Partnership NICs'.[14]

14. A report from earlier this year by the Institute for Government made clear that practices with more GP partners are associated with increased patient satisfaction, access and outcomes.[15] However, in England alone, the number of GP partners has fallen from 21,655 in September 2015 to 15,393 in August 2025 [16], a fall of 6,262 individuals or 29%.[17] With the number of active practices falling from 7,254 in January 2018 to 6229 in July 2025.

15. If implemented without sufficient mitigations and clear exemptions for GP partners, these tax changes would place even greater financial burdens on GP partnerships and hamper efforts to retain GPs and keep them working in the NHS, delivering patient care.

16. It is essential that the Government ensures any future tax and pension changes do not undermine or make it harder for GP partnerships to operate, so that patient care is protected.

10-Year Workforce Plan (10YWP)

17. According to the National Audit Office's analysis, the 2023 LTWP only aimed to increase the number of fully qualified GPs by 4% between 2021 and 2036/37, compared to a 49% growth in hospital consultants.[18] While the plan recognised the need to increase the number of trainee GPs, the plan was noticeably weak on retention, only planning to retain an extra 0-700 extra GPs by 2036/37.[19] It is clear these plans were not remotely ambitious enough to reflect the needs of the population and to ensure that all patients have access to safe, high quality and timely care. The RCGP noted at the time that the plan must be reviewed if the previous Government wanted to meet its commitments to increasing the number of GPs, and we highlighted this would be even more crucial for the current Government's aims to transfer more care in the community and to 'bring back the family doctor'.

18. As such, we welcome the Government's commitment to publish a new 10YWP with a stronger focus on shifting care into the community and addressing weaknesses in previous modelling of which the College raised concerns.

19. The new 10YWP's workforce modelling must be transparent, including assumptions relating to GP retention, working hours and role mix, to ensure projections are credible and accountable. Furthermore, the 10YWP must reflect the need to accelerate the planned expansion of GP training places set out in the 2023 Long Term Workforce Plan, reaching 6,000 places earlier than the current 2031/32 target.

20. Without significant action to increase GP training capacity – both in terms of infrastructure (explored further below) and trainer numbers – even the unambitious workforce growth plans set out in the 2023 LTWP, let alone the improved targets we hope to see in the 10YWP, will not be deliverable. According

to the GMC, emergency medicine and general practice trainers experience the highest risk of burnout, and action must be taken to support existing trainers and attract new ones.[20] In order to address health inequalities, expanded training capacity should be particularly prioritised in areas of socioeconomic deprivation.

21. If the Government wishes to place general practice at the heart of neighbourhood health services, bring back the family doctor, end the 8am scramble and shift care from hospitals to the community, upcoming workforce and resource planning must reflect this ambition, and ensure general practice has the workforce it needs to fulfil this transformation.

10 Year Plan and Neighbourhood Health Teams

22. The College has been supportive of the Government's aspiration to shift care out of hospitals and into the community. It's what is best for the NHS and, most importantly, it's what is best for patients who want accessible care close to home without long waits for appointments either with their GP or at hospital.

23. Capacity cannot be built without prior investment. The plan commits to shift resources away from hospitals and into primary and neighbourhood services but is unclear how this can be achieved at the same time as reducing acute waiting times without significant upfront investment. This significant upfront investment is needed to establish and stabilise the proposed reforms, particularly the Neighbourhood Health Implementation Programme (NNHIP) and the teams needed to deliver them, ensuring they have the capacity and infrastructure to realise the plan's ambitions.

24. We are concerned that no new funding has been set out for integrated neighbourhood teams, beyond the one-off funding of £10 million for the 43 pilot areas. The plan seems to suggest that increased funding will only flow to the community once hospital waits and demand on secondar services have started to fall but at the same time suggests that the main way hospital waits are going to fall is because of the roll out of neighbourhood teams.

25. If upfront investment is allocated to primary and community services they can have a big impact on reducing spend on hospital-based services, but they need the staff and resources to do this. Sufficient time must be given to allow for the longer-term cost savings and reductions in demand to eventuate and be appropriately evaluated.

26. We are also concerned that the proposals to allow Foundation Hospitals to control the whole population health budgets via Integrated Health Organisations will lead to spiralling deficits. As stated above, general practice is the one part of the NHS which cannot fall into deficit and is recognised as the most financially efficient part of the NHS. If a significant part of funding that is currently controlled through the GP contract is handed to hospital trusts to manage there is a very real anger of handing budgets from the most financially efficient part of the NHS to the least.

GP employment

27. With patient demand ever rising we need to make sure that practices have the resources to employ any GP who is currently looking for more work. Our latest research revealed that although 61% of practice managers say they need to expand the GP workforce to meet their patient's needs, 92% say that the lack of funding in general practice is preventing them from hiring the number of GPs they need.[21]

28. At the same time, many GPs are looking for work. Our survey found that one in four of final year GP registrars said that they have looked but been unable to find a suitable GP job. Of those final year GP registrars who have been unable to find work, 67% said that there are not enough suitable jobs

anywhere in the country, and 62% are considering leaving the UK to find work. 67% of all GPs who have been looking for work in the past year struggled to find a suitable vacancy. [22]

29. Last year the Government created additional funding for newly qualified GPs through the Additional Roles Reimbursement Scheme (ARRS). NHS England data shows that 957 FTE posts were filled through ARRS between 1 October 2024 and 30 June 2025. Without this funding it is clear that we would have faced a much more serious GP unemployment crisis.

30. The RCGP has, however, raised concerns regarding the scheme, including that GPs recruited under it often do not work in a fixed practice or clinical setting, making it harder for them to become embedded into general practice and provide continuity of care. We therefore believe that there should be sufficient core funding for practices to recruit the GPs they need.

GP retention

31. General practice is facing significant workforce retention issues, with our survey revealing that almost a third of GPs (31%) are unlikely to still be working in general practice in the next five years.[23] This shows how hardworking GPs continue to be pushed to breaking point by unmanageable and unsafe workloads, with many GPs now looking to work abroad or leaving the profession altogether. GPs are leaving the profession at all stages of their careers – newly qualified, mid-career and late career. This is a serious waste of expertise and experience, that has been funded through the public purse in their training and ongoing education.

32. The GMC's report, 'State of medical education and practice in the UK: Workplace experiences 2025', found that GPs, out of all doctors, are most likely to struggle with their workload and ability to provide sufficient patient care (44% compared with 29% of all doctors) and to describe themselves as dissatisfied (46% compared with 33% of all doctors).[24] It also reports that 19% of GPs are at a high risk of burnout.[25]

33. The RCGP's recent research study into GP workload identified significant system inefficiencies and bureaucracy which contributes to workload intensity, a known key driver of workforce attrition (awaiting publication).

34. The need for a strong and more ambitious focus on GP retention is clear to ensure public funds are being appropriately and sustainably invested.[26] NHSE's 2023 unpublished evaluation of GP retention schemes found that 79% of those who were on retention schemes said that their scheme supported them to keep working as a GP.[27]

35. Despite evidence of its success, since this study, funding for two key national schemes were cut by the last Government (New to Practice Fellowship programme and Supporting Mentors Scheme), with responsibility devolved to Integrated Care Systems with no ringfenced funding allocated. It is particularly concerning that the New to Practice Fellowship was closed, as 80% of participants said that the scheme supported them to remain as a GP at a time when one in five GPs under the age of 30 left the profession in just one year.[28]

36. We need to see immediate efforts and investment to expand retention initiatives across the whole GP career, so that we can keep up with the growing demand for care whilst we train the next generation of GPs. Without strong initiatives in place to retain existing GPs, we risk intensifying the workload crisis and losing valuable professional experience.

37. The RCGP is calling for the development of a National Retention Strategy for general practice with increased and ringfenced funding for GP retention efforts, at both national and ICB levels.

38. The College is also calling for the reinstatement of national oversight for the New to Practice Fellowship and Supporting Mentors schemes to ensure consistent, protected funding for all GP retention programmes across ICBs.

39. The College has also called for guaranteed ongoing funding for NHS Practitioner Health to provide access and services for all health and care professionals employed in the NHS indefinitely, as part of efforts to address GP burnout and workforce attrition.

40. The College has also called for appropriate protected learning time for GPs, to undertake training or Continuing Professional Development (CPD) to be appropriately financed and written into a future iteration of the GP contract, as part of negotiations between the Government and the BMA.

General practice infrastructure and estate

41. The RCGP welcomed the Government's announcement of a Primary Care Utilisation and Modernisation Fund made at Autumn Budget 2024, the first national capital fund for primary care estates since 2020. However, if we are going to build a general practice that's fit for the future, the Budget must set out a clear road map for the delivery of the additional capital that will be needed to ensure all GP practices have adequate space to both treat their patients and train the next generation of GPs we so desperately need.

42. As Lord Darzi highlighted in his 'Independent investigation of the NHS in England', the primary care estate is plainly not fit for purpose. 20% of the GP estate pre-dates the founding of the NHS in 1948 and 53% is more than 30 years old.[29] Focus for investment has traditionally been on secondary care, for example, the New Hospitals Programme.

43. According to RCGP's 2024 survey of members, over a third (34%) of GPs say that their practice building is not fit for purpose.[30] 57% of GPs said their practice requires additional works to improve or upgrade their premises in order to meet the needs of their patients.[31] Of those who need funding to improve their premises, 37% estimated the cost to be over £100,000 and 14% estimated this figure to be over £500,000.[32] Our polling also revealed that GPs felt there is a lack of available funding for these required structural improvements: of those who tried to apply for funding to improve their premises in the last year, less than a third (32%) were successful.[33] In addition, nearly 90% of respondents to our survey said their practice didn't have enough consulting rooms, and three quarters didn't have enough space to take on additional GP trainees.[34]

44. The Government's ambitions to move more care into the community rely on a properly resourced general practice with adequate infrastructure, and so the Budget must reflect the fact that premises are not in a fit state to meet demand, and that investment in infrastructure is necessary to achieve this vision. Even existing NHS premises that could be repurposed for neighbourhood healthcare will need refurbishing, as part of the Government's proposal to rollout neighbourhood health centres.

45. GP premises also need the space and resources to accommodate expanding primary care staff teams, utilise advances in technology and AI, and to deliver on the NHS's sustainability commitments and the path to net zero. Approximately 16% of general practice's emissions come from energy use.[35] Improving energy efficiency has concurrent benefits for practices, staff, patients, and the NHS, by reducing energy costs and ensuring more comfortable and controllable healthcare environments. Interventions that could produce dual benefits for staff, patients and the environment include retrofitting to improve insulation and address issues causing drafts and damp, investment in heat pumps and cooling systems, moving away from gas, and funding for solar panels. Further efforts should be made by Treasury and the Department of Health and Social Care to support primary care providers to decarbonise their estates and remove existing barriers that prevent GP practices from accessing relevant schemes. For example,

this could replicate direct investment support by Great British Energy currently being provided to hospitals and schools.[36]

46. The Government should give every patient access to a modern fit for purpose general practice building, by investing at least £2 billion in infrastructure to address the longstanding underfunding in general practice premises. Investment should facilitate co-location of community and voluntary services with practices where this works for the local population and services.

47. We note the Government's commitment to rapidly exploring the potential to use Public Private Partnerships (PPP) to deliver certain types of primary and community health infrastructure. While we certainly need significant infrastructure investment, we will need to see further details of any new PPP models and contracts and how this will work for general practice before it is rolled out. Any proposed new PPPs for primary care must learn the lessons from past efforts, and historical issues related to NHS Property Services, to ensure GPs aren't saddled with unsustainable rents and restrictive change processes. Consideration must also be given to the cost of meeting net zero and sustainability goals in any new development or retrofitting of public estates to be used for primary care delivery.

48. New housing projects often neglect consideration of GP and other health premises despite population growth that demands more health and social infrastructure. Even when commitments are made as part of a new development, the process of getting a practice up and running is often hampered by bureaucracy and fragmented working between developers, local authorities, ICBs, and providers – often at significant time delay. Without proper consideration and successful end-to-end delivery of essential health and social infrastructure, there is a real risk that new developments could exacerbate existing health inequalities, particularly in underserved or high-growth areas.

49. As the government look to deliver 1.5 million new homes, it is vital that local planning authorities and their planning teams are given the necessary powers and resources so they can properly hold developers to account and ensure that sufficient primary healthcare infrastructure is not only prioritised in the planning process but also delivered.

Health inequalities and sustainability in general practice

50. Studies have demonstrated that 80% of health outcomes are determined by non-health-related inputs such as education, employment, income, housing, and access to green space.[37, 38] The economic impact of these disparities is significant. According to research from the University of York, socio-economic inequalities cost the NHS £4.8 billion each year in additional hospital care alone.[39]

51. Within general practice, GPs spend almost a fifth of their time helping patients with social issues that are not principally health related[40]. This reveals the knock-on effects of social determinants on patient's health and in turn the impact of this on the health system. In line with the ambitions of the 10 Year Health Plan, greater collaboration and potentially co-location with other services that can help with housing, jobs, and benefits would enable GPs' time to be spent more efficiently as they can then signpost patients directly to services that will help them. This will require the building infrastructure to support this.

52. The way general practice is currently funded means that health inequalities are systematically exacerbated. Analysis by the Health Foundation shows that practices in areas with the poorest communities have on average 14.4% more patients per fully qualified GP than practices in wealthy areas,[41] and they receive 7% less funding per need adjusted registered patient than those serving less deprived populations.[42] Additionally, increasing the use of incentive schemes over the last few years has widened disparities, with practices in the most deprived areas receiving 29% less in payment from QOF than those in the least deprived areas.[43]

53. The RCGP welcomes the Government's commitment to halve the gap in healthy life expectancy between the richest and poorest regions in England. We await the production of a cross-government strategy to reduce health inequalities, underpinned with the necessary funding to drive change.

54. The College also welcomed the Government's decision to review the Carr-Hill formula and the appointment of NIHR to chair this review. The RCGP has long called for a review of all general practice funding streams so that resources are equitably distributed to combat inequality, and spending is channelled to the areas of greatest need alongside increased investment across general practice as whole. It is critical that this is not a process of reallocating existing insufficient funding, but is accompanied by an overall uplift to funding for delivering patient care in general practice. Simply redistributing a fixed pot of funding risks creating new pressures in other areas.

55. Furthermore, if we are to prevent physical and mental ill-health in the first place, additional measures must be taken to tackle issues such as poor housing, child poverty and school meals, food quality, addictions and employment, which all determine and contribute to an individual's health outcomes.

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