RCGP submission to the Health and Social Care Select Committee Inquiry - Workforce: recruitment, training and retention in health and social care

Demand for GP appointments is rapidly increasing but staffing levels are not keeping up.

Last year on average each GP in England carried out of 13% more consultations and 14% more clinical administration activities (tests, referrals, prescriptions) than in 2019.

In November 2021 there were approx. 27,750 fully qualified FTE GPs in England. This is down 1,653 or 5.6% from September 2015 (29,403).

The Secretary of State of State recently admitted that the Government is not on track to meet their commitment to employ an extra 6,000 GPs by 2025. If they are not able to meet such a prominent manifesto commitment it should be a wakeup call for how the NHS recruits and retains staff.

1. **What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?**

GPs and their teams are under intense workload and workforce pressures which have only been exacerbated by the pandemic. To meet this growing demand, it is vital to increase the size of the general practice workforce, including delivering on government targets to recruit an additional 6,000 GPs.

A key component to this lies with more GPs being trained in the first place. In recent years, there has been significant progress on this front; between 2015 and 2021, the total number of doctors accepted to GP training programmes in England rose from 2,769 to 4,001.[i]

Summary of recommendations:

- **Efficient workforce planning**
  Every 2 years, the Secretary of State for Health & Social Care must publish assessments of the healthcare workforce numbers required to deliver the work that the Office for Budget Responsibility (OBR) estimates will be carried out in future. The OBR's estimates should look at the next 5, 10 and 20 years and will be based on projected demographic changes, the growing prevalence of certain health conditions and the likely impact of technology.

- **Enhance the medical education pipeline**
  To deliver the future workforce for both general practice and the wider NHS, the undergraduate medical pipeline must be significantly expanded. Currently, there are 9,000 medical school places available per year, and we have joined the Medical

School's Council and other Medical Royal Colleges in calling for a significant expansion. This should be accompanied by a commensurate expansion in the medical foundation programme for new doctors. To reach the long-term targets, we need at least 50% of newly qualified doctors to enter GP specialty training across the UK. Commitments for equitable funding for undergraduate education in general practice must also be made.

- **Sufficient funding for training**
  Sufficient and consistent funding must be allocated for GP training for 5,000 GP trainees per year, as soon as possible. This must be accompanied by appropriate investment in training capacity.

- **Improve non-GP recruitment into wider general practice teams**
  Many GPs already work alongside nurses, pharmacists, first contact physiotherapists, paramedics, physician associates and social prescribing link workers, and funding has been made available to support recruitment of certain roles across Primary Care Networks - the additional roles reimbursement scheme (ARRS). However, this funding needs to be adapted and made more flexible to enable the recruitment of nurse practitioners or the direct employment of mental health therapists, as well as longer term, to provide assurances for staff contracts. Further support is also needed to enable effective integration of staff into practice teams, and premises need to be redesigned and expanded so they are fit for purpose to house a wider range of staff. The government should also provide resources for adequate supervision and mentoring of new practice staff and action is needed to expand the wider primary and community care workforce, including district nurses.

- **Investment in GP infrastructure**
  According to an RCGP survey, at least a third of GP premises are not fit for purpose, 90% of which are not able to accommodate the expanding staff team (RCGP survey of 1,281 GPs in England, in field March 7th to April 8th 2021) and practice teams do not have adequate digital tools to deliver high-quality patient care. We are calling on the government and NHS England to invest a significant amount of funding in order to make general practice premises fit for purpose, including sufficient space to accommodate expanded multidisciplinary teams, and deliver digitally-enabled remote care.

2. **What is the best way to ensure that current plans for recruitment, training and retention are able to adapt as models for providing future care change?**

To be able to adapt to changing workforce needs we need workforce plans that consider the short, medium and long term. The system needs to develop and implement a detailed plan to fill workforce shortages, with clear lines of accountability for delivery.

Unfortunately, opportunities to develop such a plan have been repeatedly missed.

One of the changes we have seen in the GP workforce has been the move towards more GPs working 'less than full time'. However, while it may appear that many GPs are working 'part time' it is often truer to say they are working full time but only paid for working part time. This is often because of the additional work required outside of contracted clinical sessions. While some GPs are working less than full-time in terms of the number of clinical sessions but contributing to care in other ways such as through research. Respondents to the 2021 RCGP Tracking Survey for England reported being contracted for 31 hours per week on average, but working an average of 40 hours per week, with 19% working at least 50-hourweeks;70-80% of members across all four nations report working more than contracted hours most days.

One of the main changes in the general practice workforce has been the move to expand the wider team. Many GPs already work alongside nurses, pharmacists, first contact physiotherapists, paramedics, physician associates and social prescribing link workers, and funding has been made available to support recruitment of certain roles across Primary Care Networks. However, this funding needs to be made more flexible, as well as longer term, to provide assurances for staff contracts. Further support is also needed for effective integration of staff into practice teams, and premises need to be fit for purpose to house a wider range of staff.

Data from 78% of Primary Care Networks (PCNs) in September 2020 showed they employed 7,420 FTE staff working on patient care. From this, the RCGP has estimated that there are roughly 9,464 staff caring for patients in all PCNs in England. This is important progress, but we will need to speed up recruitment to meet the manifesto pledge to hire 26,000 extra health professionals to work in GP surgeries by the end of this Parliament.

Over the COVID crisis the general practice workforce has been forced to adapt to rapidly changing demands. When the pandemic hit, GPs were told by Government to quickly move to an operating model of largely remote consultations, with the then Secretary of State declaring that after the pandemic, 'all consultations should be tele-consultations unless there's a compelling clinical reason not to'.[ii] More recently, much of the media and politicians have been calling for a rapid return to "normal" (pre-pandemic ways of working). Whether a patient is seen face to face or remotely needs to be a shared decision made between clinicians and patients, informed by both clinical need and patient preferences. The proportion of each mode will vary significantly across different local areas according to population demographics.

3. **What is the correct balance between domestic and international recruitment of health and social care workers in the short, medium and long term?**

It is challenging to determine a correct balance between domestic and international recruitment of health and social care workers, and this will be impacted by a range of external factors which are difficult to predict. Given the shortage of GPs we have in the UK, there is a need to continue to put significant efforts into domestic recruitment, as well as to sustain international recruitment.

RCGP data shows that 47% of new GP trainees in 2020/21 were international medical graduates (IMGs).

Internationally trained doctors will always have a place in the NHS and continue to play a major role in the delivery of UK healthcare systems. We also recognise that it's not sustainable for a workforce strategy to rely on the recruitment of international doctors at this scale, particularly qualified GPs, when there are not enough doctors in the world, and are mindful of the ethical issues around international recruitment. There needs to be a continued focus on recruiting IMGs to UK GP training programmes, where this is ethical and feasible.

There is a global shortage of qualified GPs and international recruitment campaigns have previously not been as successful as initially hoped. The UK is competing globally for GPs as demographic changes, rising health inequalities, and non-communicable diseases drive up demand for primary care doctors.[iii]

4. **What can the Government do to make it easier for staff to be recruited from countries from which it is ethically acceptable to recruit, with trusted training programmes?**

The NHS invests significant resources in training IMGs to become GPs, both in terms of funding - GP training costs approximately £50,000 per student per year - and in terms of trainer time and expertise. In return, IMGs make invaluable contributions to the NHS, and on top of this, are especially likely to work in areas with fewer doctors overall, meaning they have a key role to play in levelling up healthcare across the UK.

However, current visa regulations mean these trainees face significant bureaucracy if they wish to remain in UK general practice after completing training, putting both their contributions and the NHS's investment at risk.

GP training is a three-year programme, during which time IMGs, whether on a tier 2 or Health and Care visa, are sponsored by their national training body (e.g. Health Education England). On completing training, they are required to find an employing practice which can act as sponsor. This can be a significant administrative challenge for all those involved. GPs can be left feeling undervalued or anxious about their future in the UK. Practices often do not have sponsorship licences in place, and struggle to secure licenses in the short time before visas expire. As a result, NHS England is left with a significant burden of work to support newly qualified IMGs with appropriate employing practices who can sponsor visas, and there are issues which can and have arisen using this piecemeal approach. We understand that hundreds of GPs need this support each year, and this number is likely to grow as more EEA doctors who do not currently hold settled status begin to move into the workforce.

GPs are also disadvantaged compared to doctors working in other medical specialties. Current regulations allow IMGs to apply for indefinite leave to remain after five years in the UK. As every other medical specialty has training which lasts more than five years,

most IMGs are able to secure indefinite leave to remain while still sponsored by their training body.

Countries such as Canada, New Zealand, South Africa and Australia have included GPs on equivalent Shortage Occupation Lists (SOLs) and are actively competing with the UK whilst also seeking to attract UK GPs.

Recommendations:

- **Offer all IMG GP trainees indefinite leave to remain on qualifying**
  All IMGs should be offered indefinite leave to remain in the UK on successful completion of GP specialty training. This would put them on an even footing with their peers working in secondary care and would encourage them to continue to live and work in the UK after their training, meaning the NHS's investment is not lost. Such an approach would also make general practice a more attractive career path for IMGs, helping to deliver the 6,000 more GPs this country needs.

- **A default 3-month visa extension for IMGs post-qualification**
  Steps should be taken to make it easier match newly qualified international GPs with appropriate employers. Visas for IMGs should, by default, extend for at least three months after the trainee's expected completion date, to give these newly qualified doctors time to find an appropriate employer, and the employer time to secure a sponsorship licence if necessary. The Home Office and UKVI should also work with NHS bodies in the four nations to support practices to navigate the process of becoming sponsors, which will likely be new territory for many.

- **Improve support for settlement in the UK for IMGS**
  As well as reforming visa requirements for international GPs, further support is needed to support their integration and retention the UK. This should include things like enabling immediate family members to move to the UK, and providing additional wellbeing support locally.

5. **What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors? In particular:**

    - **To what extent is there an adequate system for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need?**

There is not an adequate system for determining how many doctors, nurses and allied health professionals we require to meet long-term needs. The NHS cannot deliver the care patients need without the workforce to do it and the general practice workforce has not grown in tandem with demand in recent years. This means GPs and their teams are having to work harder to meet patient needs, and some patients are facing difficulties in accessing care. This pressure is becoming unsustainable, driving many GPs and other

staff out of the workforce, and threatening to destabilise general practice.

In 2020, 70% of surveyed GPs found it difficult to recruit a GP.[iv] In addition, 34% of surveyed GPs in England, in 2021, have indicated plans to leave general practice within the next five years.[v]

The Health and Care Bill is a significant opportunity, and the first in a long time, for parliamentarians to ensure the government is held accountable for improving the immense workforce challenges that patients, and our healthcare workers continue to face. To address this, the RCGP is one of nearly 90 organisations to strongly support the workforce planning amendment - Amendment 10 in the House of Commons or Amendment 170 in the House of Lords. This amendment would put a clear duty on the Secretary of State for Health and Social Care to report to parliament on the long-term NHS workforce needs. This would make it much easier to hold the government and the system to account and ensure that workforce planning is prioritised.

- **Do the curriculums for training doctors, nurses, and allied health professionals need updating to ensure that staff have the right mix of skills?**

GPs have the broadest curriculum, yet shortest training programme of any medical specialty, which aims to expose trainees to the full breadth of conditions they are likely to see in general practice.

The RCGP has continued to call for the GP training period to be increased from the usual 3 years, to a minimum of 4 years in length. This extra training time should be spent based in general practice and is essential for qualifying GPs to experience consistent and appropriate training; prepare for new models of general practice and systematic changes such as the formal introduction of ICSs, and; better understand the increasingly complex needs of the patient population.

- **Could the training period for doctors be reduced?**

The RCGP strongly advises against reducing the training period for trainee GPs, and continue to call for GP training periods to be enhanced from 3 years, to a minimum of 4 years in length. This extra training time should be spent based in general practice and is essential for qualifying GPs to experience consistent and appropriate training; prepare for new models of general practice and systematic changes such as the formal introduction of ICSs; and better understand the increasingly complex needs of the patient population.

- **Should the cap on the number of medical places offered to international and domestic students be removed?**

The current cap on medical school places makes no sense when so many parts of the NHS are struggling to recruit doctors. The cap has meant medical schools are turning

away thousands of bright young people with top grades at a time when the NHS is crying out for new doctors,

This is especially true in general practice where 70% of surveyed GPs found it difficult to recruit a GP, almost half of new GP trainees went to a medical school abroad and the Secretary of State recently admitted the Government were not on track to meet their manifesto commitment to expand the workforce by 6,000 GPs.

The recent expansion of the cap of medical school places because of COVID difficulties was welcome but we need a long term plan that takes account of the long term needs of the NHS.

To deliver the future workforce for both general practice and the wider NHS, the undergraduate medical pipeline must be significantly expanded. Currently, there are 9,000 medical school places available per year, and we have joined the Medical School's Council and other Medical Royal Colleges in calling for a significant expansion[vi]. This should be accompanied by a commensurate expansion in the medical foundation programme for new doctors. To reach the long-term targets, we would also need to continue to see at least 50% of newly qualified doctors enter GP specialty training across the UK.

6. **What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?**

An RCGP survey found that 34% of GPs expect to leave the profession within 5 years, which could mean the loss of over 14,000 GPs to the workforce.

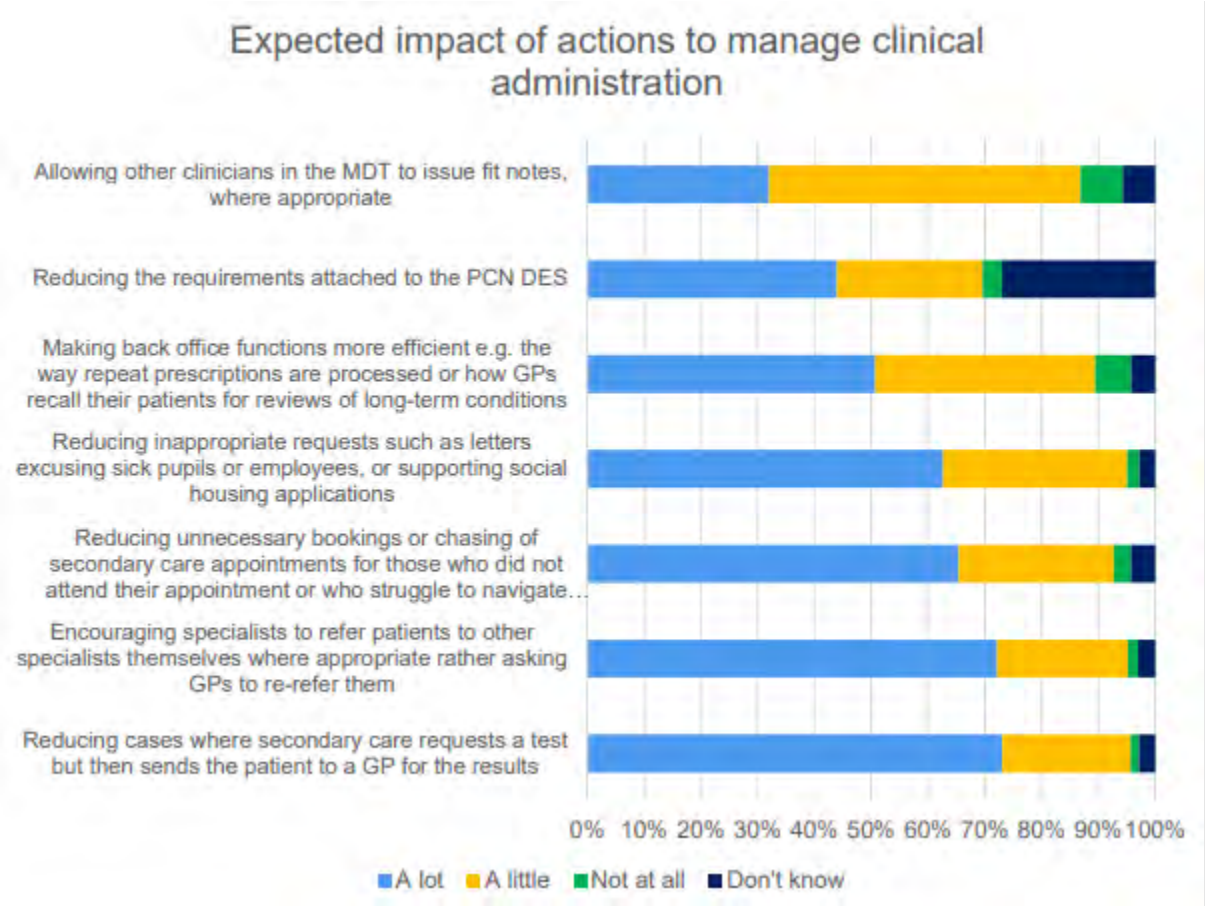
According to a GMC survey of doctors who had recently left the profession, 43% of former GPs said that they were leaving because of burnout/work-related stress,[vii] which was the second highest reason behind retirement.

The GMC report 'The state of medical education and practice in the UK 2021' found that on average GPs described that they were working at ‘high intensity’ for three quarters of the time and more than half of GPs (54%) are struggling with their workload far higher than other specialists (28%).

It is therefore unsurprising that the same report found that 32% of GPs reported they are at high risk of burnout – this was the highest amongst all doctors, about twice as likely as other doctors.

Too much of this unsustainable workload is unnecessary bureaucracy. The GP Worklife survey suggests about 9% of GP time is spent on non-clinical administrative tasks, and data from the Research and Surveillance Centre suggest that clinical administrative workload has gone up by 30% over the last year.[viii]

The chart below shows a range of key issues which our members think tackling would significantly reduce their workload[ix]. This includes preventing work being inappropriately passed on from secondary care, such as follow up on tests or referrals which should be dealt with elsewhere. The 2021 RCGP tracking survey found that over 60% of GPs said they thought reducing inappropriate requests such as letters and applications would have a major impact on their workload., other findings include:



In 2020, the then Health Secretary launched a new strategy to streamline processes and reduce bureaucracy in England, and NHS England and Improvement launched a specific review into reducing bureaucracy in general practice. However, these programmes have, to date, yielded very little impact on the daily working lives of GPs. With the NHS review doing little to address requirements on GPs or cutting any red tape outside of what had already been planned or adopted.

As well as cutting red tape it is important that we allow GPs to use their expertise to determine how best to help vulnerable patients rather than rely on the current box-ticking target-focused Quality Outcomes Framework (QOF). This system incentivises GPs to hit nationally agreed targets for things like how often they check up on certain groups of patients. This can prevent GPs to use their own clinical experience and local knowledge to determine who needs their help.

With significant numbers of GPs planning to retire it is concerning that the retention programmes set up to encourage them to stay are piecemeal and underused. Around one in five CCGs are not reporting helping a single GP through the NHSEI National GP

Retention Scheme and other retention efforts, such as the fellowship programme for early career GPs, are also struggling to get off the ground.

One short term issue of retention is the mandatory vaccination of healthcare staff. A survey of RCGP members conducted ahead of the Government's consultation[x] suggested that a COVID-19 vaccination mandate for healthcare workers would have the effect of 6% of GPs ceasing clinical work. This may be for numerous reasons including medical exemption from vaccination and ethical objection to such a mandate as well as vaccine refusal. Similarly, the Government's own impact assessment of mandatory vaccination for staff in social care settings suggested that between 12% and 3% of staff would refuse vaccination, with a central estimate of 7%.[xi]

A 7% decrease in the general practice workforce would mean, in real terms, that the number of fully qualified, full-time equivalent GPs would fall from 28,023 to 26,061, and the number of patients per fully qualified FTE GP would increase from 2,178 to 2,341.[xii] Such a dramatic decline in GP numbers could catastrophically undermine the ability of general practice to deliver the care patients need and rightly expect. Indeed, this loss of workforce could well result in greater harm to patients than that caused by exposure to small numbers of unvaccinated staff.

Recommendations

- Implement light-touch and risk-based regulatory models, reducing paperwork and reporting requirements, enabling GPs to focus on delivering patient care.
- Establish an independent review of the QOF system to one that is based more on an individual's needs rather than a nationally determined box ticking exercise.
- Current retention programmes should be reviewed to ensure they are effectively implemented and accessible to those who need support, and NHSEI should work with the RCGP, BMA and others to create a universal offer to enable flexible and sustainable careers in general practice for all GPs.

7. **Are there specific roles, and/or geographical locations, where recruitment and retention are a particular problem and what could be done to address this?**

It is significantly harder to recruit into general practice in rural areas and those with higher rated of deprivation. Once you account for the different levels of need:[xiii]

- General practices serving more deprived populations receive around 7% less funding per patient than those serving more affluent populations.
- A GP working in a practice serving the most deprived patients will on average be responsible for the care of almost 10% more patients than a GP serving patients in more affluent areas.

In addition to this, the recent Additional Roles Reimbursement Scheme (ARRS), implemented as part of the PCN Direct Enhanced Service in 2019, did not take deprivation into account when allocating funding to pay for new roles. This means that

GPs and their teams serving populations that are socio-economically deprived are being asked to do more work for less money, which makes it harder to recruit new team members and harder to retain staff already employed.

There is no simple answer to the issues facing under-doctored areas, and the solutions will need to include ramping up efforts to increase the number of GPs overall, as well as improving the working lives on GPs. However, government should also implement effective strategies for under-doctored areas. This should include developing a 'wrap around' package of incentives and support, to facilitate recruitment of new and returning GPs to under-doctored areas, drawing on the example of the Welsh government's Train, Work, Live programme, and building on the learning from Targeted Enhanced Recruitment programme.

8. **What should be in the next iteration of the NHS People Plan, and a people plan for the social care sector, to address the recruitment, training and retention of staff?**

As described above the next NHS People Plan needs to be based on independently verified assessments of the workforce needs for the 5, 10 and 20 years and will be based on projected demographic changes, the growing prevalence of certain health conditions and the likely impact of technology.

Taking these projections, the NHS People Plan needs to set out in clear terms what steps are going to be taken to meet these needs. So, for example if you want to expand the number of GPs working 20 years down the line you need to set out how many of these need to be trained in UK medical schools, how many international medical graduates and how much the workforce will grow by encouraging more doctors to stay in the NHS.

Once the People Plan has set out these numbers it needs to say what policy changes they are going to take, such as how to expand medical school and trainee places and what policies are going to be introduced to encourage retention.

9. **To what extent are the contractual and employment models used in the health and social care sectors fit for the purpose of attracting, training, and retaining the right numbers of staff with the right skills?**

This area is predominantly within the remit of the BMA GPC and not an area that the RCGP gets heavily involved in in terms of the contractual details. However, as the professional body for GPs we do believe there is room for improvement in the current contracting and payment system in general practice.

Some of the contracting systems seem to favour box ticking over patient care which add to GP workload. For example, the RCGP is calling for an independent review of contractual requirements, such as the Quality Outcomes Framework (QOF). Reforming contractual requirements such as QOF will not only enable high-trust environments that

encourage quality improvement processes and professional judgement, rather than top-down edicts which perversely incentivise tick-box approaches to medicine.

However, we do not believe that there is any need to overhaul the whole partnership model of general practice. This would likely require significant resource, and there is no evidence that this would have a positive impact on the delivery of care.

10. **What is the role of integrated care systems in ensuring that local health and care organisations attract and retain staff with the right mix of skills?**

Replacing Clinical Commissioning Groups with ICSs will move us away from a system where GPs are at the centre of the commissioning and decision-making process, to one where there is a danger that the voice of GPs and wider primary care system will be drowned out.

It is therefore essential that a more holistic view of the workforce across each ICS is considered in the new systems. This will help ensure that local health and care organisations attract and retain the staff they need, and that the workforce within different sectors in each ICS are made to feel their concerns and needs are heard and valued.

As we have already outlined, it is essential that workforce planning is improved at a national level however, workforce planning is also integral at a more local level too. ICSs will need to plan ahead and know what skill mix is going to be needed in their designated localities, so they can train people appropriately to enter the workforce in a way that they are already competent to do the work.

We must also remember that the health and care sector is likely to be a large employer within its own footprint in the future. ICSs must therefore ensure the health needs of their own workforce are attended to and factored in.

Recommendations:

- To enable healthcare staff to work across different providers for long, locum or support periods, ICSs must ensure staff have access to any paperwork or checks relevant to these alternative roles.
- To ensure different parts of the system aren't competing for staff to the detriment of another, ICSs must introduce career structures to retain people across a working lifetime within the system by offering progression, and perhaps a slower reduction to no work at the retirement end of a staff members career.
- To support staff to work when they have other responsibilities such as caring or childcare, ICSs must ensure a more flexible-working approach for those that need it.

[i] https://gprecruitment.hee.nhs.uk/Resource-Bank/Recruitment-Figures
[ii] https://www.theguardian.com/society/2020/jul/30/all-gp-consultations-should-be-remote-by-default-says-matt-hancock-nhs
[iii] RCGP (2019). RCGP response to the Migration Advisory Committee review of the Shortage Occupation List. Available at: https://www.rcgp.org.uk/policy/rcgp-consultations.aspx
[iv] Based on surveys of GPs in each nation of the UK in 2020. In field Feb–April 2020 (sample of 1183 GPs). Data representative of GPs who said they were involved in recruitment, excluding "don't knows"
[v] RCGP (2021). Tracking Survey 2021 (Unpublished).
[vi] https://www.medschools.ac.uk/news/msc-and-aomrc-publish-joint-statement-on-the-expansion-of-medical-student-numbers
[vii] GMC, Completing the Picture (2021).https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/completing-the-picture-report.
[viii] RCGP and Oxford University Research and Surveillance Centre, https://orchid.phc.ox.ac.uk/index.php/rcgprscworkloadobservatory/
[ix] RCGP online survey of 1,284 GPs in England, in field 6 March to 7 April 2021.
[x] CGP Mandatory COVID-19 and Flu Vaccination survey, conducted October 2021, 1779 responses received
[xi] Department for Health and Social Care, Statement of impact – The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021. https://www.gov.uk/government/consultations/makingvaccination-a-condition-of-deployment-in-older-adult-care-homes/outcome/statement-of-impact-the-healthand-social-care-act-2008-regulated-activities-amendment-coronavirus-regulations-2021#central-estimate
[xii] RCGP Analysis of NHS Digital GP Workforce Data. 2021 data does not include estimates of the GP workforce
for the small number of practices not returning data, so has been uplifted to account for this.
[xiii] Health Foundation (2021), *Level or Not. https://reader.health.org.uk/level-or-not/key-points*