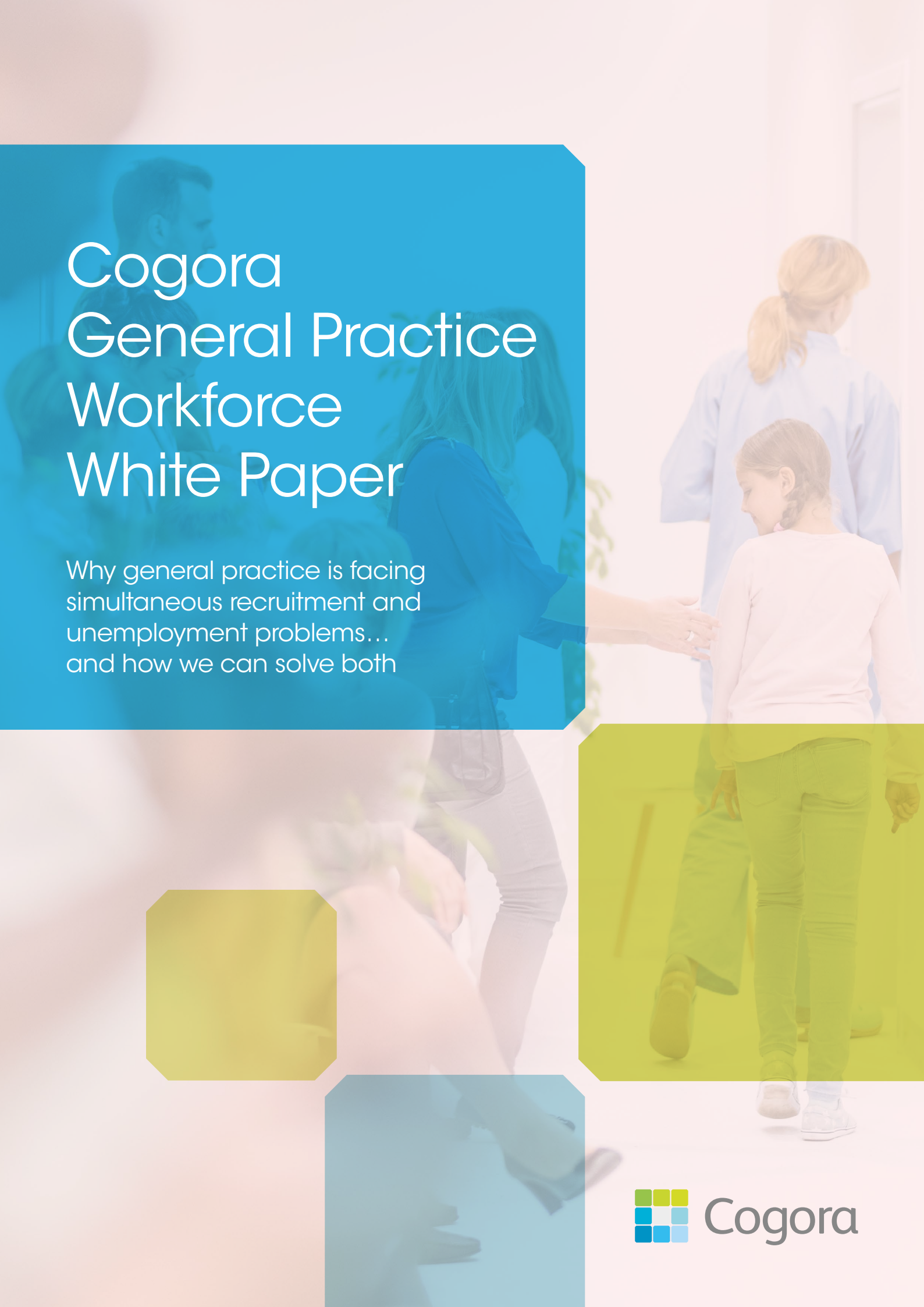
Cogora General Practice Workforce White Paper

Why general practice is facing simultaneous recruitment and unemployment problems… and how we can solve both



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Introduction

Workforce issues have plagued general practice for the past decade. Despite countless promises by governments and innumerable new initiatives, the problem continues to dominate health-related headlines.

GPs and their teams are working flat out, with exhaustion and burnout common, yet patients still struggle to get appointments.

In 2023, the NHS released its *Long Term Workforce Plan*.[1] While this focused on the whole of the NHS, there were some laudable ambitions for general practice. The plan sets out to address the projected 15,000 shortfall in GPs by 2036/37, at the same time as increasing non-GP direct patient care staff by around 15,000 and primary care nurses by more than 5,000.

Yet health secretary Wes Streeting has already vowed to rip up this report in order to put more emphasis on training GPs and less emphasis on secondary care doctors.[2] A new report is expected to be released in summer 2025.

Despite its laudable aims, the 2023 plan failed to address a number of systemic issues within general practice, including one in particular that has come to the fore since it was published. In the past year or so we've seen the unexpected problem of GPs reporting that they are unable to find work. Some are having to travel across the country to take up roles while others are having to do completely different jobs just to pay the bills.

The new Government has acknowledged this. In one of his first acts as health secretary, Mr Streeting extended the additional roles reimbursement scheme (ARRS) to enable primary care networks (PCNs) to appoint GPs for their practices, with NHS England paying the costs. Previously the scheme was restricted to staff such as pharmacists, physiotherapists and physician associates.

In December 2024, the Government announced it was increasing funding to general practice by £889m a year, and further extending the ARRS to provide funding for PCNs to appoint nurses. Both announcements were given a cautious welcome by the profession.[3]

However, we have a long way to go before the workforce in general practice is fit for purpose. Practices continue to struggle with workload, and find it hard to recruit not just GPs but also nurses and pharmacists.

This major new report by Cogora, launched in partnership with the Rebuild General Practice campaign, will explore the systemic issues within general practice that will need to be addressed by the 2025 workforce plan – and by wider government policy as a whole. A plan that fails to tackle these issues will be of little value to GPs or their staff.

Contradictory crises

The first part of this paper will examine what lies behind the seemingly contradictory crises that see a shortfall of doctors in general practice at the same time as GPs are looking for work. It will analyse how other groups within the multidisciplinary teams have been affected by the changes in the general practice workforce over the past decade, and the knock-on effects on other parts of the health system, including community pharmacy. It will also look at the effects of deprivation, funding, geography and other factors on workforce and employment.

The second part will look at what is being done at a national level, particularly to increase training numbers for professional groups within general practice. It will consider the extent to which integrated care boards (ICBs) are prioritising general practice, especially as ringfences have been removed from funding pots targeted at workforce issues. And it will look at what practices and PCNs are doing to alleviate their own recruitment problems.

The final part will offer conclusions and recommendations.

Cogora has surveyed more than 700 distinct practices in England, and around 2,000 healthcare professionals (HCPs) in general practice and community pharmacy, and conducted email and phone interviews with around 150 HCPs. We have analysed around 250 pieces of data on every GP practice in England. These will all inform our recommendations at the end of this report.

PART ONE

The situation as it stands

The 10-year recruitment crisis in general practice

Pulse stopped publishing a print issue in January 2024. For the final edition[4], it revisited its back catalogue, going as far back as 1960. Many of the early editions focused on workforce crises. Since even before then, general practice has regularly lurched between crises in recruitment (not enough staff for jobs) and crises in unemployment (not enough jobs for staff).

The current recruitment crisis has been a particularly long one. Before the Coalition Government came to power in 2010, the main issue was a reduction in the number of GP partnerships available after the implementation of the 2004 contract, and there was no problem with filling vacancies.[5] This started changing around 2011 to 2012, with reports of practices – particularly outside London – struggling to recruit.[6] The health secretary at the time, Andrew Lansley, announced plans in 2011 to increase GP training places by 20% to counter these problems.[7]

But by 2015 this had become a full-blown crisis. Lansley's successor Jeremy Hunt announced a 10-point plan to increase GP recruitment, which included a £10m fund to turn around struggling practices, incentive schemes to attract GPs to under-doctored areas and a marketing campaign to promote a career in general practice.[8] Notably, it also included the now infamous commitment to increase the GP workforce by 5,000 within five years, as well as a promise to increase the number of non-GP healthcare professionals.

Sajid Javid, who became health secretary in 2021, made similar commitments, with a £250m winter fund to boost GP access, which allowed commissioners to fund practices to recruit locums and non-GP healthcare staff.[9] But this came with targets around face-to-face appointments, which were unwelcome within the profession.[10]

Increase in GP trainees

The first thing to say is that, despite the difficulties with personnel and workload, the total number of GPs is steadily increasing (Chart 1).[11]

This is partly due to governments' undoubted success in increasing the number of GP trainees through Health Education England, which was later incorporated into NHS England (see chapter entitled 'How the NHS intends to boost training in general practice)'.

Chart 1 Total number of GPs in England (headcount)[11]

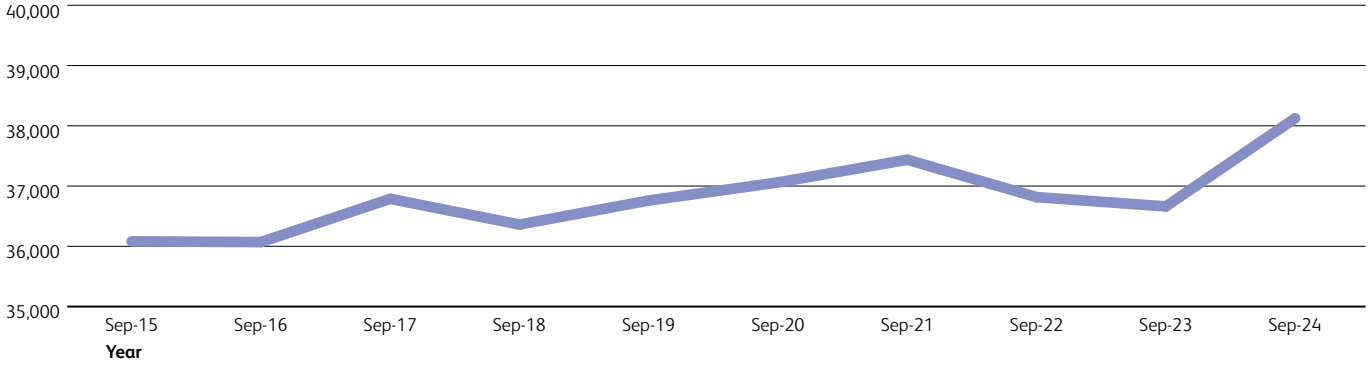


Chart 2 Total full-time equivalent GPs[13]

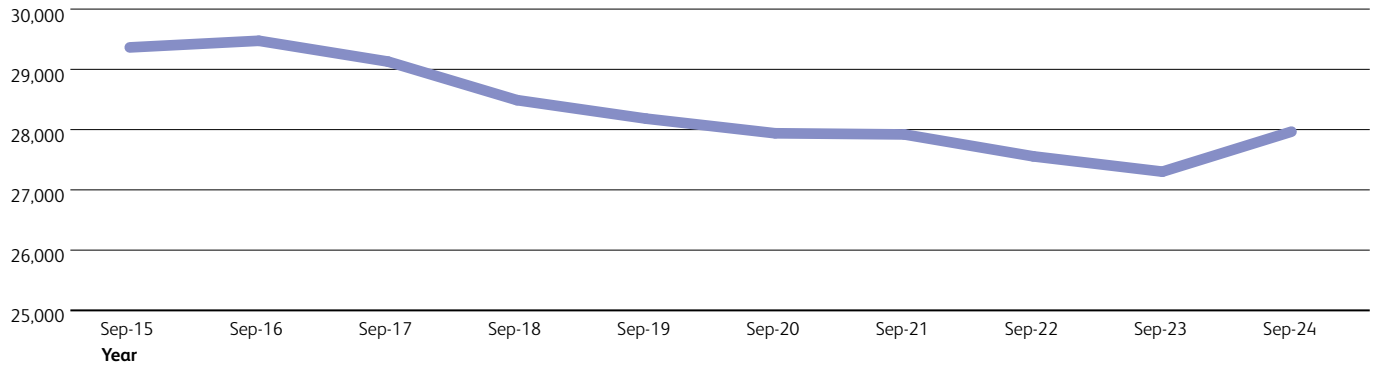


Chart 3 Percentage of GPs working less than full time[14]

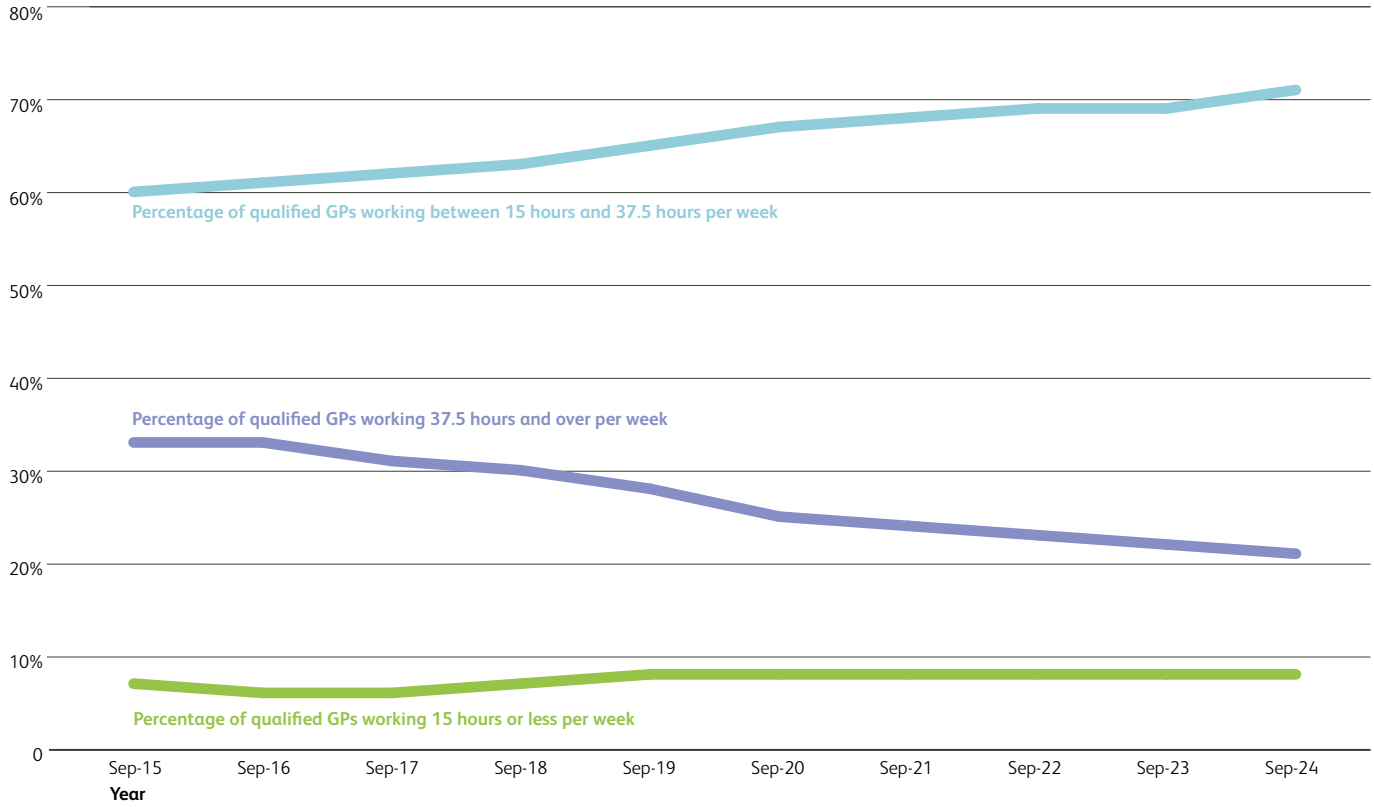


Chart 5 GPs per 1,000 population across the world[21]

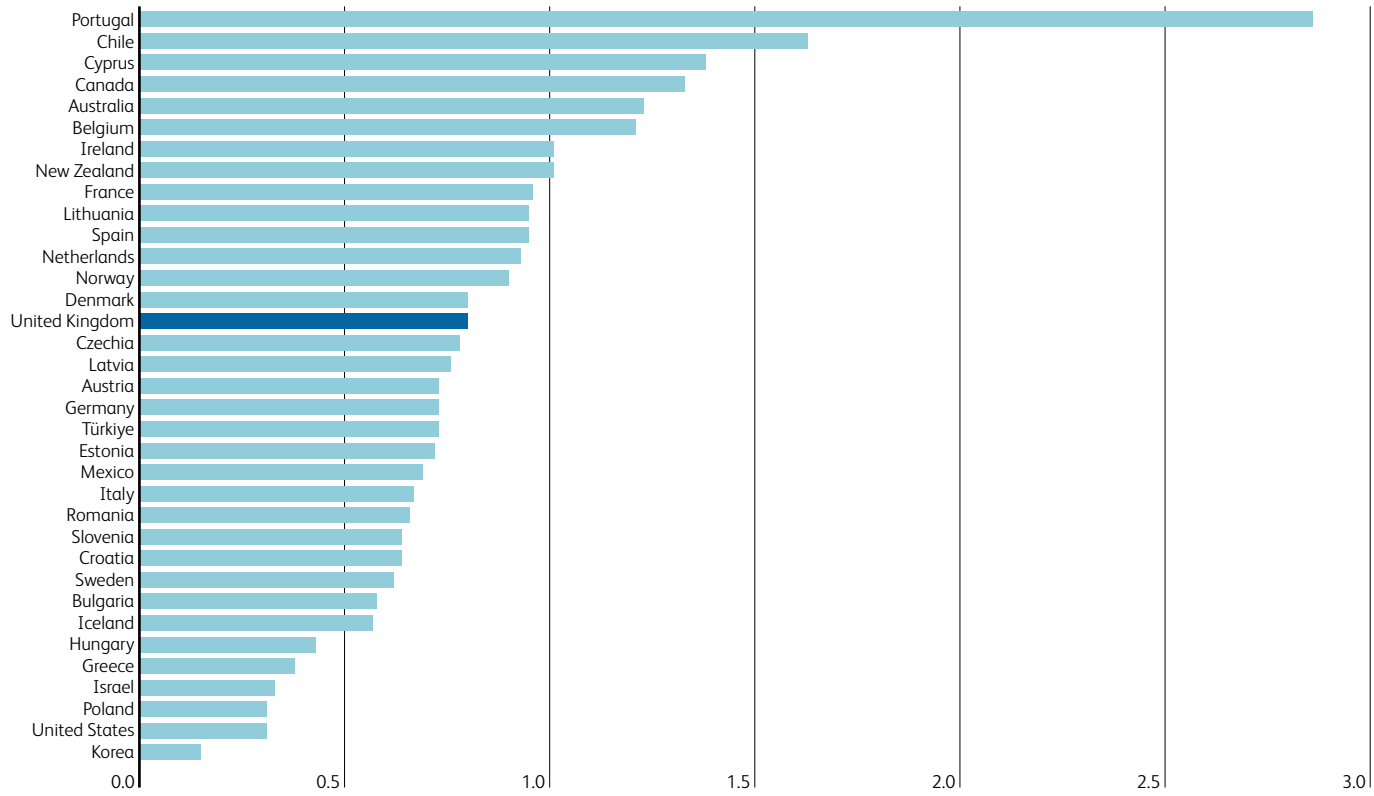


Chart 4 Patients per FTE GP[20]

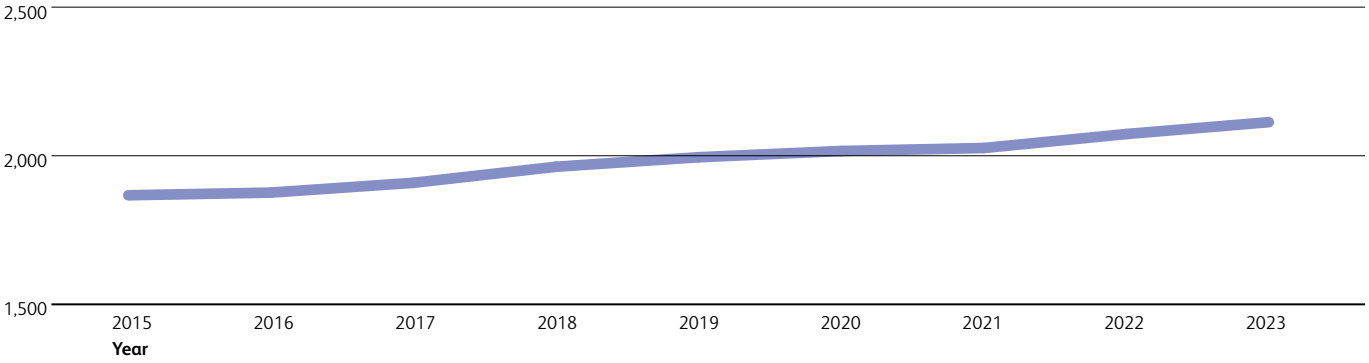
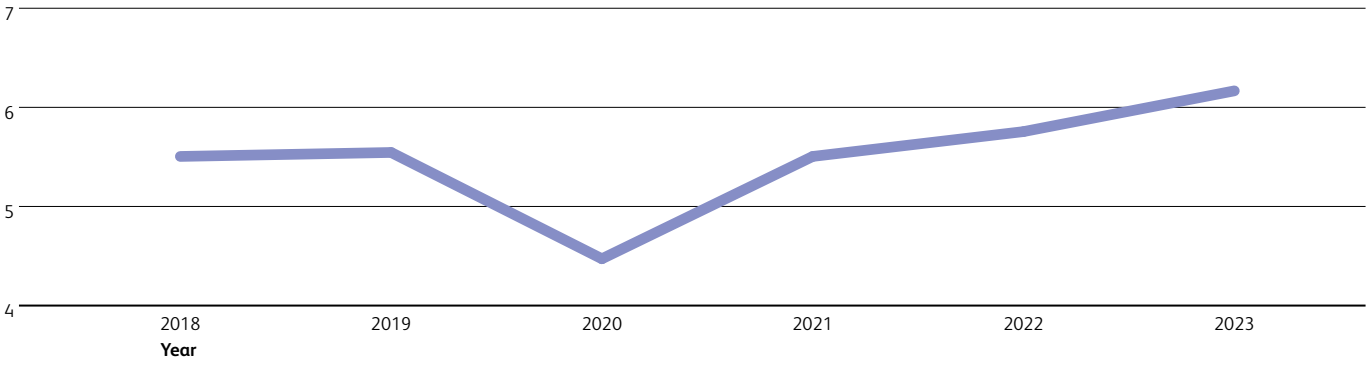


Chart 6 Number of appointments per patient per year[22]



The NHS has also looked to recruit trained GPs from abroad. The latest GMC statistics show 23% of fully trained GPs are from overseas.[12]

That all said, the overall story in terms of GP numbers is one of continuing failure. The pledges made by Hunt and Javid were not around GP headcount – they were based on fully trained full time-equivalent (FTE) GPs. By these measures, their governments failed miserably (Chart 2).[13]

The fall in the number of FTE GPs alongside an increase in GP headcount is partly explained by GPs working fewer hours. According to NHS Digital figures, GPs are increasingly working less than 37.5 hours per week (Chart 3).[14] This is more or less in line with *Pulse*'s September 2024 survey, which showed GPs are working an average 35 hours per week, and just under six sessions.[15]

There are a number of reasons for this. Although the proportion of female GPs has been rising – the total percentage of headcount GPs who are female has increased from 52% in September 2015 to 58% in November 2024[16] – it is too simplistic to attribute the trend of working less than full time (LTFT) to this. Indeed, one statistical analysis concluded it was 'mainly a result of male GPs reducing their contracted time commitments'.[17]

This trend shouldn't be too surprising. NHS England has actively promoted the merits of more flexible working, highlighting how GPs can pursue more portfolio careers, including stints in different healthcare settings and academia, as well as work with regulators, medical examiners and in a number of other roles.[17]

But a bigger reason for this shift is more likely to be the increasing intensity of general practice sessions, which has forced GPs to – as the GMC puts it – 'take matters into their own hands' by reducing hours to improve their own wellbeing and reduce potential risks to patient care.[18a]

Regardless of the reasons for greater LTFT working, it has

resulted in fewer fully qualified FTE GPs. To compound matters, this has come at a time of increasing patient numbers. This leaves the ratio of GPs to patients well below that called for by professional bodies. The BMA has set out an aim to have one FTE GP per 1,000 patients by 2050.[18] In 2009, there were 1,520 patients per GP[19]; that figure is now more than 2,100 (Chart 4).[20]

This compares poorly with other developed countries, with the UK having 16% fewer GPs per patient than the Organisation for Economic Co-operation and Development average (Chart 5).[21]

Rising patient demand

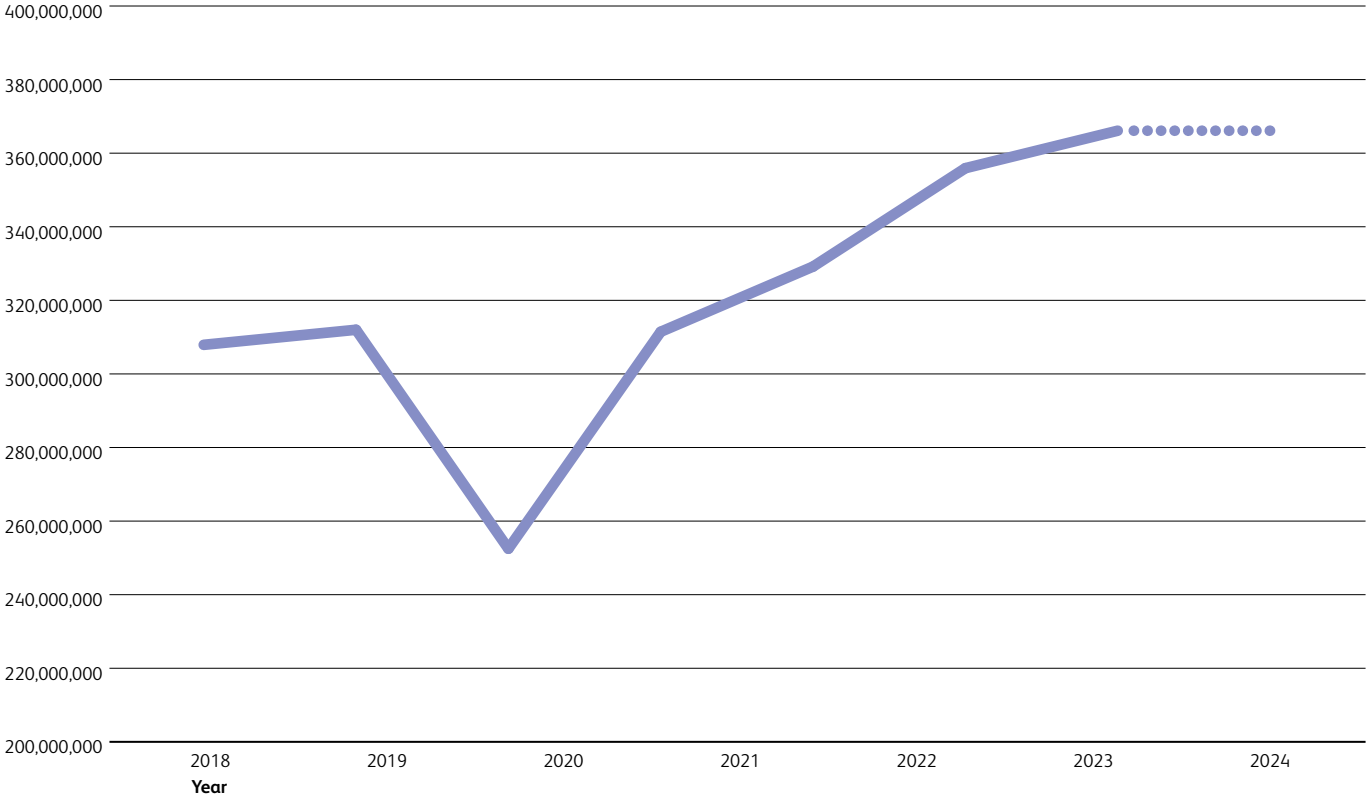
Not only are patient numbers per GP increasing, but the demand per patient per year is increasing as well – a trend that began before the Covid-19 pandemic (Chart 6).[22]

There could be many reasons for this – an ageing population, greater co-morbidity or demand stoked by ministers and the NHS.

Governments have tried to ease this demand through initiatives such as Pharmacy First, which encourages patients to see their community pharmacist for seven minor, self-limiting conditions: acute otitis media; impetigo; infected insect bites; shingles; sinusitis; uncomplicated urinary tract infections; and sore throat.[23] They have also expanded self-referral for patients, allowing them to bypass GPs for certain requirements such as podiatry, hearing tests or incontinence advice.[24]

It might be too soon to assess the effect on patient demand of such initiatives but so far they don't seem to be working, with GP appointment numbers continuing to increase (Chart 7).[25]

Chart 7 Total appointments in general practice[25]



Amid the crisis, staffing numbers explode

Successive Conservative administrations did acknowledge their failure to increase GP numbers.[26] But at the same time as their ineffective recruitment initiatives, ministers and the NHS were pursuing a parallel policy for which they were far more successful in achieving their stated aims.

Around the middle of the last decade, ministers and the NHS began to pivot towards multidisciplinary working. While it is likely that this would have happened anyway, the shortfall in GP numbers made the need far more pressing.

Before 2015, the typical practice comprised GPs and nurses who provided almost all the clinical work, with the practice administration carried out by a manager and reception staff.[27]

But in the early 2010s, the idea of other healthcare staff taking on clinical work became more prominent, most notably through then RCGP chair Professor Clare Gerada.[28] In 2014, NHS England launched its *Five Year Forward View*, which recommended that GP practices become 'multispecialty community providers', that would employ 'senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff'. In 2015, the first concrete policy change came in, with a £15m scheme for GP practices to employ pharmacists.[29]

This was turbocharged in 2019 by the new GP contract. Through the additional roles reimbursement scheme (ARRS), practices were incentivised to join 'primary care networks', groups of practices that would mainly cover populations of 30,000-50,000 patients. The contract committed £938m of extra funding per year by 2023/24, with a total of £1.79bn directed towards the new PCNs, predominantly through the ARRS.[30]

This scheme funded the recruitment of non-GPs to general practice, with the five-year 2019 contract providing pharmacists (building on the earlier scheme) and social prescribers in the first year, followed by physiotherapists, physician associates and paramedics in later years.[31] Since then, the ARRS has been expanded to include occupational therapists, dieticians, podiatrists and mental health practitioners among others[32], with newly qualified GPs added in 2024 by the new Government.

While the number of FTE GPs has gone down, the total number of practice staff has increased, mainly due to the influx

Chart 8 Number of FTE GPs, nurses, direct patient care and total clinical and total non-clinical staff[33]

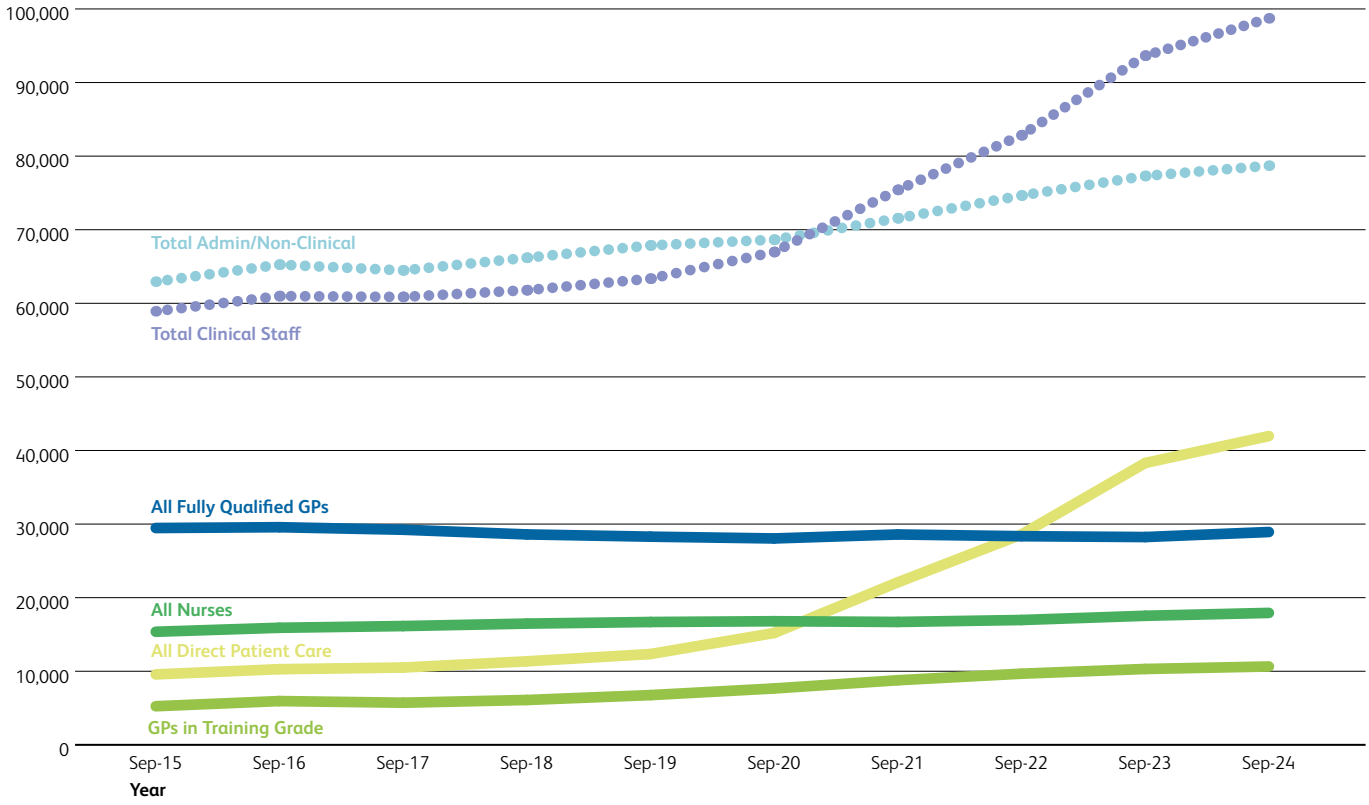


Chart 9 Total FTE practice staff[34]

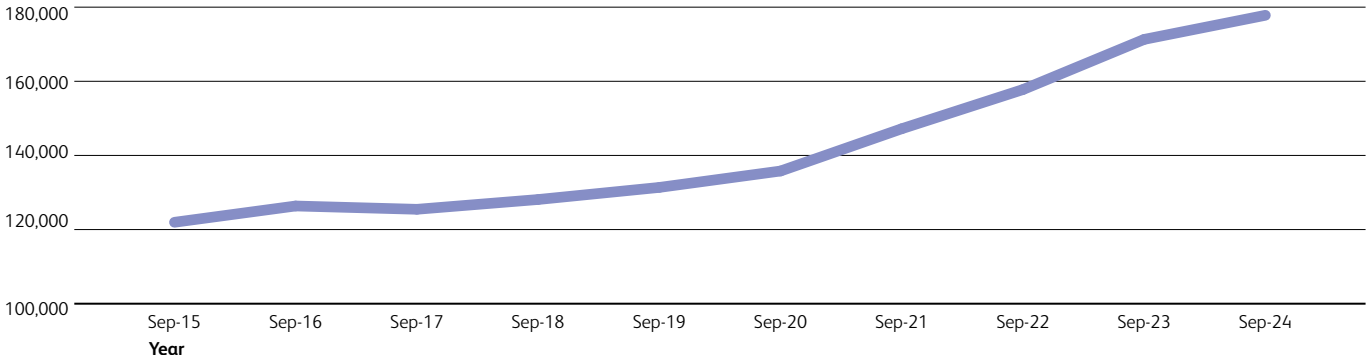
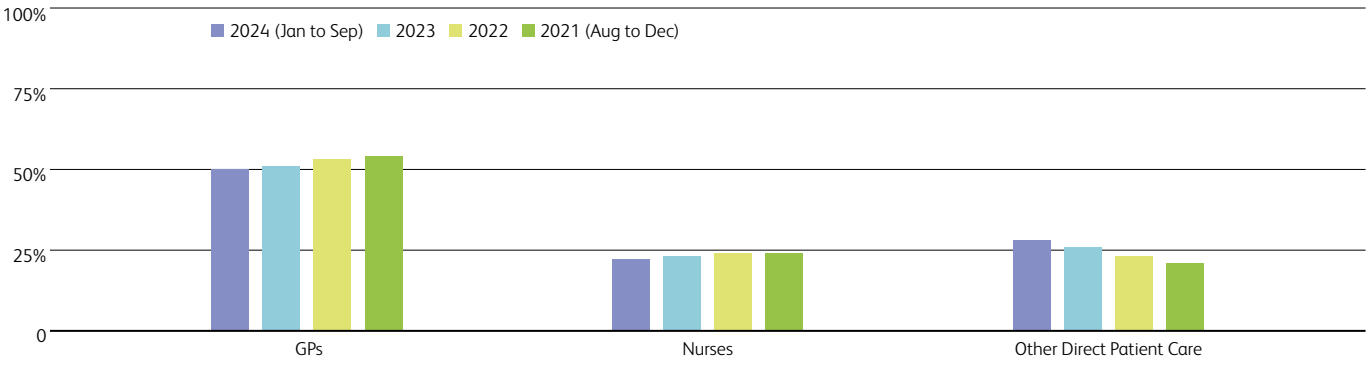


Chart 10 Percentage of appointments conducted by each staff group[35]



of non-GP healthcare professionals. At the same time, practice nurse numbers have been rising at a steady rate (Chart 8).[33]

The addition of clinical staff who are not GPs or nurses, and a huge increase in administrative staff, has led to more people than ever before being employed in general practice (Chart 9).[34]

Of course, there are caveats to this – since the introduction of the ARRS, we have gone through Covid and a major economic downturn. But this has been the key policy for all recent health secretaries and NHS England, and it is likely this would have been the direction of travel regardless of these disruptions.

There has been an obvious effect on provision of patient care. In 2024, for the first time, only half of appointments in general practice were with GPs (Chart 10).[35] This shift is likely to continue, with many ARRS staff being upskilled. For example, from 2026, all new graduate pharmacists will be qualified to prescribe.[36]

But there are two burning questions around multidisciplinary working. The first is whether the roles are clinically appropriate – and safe – for the tasks associated with them.

Here, much of the debate has focused on the role of physician associates (PAs).[37] GP groups are united in wanting to limit their scope of practice to exclude tasks that should be done by fully trained GPs, such as managing undifferentiated patients,[38,39]

But PAs do not have a huge role in general practice, making up a fraction of the workforce (Chart 11).[40] The NHS workforce plan commits to expanding their number to 10,000 by 2036 without saying how many will be in general practice. Importantly, health secretary Wes Streeting has launched a review into the role.[41]

This question becomes more relevant when looking at the more established roles. A survey by *Nursing in Practice* revealed that nurses feel they are taking on responsibilities way above the levels they should be within multidisciplinary teams (Chart 12).[42]

Asha Parmar, an advanced care practitioner in London, points to covering two practices with populations of 10,000 and 5,000: 'All the liability of all things nursing relies on you – immunisations, infection control, smears, diabetic physical checks, wound dressings, stock, fridge responsibility.' Nadine Laidlaw, a lead practice nurse in Newcastle, says she is 'single-handedly managing chronic diseases with some of the most complex patients in our practice [including patients who] speak no English and have no health literacy, let alone any idea how to navigate the healthcare system'. This involves 'following national guidelines, addressing holistic issues with social care or domestic issues, alongside "routine jobs" like cervical screening, immunisations and health promotion'.

Some nurses say the GP industrial action has exacerbated this. An advanced nurse practitioner (ANP) in Somerset says it has meant providing more 'routine appointments' for management of ongoing conditions. 'In these circumstances, I find patients are more likely to become frustrated at not seeing a GP. As an ANP in an acute care role, I feel I experienced this frustration far less.'

The knock-on effects of secondary care pressures – and gaps in ICBs commissioning certain care – are also adding to complexity. A practice nurse in South Yorkshire says: 'We do have fewer breaks. This is for various reasons, partly because chronic disease reviews are now more complex due to multimorbidity, socio-economic and mental health problems impacting increasingly on health, and more options in terms of medical and lifestyle management to discuss. We also have had an increase in workload that used to be absorbed by secondary care – for example, wound care.'

The effectiveness of ARRS staff

The second burning question is less concerned with patient safety than the usefulness of ARRS staff. It is still too early for long-term studies on the effectiveness of the scheme. But for many GPs, even established staff are often not effective in easing workload, especially as they may need GP support in consultations.

One GP partner in Salford says: 'Apart from pharmacists and perhaps physios, I feel the ARRS funding has been a massive

Chart 12 Which of the following best describes the level of clinical responsibility of your current work[42]

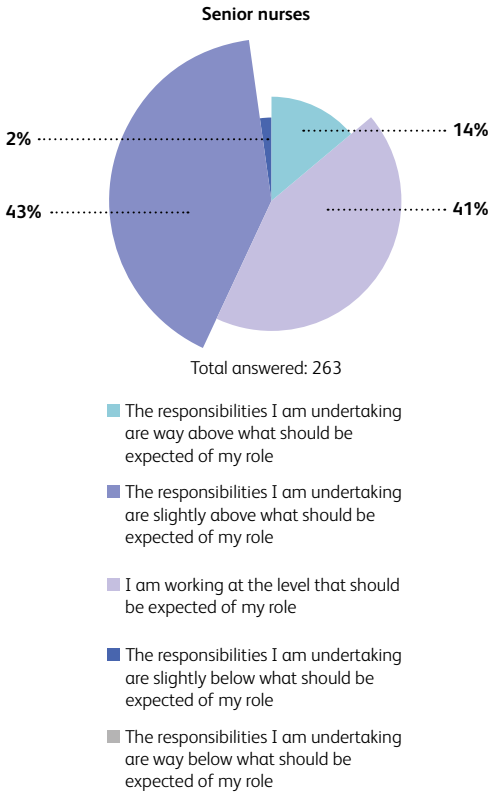
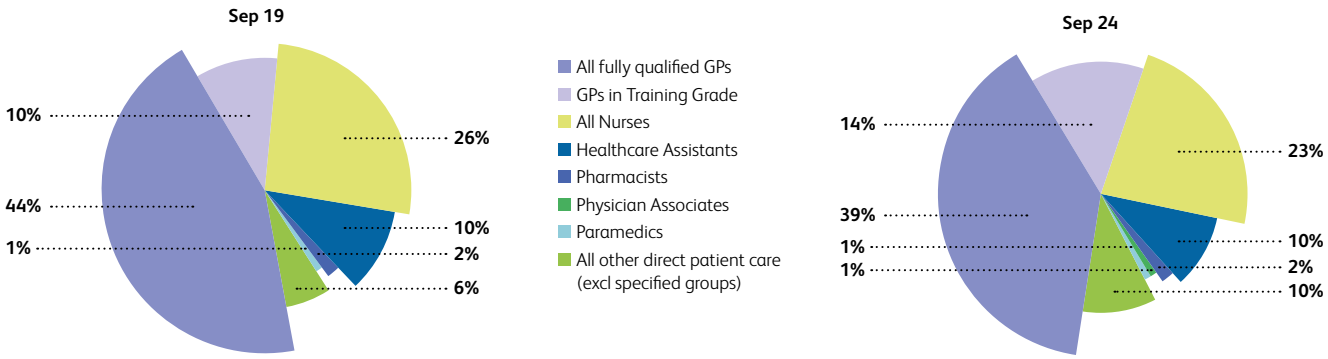


Chart 11 Configuration of practice clinical teams[40]



black hole that swallows huge amounts of GP funding for roles such as social prescribers that make little difference to workload.'

Others say ARRS staff can often increase workload. A GP partner in Warwickshire says: 'I don't want an advanced care practitioner on a high salary seeing a patient every 15 minutes for a single issue when I'm still legally responsible for them even though I've not seen their patients.' The partner says the PCN-employed ACP is very competent, but 'can't prescribe and asks to review five patients a day with a GP', adding: 'I want a GP who can deal with complex cases, triage effectively, see non-differentiated patients safely.' Another GP in a deprived area agrees: "ANPs are helpful but can often add another step to the management of a patient. Although a GP appointment can be more costly, it can mean fewer appointments are needed to sort out a problem, so money can be saved in the long run.'

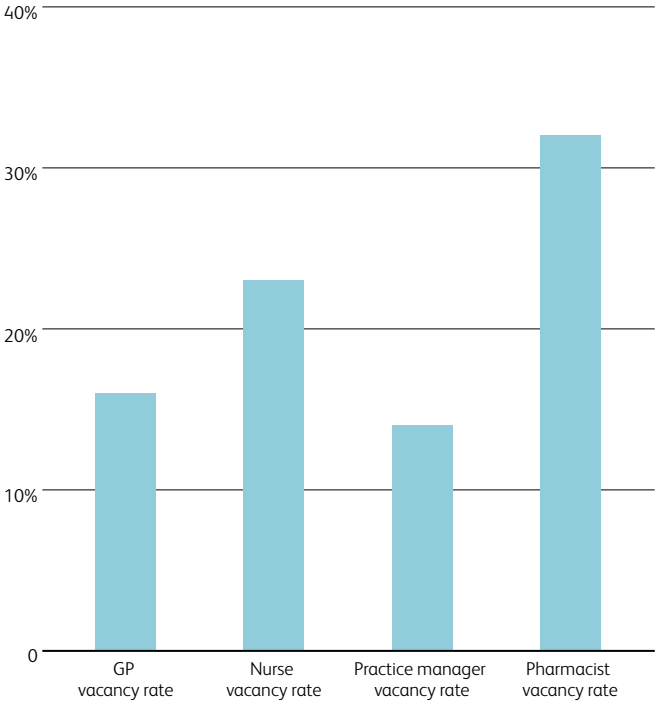
The capabilities of ARRS staff are not uniform. A Leicester GP partner says: 'The ARRS staff have very variable ability and sometimes do the minimal related to their experience for partners to pick up the deficits, again.'

Furthermore, it is misleading to suggest these new staff are 'free' for practices. The funding for the ARRS doesn't go directly to the practice, but to the PCN. A *Pulse PCN* survey of 276 GPs who have a say in their PCN's decisions found a mix in how ARRS staff are distributed across a network's member practices. And in exchange for this funding, PCNs – through their member practices – have to take on more work, such as enhanced care for care home residents. A practice manager in Yorkshire says: 'We do have access to some ARRS staff including ANPs and paramedics. But in our view the vast sums spent on the ARRS care home team vastly outweigh the need – in cost terms, the money is wasted and would be better spent on our wider patient population by practices rather than PCNs employing GPs through core funding.'

The nature of the ARRS funding also means staff may not have the same commitment to a practice and, being part of the PCN, are less likely to be truly embedded in the practice. A nurse team lead in the north of England says: 'ARRS staff seem to be unaware of the QOF [Quality and Outcomes Framework, a scheme that incentivises practices to achieve set clinical goals] and its impact on practice finances. This makes the nurse team feel demoralised as we have to chase information to achieve QOF and bring in money. [ARRS staff] are less likely to be impacted by a poor QOF achievement as they're not paid by the practice.'

Chart 13 What are the vacancy rates in your practice?[43]

GP partners and practice managers were asked how many of each role work in the practice, and how many they would like if recruitment wasn't an issue



Total practices answered: 642

Recruitment of key roles

With these two issues of safety and utility, the ARRS presents problems to practices. Practices do want to recruit certain staff – particularly GPs, nurses and pharmacists (even with concerns around cost-effectiveness for the latter two). A joint *Pulse* and *Management in Practice* survey found practices would like a 19% increase in the number of GPs if recruitment issues were not a problem (Chart 13).[43] Furthermore, only 35% of practice managers said they had no need to hire GPs (Chart 21, page 17).

There are many caveats to this. The main one is that, due to the problems of the past 10 years, many practices have given up on recruiting GPs, with their work absorbed into the team.

But there is little doubt about the demand for pharmacists and nurses, with a shortfall of 47% and 29% respectively.

One practice manager in Humber and North Yorkshire says: 'We've been working to invest in our pharmacy team to relieve GPs from prescription admin and medication reviews. But clinical pharmacists and pharmacy technicians are like hen's teeth.'

A practice manager in Blackpool says they can't afford to match salaries for nurses and pharmacists. 'We currently have four practice nurses; they do the bulk of our chronic disease management and are worth their weight in gold. Nurses are particularly difficult to recruit, mainly because the local out-of-hours provider pays significantly more than we can ever offer.

'We had an advert out for a pharmacist for six months without a single applicant. Ideally four pharmacists would work for us.'

This competition leaves practices and PCNs vulnerable to them leaving. A GP partner in the Home Counties says: 'We have taken on several ARRS paramedics and clinical pharmacists, spent two to three hours per week of my time training them in the ways of primary care, only to have them leave for jobs in other PCNs.'

Dr Bethany Anthony, a research officer at Bangor University who wrote a paper on the ARRS,[44] says: 'There was some evidence that substituting GPs with nurses for common minor health problems is cost-effective. A separate qualitative systematic review uncovered a number of barriers and facilitators to pharmacists and PAs providing general medical services instead of GPs.'

For the individuals working in general practice the effects are even greater – and this is having sector-wide consequences.

The unthinkable... GPs face unemployment

It may not be news to anyone that there is still a recruitment crisis and more GPs are needed – the NHS workforce plan was emphatic about this. But what is new is the nature of it. Because it seems there are more factors in play than just a lack of GPs in the system.

A *Management in Practice* survey of 385 practice managers in England found only 16% received insufficient applications when they advertised GP vacancies (Chart 21, page 17).[45] In other words, the problem is not a lack of GPs looking for work.

Locum work shortage

The canary in the coalmine has been a lack of work for locums. Reports emerged in autumn 2023 of locum GPs having to change their rates to compete with ARRS staff.[46] By September this had become of flood of reports about locums being out of work.[47] Andy Pow, board member of the Association of Independent Specialist Medical Accountants (AISMA), says: 'That would have coincided with the Government announcing the uplift to staff pay of 6% but then not providing the full funding for it.[48] It's quite limited how practices can control costs, and locums are a variable cost which you can cut when money is tight.'

This situation has only intensified over the past year. In *Pulse*'s September 2024 survey, locums overwhelmingly reported a cut in shifts since September 2022 – more than half said work had dried up, while a mere 4% of the 172 locums who responded reported an increase in shifts over that period (Chart 14).[49]

Sam Hargreaves, director of Hargreaves Medical Chambers in Liverpool, says locum bookings 'fell off a cliff from September 2023'.

'We used to be booked at least three months in advance outside school holidays, and always 100% booked for the month we were going in to. School holidays were booked even more in advance, with August being fully booked by the previous January.

'We would usually have an average of 200 sessions booked per month, year-round. Now we are lucky to have 80-100, and most of those are booked at very short notice.

'Locums are having to cope with unprecedented income insecurity, as work is now scarce and much less reliable,' she says.

Chart 14 Since September 2022, have your locum sessions worked[49]

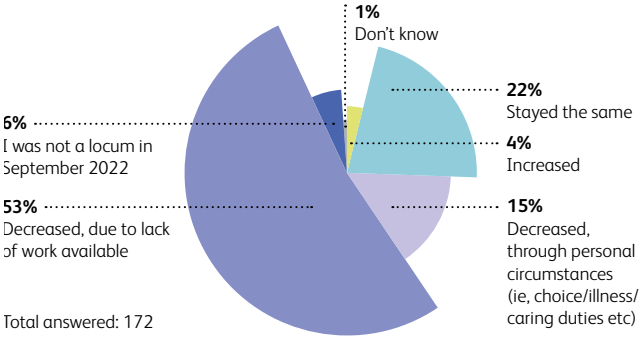
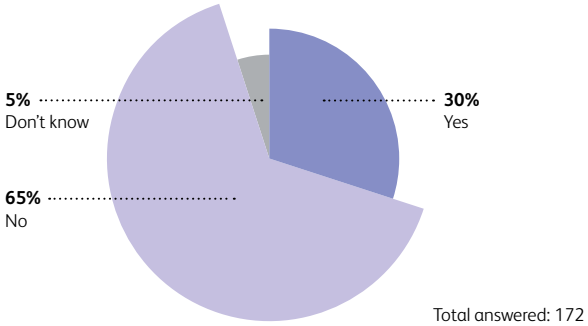


Chart 15 GP locums: Have you travelled further than you would reasonably wish in order to take work?[50]



Locums' experience on the ground reflects this. One locum in London says: 'Our work has significantly reduced in the last 18 months in West London and all over the UK. Many colleagues are finding it very difficult to find work. Furthermore, we have accepted a reduced hourly rate in order to get some work. This is not sustainable. I have spoken with many colleagues who are planning to leave London, the NHS or retrain in something else. Some have already left and moved to Canada or Australia.'

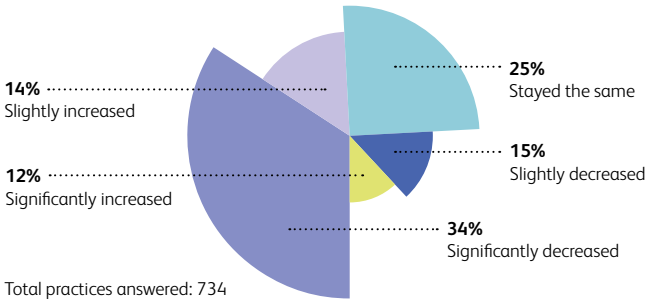
Some are having to look much further afield (Chart 15).[50] One Bristol locum reported having to take shifts in the Shetland Islands. She says: 'For 20 years, I had been earning most of my income as a locum GP in Bristol. In March 2024, I noticed fewer vacancies being advertised in Bristol. I saw an agency advertising for vacancies in NHS Highlands. I'd previously worked for a week in Shetland - because I wanted to at that point, not because I needed to. But when I saw the role come up this time around, I felt like I had no other option.' Meanwhile, *Pulse* has reported on locums travelling several hours to shifts, including from Cumbria to Cornwall.[51]

GPs and practice managers agree there are fewer locum shifts available, with 50% saying the number they offer has fallen (Chart 16).[52]

Lisa Fall, a practice manager in Dorset, says her practice found two salaried GPs in early 2024, which meant reliance on locums was reduced. 'Since then we have been very careful about when we do and don't employ a locum due to the financial restrictions that practices now find themselves in and the fact that some locums now want quite a high hourly rate.'

A practice manager in South Cumbria says: 'We had seen our locum cost increase from £34,000 in 2016 to almost £80,000

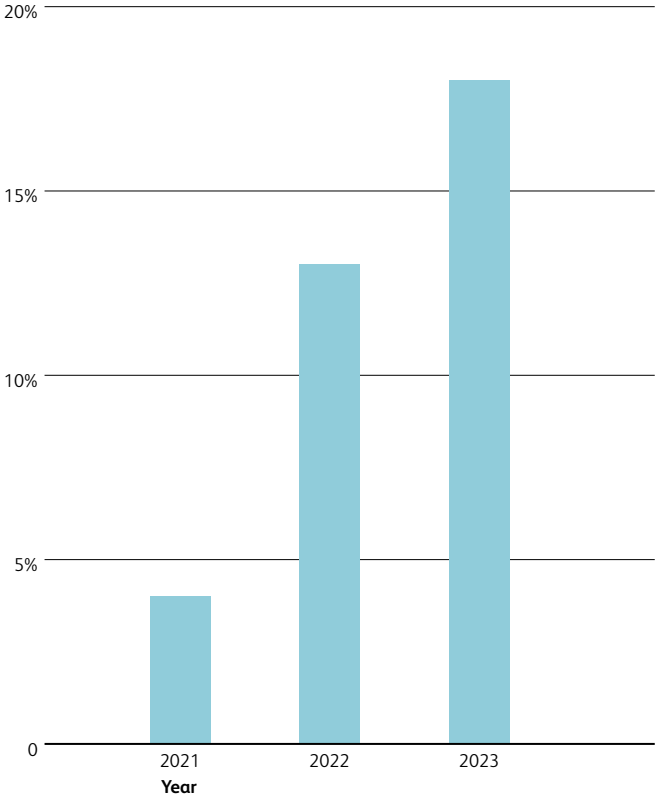
Chart 16 GP partners and practice managers: How does your use of locum GPs compare now with September 2022?[52]



in 2023. In addition, like most practices, we were replacing like for like – ie a full-day clinician for a full-day clinician. In the autumn of 2023, we recognised we needed to reconsider our use of GP locums due to the increasing costs and incoming funding not keeping up with inflation and other rising costs, so started proactively planning for the whole of 2024.'

The study *You're just a locum* found that 'some policymakers have problematised locums, seeing them as undermining traditional and more cost-effective ways of working'.[53] It cited NHS England's 2017 five-year strategy, which said locums were 'individuals who are actually available to work and are doing so – but in a way that is unfair to their permanent colleagues and is placing an unacceptable burden on the rest of the NHS'.[54]

Chart 17 GPs switching to locum work[55]



Yet as the *You're just a locum* study found, locuming may allow GPs 'greater control over their workload, offer career flexibility, increased income and improved work/life balance, and trade some occupational stability for greater autonomy'. Such flexibility has been promoted as a benefit of a career in general practice. Furthermore, the study found 'work intensification, workload pressures and resource constraints in the NHS and the attendant problems of work stress and burnout may also be important factors' in doctors moving to locum work. The GMC backed this up – in September 2024, it found 18% of GPs had switched to locum work in 2023 due to workload pressures (Chart 17).[55]

Therefore, the fall in available locum work has also had the effect of removing an option for GPs facing burnout who might want to step back for a while from permanent work while remaining committed to the profession. Sam Hargreaves says her locums 'feel highly valued the by the local NHS practices they provide services to but over the last year have been feeling really upset and demoralised by NHS decision-making which has excluded locum GPs and left practices without the resources to continue to employ them'.

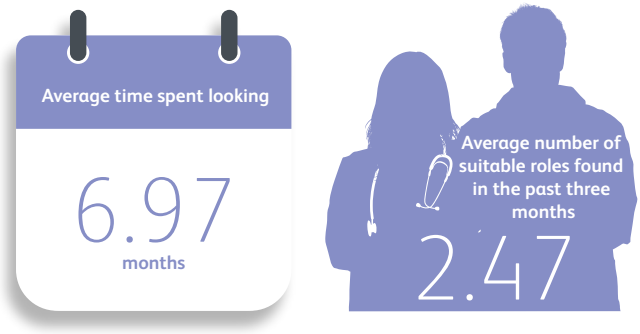
'They've become quite angry about being marginalised and not factored into financial planning for the NHS as a legitimate part of the ongoing GP workforce'.

She stresses locums' 'genuine loyalty to the NHS' and says GPs have often opted for the locum route because they're 'burnt out, or need the kind of work-life balance and flexibility that aren't offered by salaried or partner positions, where very long days are still the norm'.

The move to locum work is a trend seen more frequently over the past 15 years – although the exact numbers are unclear as there are no robust figures on the growth in the locum GP workforce. According to NHS Digital, there were 602 'regular' locums in England in September 2024, but this only captures those with regular shifts and not those who perform ad hoc roles, and is therefore a significant underestimation.

Nevertheless, there is consensus that the number of locums has gone up over the past 15 years. For example, a 2018 GMC study found the proportion of GPs who were locums increased from 28% in 2013 to 36% in 2017.[56] Using the same methodology as the GMC, the National Association of Sessional GPs estimates there are now more than 21,000 GPs doing locum

Jobseeking GPs[59]



work in England, which represents an increase of 5,000 from five years ago.[57]

Competition for salaried jobs

As well as removing a route for some GPs who are facing burnout, the shortage of locum work has had a wider knock-on effect.

Because of falling numbers of shifts, many longer-term locums started looking for permanent roles for income security. This influx of new jobseekers meant some areas had more demand for jobs than available roles. One locum in Hampshire says she has not put up her rates in six years, and now expects to have to travel further for work. She adds: 'I don't particularly want a salaried role but I've looked at what's available out of interest and there seem to be considerably fewer roles available than in previous years.

Another GP in the North West says: 'I was salaried, and then I left my role in October 2023 to get a better work-life balance. Finding locum work wasn't easy at the start, but I was able to get some roles, including in one practice for a couple of months.

'Then in September, October 2024 work started to dry up. I applied for salaried roles and was either getting no responses,

Case study

I qualified as a GP in 2022 in the Midlands, and after that I worked as a long-term locum until going on maternity leave in September 2023. As I was self-employed, I funded my own maternity leave and planned to go back to work after nine months, hoping for a salaried role. However, by summer 2024 there were few vacancies and salaried posts that were advertised were inundated with applications.

Often you don't even get an email back in response, let alone an interview.

There are a lot of ARRS-funded posts. The main criteria are that you can't have had a substantive post, which I hadn't. But you also have to be within two years of your CCT, which I'm not because I had a baby in September 2023.

Being excluded from eligibility for ARRS-funded roles due to my time spent on maternity leave is quite a big issue in itself.

Due to the lack of salaried roles, I've also been applying for health tech roles and roles elsewhere in the NHS. I have now secured a role, not as a GP, but teaching medical students from January. You don't have to be a GP to do this – you can be a junior doctor. The salary is half of that of a salaried GP but I have had to take this role.

I've applied for about three or four prison GP roles and between five and 10 salaried roles. I've also applied for around four or five ARRS roles. I've also just been emailing my CV with a cover letter to well over 50 practices about salaried roles, for any amount of sessions. I got only one response, asking for my locum rate – I sent over my terms and conditions but didn't hear back.

Before going on maternity leave, I was getting offers of locum shifts every day. Sometimes I'd be on shift and get a call from another surgery asking me to provide cover and have to turn them down. I was also asked to apply for salaried jobs at surgeries where I had been a locum.

There didn't appear to be any issue at that time with availability of work. After qualifying, I worked as a locum because we were in the process of moving from the Midlands back to my hometown, so I didn't feel I could take a salaried role in the Midlands.

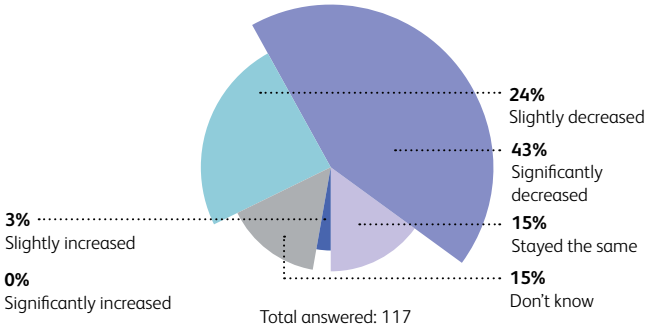
But over 2023-2024, something drastically changed in primary care. I contacted the local out-of-hours provider after returning from maternity leave, and I got a response saying 'we're no longer employing GPs for day shifts because we are mainly covering them with ANPs/ACPs. However, if you're willing to do night shifts, where you also provide a supervisory role to colleagues, please let us know'.

They seem to want GPs to essentially provide debriefs and advice over nights to allied professional roles, such as nurse practitioners and paramedics. But those roles take on a lot of risk and essentially I'm one to two years after qualifying/CCT, so I don't feel comfortable with that level of risk. I also have very young children, who I would struggle to leave while on a night shift for 12 hours.

In the last two months, I have secured two locum shifts at a surgery an hours drive away. I am continuing to apply for salaried roles. Never did I imagine I'd be coming out of medical school and three years of GP training, and struggle to find work.

GP locum in the Midlands

Chart 18 GP jobseekers: Since you first started looking for a permanent role, have the number of suitable roles[60]



or being told posts were closed because of too many applicants. I started panicking – thinking of getting work in Aldi over Christmas. I have a job now for two days a week. Ideally, I'd like to have stayed in a locum role, but I needed a bit more security.'

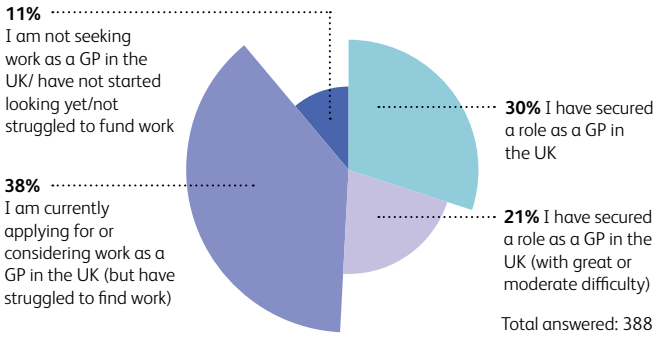
Their experiences are not unique. Of the 850 respondents to *Pulse*'s survey, around 117 were salaried or locum GPs who said they were actively looking for a new permanent role – either seeking a move or because they are currently out of work.[58] On average, these respondents had been looking for seven months, and had identified 2.5 suitable roles over the past three months.[59] They also reported a decrease in the number of appropriate roles since they had first started looking (Chart 18).[60]

This has had an even greater effect on newly qualified GPs. An RCGP rapid survey from 25 July to 8 August 2024 found around 60% of new GPs had either struggled or failed to find a role Charts 19 and 20).[61, 62]

At the time, RCGP chair Professor Kamila Hawthorne wrote in an op-ed for *Pulse*: 'It's absolutely staggering that there are not enough GP roles available when existing GPs are being pushed to breaking point. It's especially worrying to see stark regional disparities in our findings, with GPs struggling hardest to find roles in areas that have higher levels of deprivation – potentially further entrenching health inequalities.'[63]

While PCNs are now allowed to hire GPs under the ARRS, in mid-December, Professor Hawthorne told the Westminster Health Forum only 300 of the 1,000 roles had been filled.[64]

Chart 19 Newly qualified GPs: What are your plans post qualification?[61]



Funding uncertainty

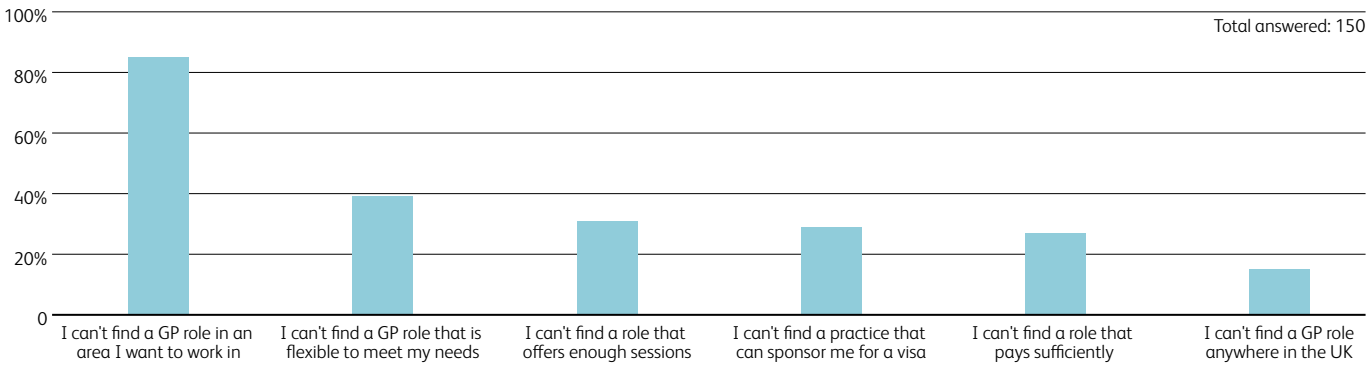
This ARRS extension hasn't yet proved helpful for either practices or jobseekers. For practices, Professor Hawthorne said this low uptake was due to the uncertainty around the funding of the role, with some PCNs only able to guarantee this until March 2025. The level of funding itself is problematic, according to the BMA. It pays towards the bottom of the pay scale, and at £73,114, is only £600 more than GP registrars at the end of their training receive following the resident doctor deal agreed in September 2024.[65]

The jobseeking GPs responding to our surveys are also finding problems. 'A lot of the jobs were only for ARRS GP roles,' says the GP in the North West. The GP in Hampshire adds: 'Some roles are restricted to newly qualified GPs due to ARRS funding restrictions, so experienced locums are in a difficult position.' The ARRS GP funding terms say candidates must have qualified in the previous two years, and not done a substantive role before.

However, the funding is going some way to alleviating practices' recruitment problems. The GP in Salford says: 'We have recently recruited a new salaried GP... who came highly recommended. We didn't need to advertise as there seem to be lots of GPs looking for jobs at the moment. We are using the GP ARRS money to almost fund one session of the new salaried GP's time. Recruitment doesn't seem to be an issue at the moment.'

A Liverpool managing partner says: `If we were looking to recruit further, there are currently lots of GPs in the city seeking employment, so I'm confident we would be able to find one that matched our recruitment needs.'

Chart 20 Newly qualified GPs: Why have you struggled to find an appropriate role?[62]



Not enough funding and not enough space

There is both a shortage of GPs in the system, and a shortage of jobs for GPs, which could be seen as a ludicrous situation. Practice managers say there are two reasons for this, and the ARRS touches on both. First, there is a lack of funding; second, practice premises are often inadequate to accommodate GPs (Chart 21).[66]

In 2019, as part of the five-year contract, the BMA GP Committee and NHS England agreed to set annual increases of around 2% a year. At the time, many saw this as helpful for GPs – and there were even suggestions that other parts of the NHS were envious.[67] Up until 2021/22, GP practices were seeing a real-terms increase in funding. Part of this would have been the money they received for carrying out Covid vaccinations. But 2022/23 saw a real-terms funding decrease (Chart 22).[68]

Since then, we have seen huge inflation and the cost-of-living crisis, yet the funding uplift remained at around 2% a year. This means that there has been a drastic cut in practices' real-terms funding. The Labour Government's first Budget has exacerbated matters with the increase to employers' National Insurance Contributions (NICs), which was intended to raise money for the NHS. GP practices were considered the big losers in this policy; they were not guaranteed public funding from the increase because they were considered 'private sector'[69], yet GP practices do not benefit from tax breaks for smaller businesses because they are considered 'public sector' for this purpose.[70]

Since then, Wes Streeting has announced the increase in funding of £889m a year – roughly 6%. This funding has been welcomed by the profession, although cautiously. One analysis suggested the increase in National Insurance will cost practice £260m.[71] Furthermore, the details of how the funding will be provided to practices – and, crucially, what extra work they will be expected to do – won't become clear until 2025/26 contract negotiations with the BMA's GP Committee England are concluded.

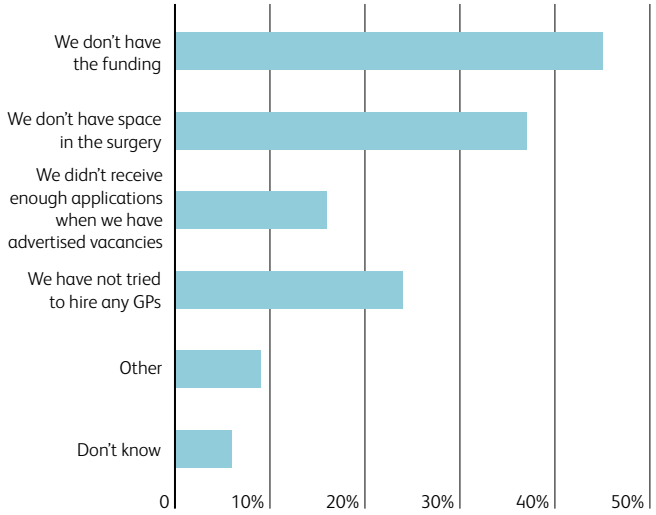
But practices are currently facing a funding squeeze that has the effect of making ARRS staff look more attractive, even if the available roles are not the most appropriate for patient care. These staff are not only paid lower salaries but their costs are at least partly reimbursed by the NHS.

Dr Ian Sweetenham, a GP partner in Cambridgeshire, says: 'We couldn't find GPs two years ago. Now that I have them coming out of my ears, I have no money to employ them.'

The general practice funding shortfall leaves practices facing unwelcome decisions. Around 6% of practices said they have had to make redundancies, while a further 20% said they had to decide not to replace departing staff (Chart 23).[72]

This is affecting care. A GP partner in Leicestershire says: 'As a practice we are always short of appointments, patient demand is tremendous. However, purely for financial reasons and the fact that the practice is struggling to function at a profit, when our three-session salaried GP resigned we made the decision not to replace them. Instead, we decided to try to manage as best as we could without these sessions. This was in spite of the fact that when we advertised to recruit a replacement for another departing GP in the last year, we had more than 20 applicants,

Chart 21 Reasons why practice managers say they cannot hire GPs[66]



Total answered: 387

Chart 22 Real-terms and overall funding[68]

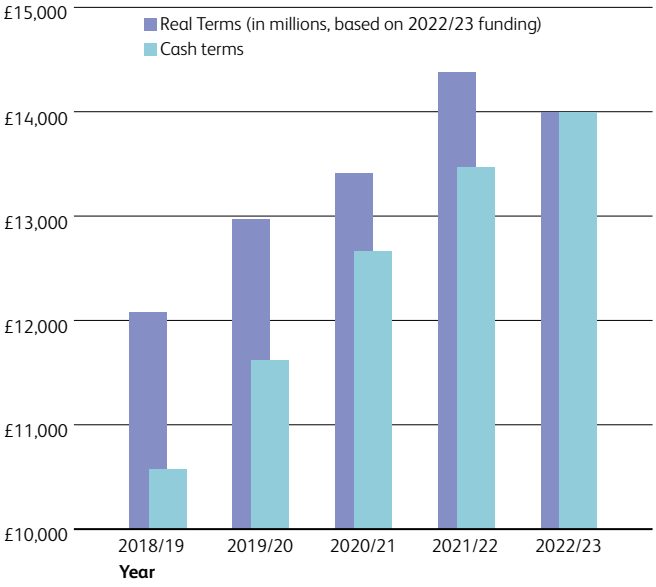
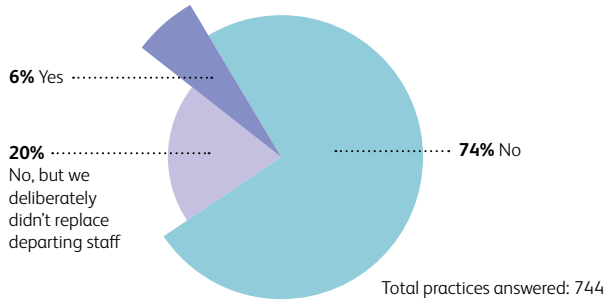


Chart 23 GP partners and practice managers: Have you had to make any redundancies in the past 12 months?[72]



so would have had no difficulty finding a good-quality candidate to fill the sessions had we chosen to.

'In addition to this, we have also chosen not to replace two reception staff members who left – again, in the hope to save money. I reiterate, not for profit, but hoping to break even.'

In this context, cheaper non-GP staff look more attractive. One GP partner in Buckinghamshire said their practice had to 'restructure [to] keep our doors open and allow us to continue to provide a service including not replacing all the clinical sessions a retiring GP used to offer. More GP sessions are being replaced by cheaper clinicians'.

GP pay is often highlighted when practice funding is under scrutiny. In 2022, following such scrutiny, the Government

Case study

We made the nurse associate role redundant and we have not been able to pick up the slack with any other roles. We have had two salaried GPs leave and we now have two partners remaining – we used to be four partners in 2016. We have to offer one of the highest wages in our county to attract staff, which has meant personal losses for two consecutive years for us partners.

Our ratio of staff expense to GMS contract income is 90%, which is very high. With the rising costs, we are unable to offer any pay rises and a 6% rise from the ICB we had been discussing didn't materialise.

The employers' National Insurance rises will mean some more of our staff may end up being made redundant or let go, which is a difficult decision if we want to carry on working as a GP surgery. It seems that instead of helping us attract partners, the Government's decisions are punishing us for helping our patients.

We would ideally want to have two more full-time GPs, ideally partners, and one to two more nurses and a pharmacist. However, we are actually squeezed and worse than we were in 2016 in terms of numbers, equivalents and what we can offer.

GP partner in the West Midlands

amended the GP contract so that partners earning more than £150,000 would be forced to declare their earnings.[73] But simply reducing earnings would not enable them to hire more GPs. The GP partner from Warwickshire says: 'I earn good money as a part-time partner, and there's an argument that my partners and I could earn less and there would be money for another GP.

'However, it isn't as simple as that. We're being offered two days of an advanced care practitioner anyway by the PCN, and it seems silly not to use this. One of our nurses has just completed her ACP training, so we'll have her for another two-and-a-half days. I'd rather have another GP, but we're reluctant to have both. We're unsure what Wes Streeting plans for general practice, and we don't want to commit to another GP unless we know our funding will continue at the same level.'

Lack of premises space

Even if practices did have money, the state of GP premises often means there is nowhere for additional staff to practise. GP premises are in dire need of modernising – a major 2023 RCGP report found they were 'inadequate', concluding that the allied healthcare professional staff had 'expanded greatly in recent years, without a parallel expansion of clinical space for them to work in'.[74] While the Budget in November 2024 did commit £100m to modernising GP premises, it specified that this would be limited to 200 surgeries.[75]

One GP in Northamptonshire says: 'We do not have any more space in our building to recruit additional clinical or administrative staff, and this has led to us running at a far higher number of patients per FTE staff that we would ideally have. In our recent round of recruitment to salaried GP roles, we had many more suitable candidates that we have the space to employ and undertook competitive interviews to select our current employees including ARRS-subsidised recently qualified GP roles.

'We really need to find an additional or alternative site but options for funding this are limited or unattractive. We already undertake remote working where it is possible to do so safely, and most of our ARRS staff are based in other GP surgery buildings within our PCN. Some clinical rooms are even shared between clinical staff within a session, with a staff member using a room while another has left to undertake a care home round.'

This is a common problem. Dr Grant Ingrams, chief executive of Leicester, Leicestershire and Rutland LMC, says his practice 'has GPs working from home at times but there are continued problems finding space for people to work from'. Another GP in West London says they 'could certainly do with additional nurses but are already struggling with space for existing staff, who are having to cope with hot-desking'. A GP partner in Lancashire says: 'In 2023, we changed some storerooms into additional clinical rooms and we still don't have enough space. We have no expansion land as the NHS sold it off years ago. We have nowhere else to go to get more rooms. This impacts who we can hire and what days they can work, as we find clinicians have to room-share or change rooms daily depending on who is in.'

This lack of space also has an effect on training, which we will consider later in this report.

Case study

I am literally in the process of converting a toilet and cupboard into a telephone consultation room, which isn't ideal but needs must. Anywhere non-clinical on the ground floor is turning into clinical space. We've had to make a waiting room smaller to create another clinical room and are being creative in the way rooms are shared. Meanwhile, my non-clinical team is being shoehorned into smaller spaces upstairs with many more per office than they were designed for.

The ARRS staff are great but for our PCN we have to house them in our building as the other practices are smaller and just don't have the regular space for them. Not only do they need desk space, they need access to clinical space to see patients.

We are able to get small premises grants from the ICB but these are particular about which hoops we need to jump through to get them and rather specific on what we can use them for. I've done the floors, taps, refurbished nurses rooms, etc. Expanding the premises by an extension with additional rooms is what we actually need but capital funding is not there and as partners we don't have the capital or wish to increase our practice debt to do this even if it was available, as it's not affordable by the business to do so.

We used to be able to let other agencies use our rooms, for instance health visitors or Citizens Advice counsellors and even local small private services beneficial to our patients, such as foot care and podiatry – but we now need all the space for our own staff so those links between agencies on the ground have been lost.

We have space we could utilise which is taken up by having to hold paper notes. Yes, we could pay to digitise them, and then we would still need to pay to store the paper records offsite. I could fit two treatment rooms for the nursing team in the space these currently occupy. But it's a cost I can't add to the practice finances.

Alex Kimber is a managing partner in Dorset

The seismic effect on practice nursing and pharmacy

It's not just GPs who have seen their roles within practices changing. There is little doubt that morale in practice nursing is low. The *Nursing in Practice* (*NIP*) September survey revealed half of practice nurses were considering leaving the profession in the next 12 months[76], and in an interview with *NIP*, the new professional lead for primary care at the Royal College of Nursing (RCN) Kim Ball said the profession was in a 'precarious' position.[77] There are several factors behind this and, as with GPs, some of the issues predate the ARRS.

But it is apparent that the ARRS has compounded this low morale. More than half of respondents to *NIP*'s September survey said their work is more solitary than two years ago (Chart 24)[78], and this is on the whole due to new staff taking over nurses' work and nursing teams being shrunk. Around a third say their job has changed for the worse since the ARRS was introduced in 2019 (Chart 25)[79]. Most feel they are poorly recompensed and – while this is not completely linked to the ARRS – comparisons with the new staff (especially those whose pay is linked to Agenda for Change) are exacerbating their displeasure. Furthermore, there is a growing feeling among practice nurses that they are being replaced, and that is closely linked to the ARRS.

In her *NIP* interview, Ms Ball said the practice nurse role 'can be very isolating'. She added: 'I think there's been a lot of change in general practice in terms of having more of a multidisciplinary team and nurses feel that they're being excluded from discussions about service provision.'

One nurse, who has been practising for four decades, agrees that the job is more solitary now. 'There used to be time for nurses to meet up in peer groups. Now, often, there may only be one nurse in a practice along with ARRS staff. The nurse might be doing mostly cytology and baby immunisations. Long-term conditions will be delegated to the physician associate or nursing associate, who will not have the clinical knowledge that I do.

'Without practice nurses, general practice will lose its heart.

Chart 24 Nurses: How has your team working changed in the past two years?[78]

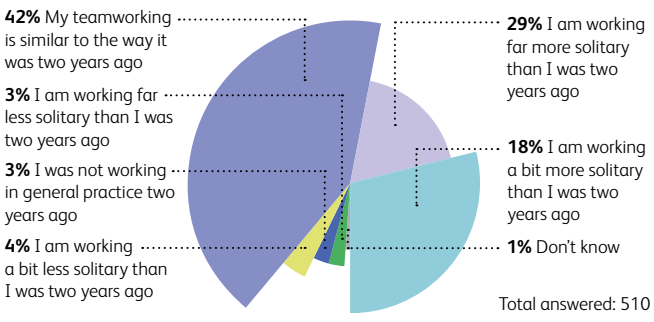
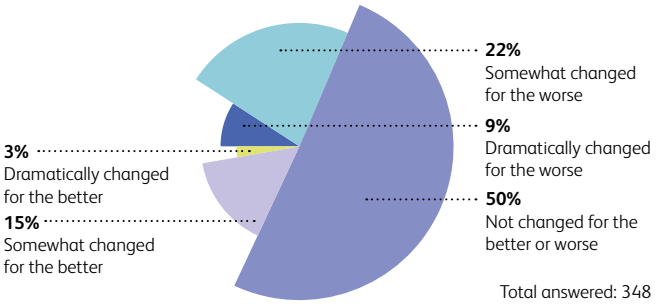


Chart 25 Nurses: How much has your role changed since the additional roles reimbursement scheme was introduced in 2019?[79]



When I read that GPs will have to do all these new immunisations or checks, I know the truth – it will be the nurses who do them.'

Pay has been a huge issue for practice nurses. *NIP*'s September survey found that half of practice nurses received no pay rise in 2024.[80] The RCN cited NIP's findings in its evidence to the independent pay review body for GPs, calling for an investigation into why practice nurses are not getting pay rises. The college also issued a joint statement alongside the BMA in December 2024[81] urging practices to give nurses the 6% pay rise recommended by the Government.

The RCN said nurse practice pay was lagging behind that of hospital nurses. Its pay review body submission said 'large numbers of staff now find themselves further away from the pay, terms and conditions of their peers who are directly employed in the NHS'.

One nurse team lead in Dorset says that even if hospital nurses wanted to come to general practice, they would be put off by the pay. 'Morale in general practice is very low. There are limited numbers of nurses able to afford to come out of hospital even though they would like to, as our practice cannot afford anywhere near the level of pay in secondary care.

'Some of the very large, multiple-site practices seem to be able to afford a higher wage, although I understand from colleagues that working in them carries its own difficulties.

'Due to the funding not having been available for practice nurses via ARRS, there is little possibility for our career progression. Even if we are allowed time towards additional training, there is no money to then financially reward the additional qualifications and responsibilities or to pay for extra hours to offer more consultations to patients.'

Concern that practice nurses are being replaced is widespread. A nurse team lead in Herts and West Essex puts it bluntly: 'GP nurses will soon be replaced with nursing associates, physician associates and advanced nurse practitioners.' She says practice

nurse roles will be 'reviewing long-term conditions, which can be repetitive and sometimes boring. Our years of experience and knowledge will be lost. There should be a way to encompass this. Not everyone wants to do further training.'

This will all have an effect on patient care, nurses say. A practice nurse in Manchester says: 'Many peers have expressed concerns about the erosion of the GP nurse role with a move to less holistic care and a desire to 'get through the numbers' by using shorter appointments with staff who give brief advice rather than personalised care. They are often inexperienced in primary care and have a broad overview of conditions but lack additional training in chronic disease areas.'

A November 2024 study from London South Bank University supported these findings.[82] It concluded: 'There was positive impact on workloads from ARRS roles working in original scope, for example pharmacists' medicine reviews. However, any benefit was offset by the increased workloads created by those new to general practice and/or working outside of traditional scope.

'This ranged from a lack of resources to provide the support those new to primary care require to practise safely, the expectations of others that [practice nurses] will fill the gap in support and teaching to directly safety netting the work of others. There was a lack of consultation regarding a major workforce change, leading to feelings of devaluation. There are some significant equity issues highlighted particularly around pay and opportunity.'

Pharmacists

For pharmacists who have come in to general practice, morale seems higher. Around 70% of practice pharmacists see themselves still being in general practice in five years' time (see chapter entitled 'What is being done to retain experienced staff?'). On the whole, practice managers and GP partners responding to the *Management in Practice* and *Pulse* surveys have found pharmacists useful.

But there is debate around whether their introduction to general practice has had a destabilising effect on community pharmacy. One thing is certain – a significant number of pharmacists who are now in practice originally worked in the community. The House of Commons Health and Social Care Committee's report on pharmacy concluded there should be a review of the ARRS to explore flexibility on the funding criteria that could 'reduce the drain of community pharmacists into primary care networks'.[83]

Of the 137 practice pharmacists surveyed by *The Pharmacist*, only 9% had never worked in community pharmacy, with 76% transferring to general practice completely and 17% working across both sectors.

The Pharmacist survey found that 58% of the 101 practice pharmacists who had left community pharmacy said they made the move because they preferred the work in general practice, while 42% said they wanted to develop their prescribing skills. From summer 2025, all newly qualified pharmacists will need to be able to prescribe (see chapter entitled 'How the NHS intends to boost training in general practice').

Utilising skills was a major factor for those who made the move. Mayoor Kerai, a practice pharmacist in Kent says: 'I had completed independent prescribing training in community pharmacy and I wanted to use this skill. I had also reached a glass ceiling in community pharmacy and was unable to progress any further. I chose the practice role to allow for this personal development along with better salary and work/life balance.'

Another practice pharmacist in Swindon says: 'I worked in community pharmacy for many years and I really loved interacting with people. That's something I knew I would miss when I left community pharmacy. But although I was learning new things from time to time, I didn't feel I was learning enough. I wanted to have a more clinical role and I wanted to learn more in that area. Although there were new services being offered by community pharmacists, I did not feel we had enough support to deliver them.'

There are also those who say there were issues with workload in community pharmacy. One practice pharmacist in Staffordshire says they left due to 'pressures in community, underfunded pharmacy contract resulting in fewer staff, with more stress

Case study

Not including all nursing staff in the ARRS has diminished the nurse title in general practice. It is fantastic that nursing associates can be funded under ARRS, but it is a shame practices feel this is a nurse substitute and do not appreciate the need for a registered nurse to support the associate. Some practices only have a nurse associate with no nurse.

In terms of CPD, while ARRS roles get funded support, we have to fight for this every year. There are clinical leads and supervision for the ARRS roles but whether nurses receive this depends on their practice/PCN.

I have been trying to get a GP nurse trainee for two years across two practices but have been getting pushback on renumeration of the nurse and lack of space.

This has led to poor QOF performance on immunisation and smears, and having to use locum nurses to improve scores. But this puts immense pressure on me as a nurse.

Being the only nurse for two practices of 10,000 and 5,000 patients is difficult as liability for all things nursing relies on you – immunisations, infection control, smears, diabetic physical checks, stock, fridge responsibility. It is difficult as a practice to provide continuity for things like complex wound dressings, high-risk blood pressure reviews and immunisations, as there are limited appointments.

As an ANP I am regularly asked to do practice nursing and ANP tasks in a single appointment. My skills could be better used if there were ANP sole appointments and more nursing staff to take on practice nurse responsibility.

Asha Parmar is an advanced nurse practitioner in North Central London

and more services alongside a prescription factory system that didn't make best use of clinical skills'. Another based in southeast London says: 'I work fewer hours and don't have to stress for being late and finding a queue of angry patients or even angry staff on occasions. I have the flexibility of managing my own break times without feeling like being micromanaged. And of course not having to stand on my feet the whole day was the icing on the cake!'

There is also little dispute that community pharmacy is facing workforce problems. A Community Pharmacy England (CPE) survey representing 6,100 pharmacy premises in 2024 found that 58% of pharmacy owners said they were short of pharmacists, while almost two-thirds (62%) of pharmacy team members reported a reduced ability to offer services or advice to patients because of staffing shortages.[84]

But there is some dispute over whether this is a direct result of the ARRS. CPE said the scheme had 'led to the recruitment of over 5,000 pharmacists, primarily from community pharmacy, into GP surgeries and PCNs', resulting in 'shortages, temporary closures and rising costs'.

But President of the Primary Care Pharmacy Association Dr Graham Stretch says there should still be enough pharmacists to support both sectors. He told the select committee in November 2023: 'The actual numbers are very interesting. ARRS supports 4,689 pharmacists, of which, in July 2019 to September 2023, 3,047 have come from the community sector. That is a significant number and I am not pretending otherwise. In the same period, the General Pharmaceutical Council's register has grown by 7,308, more than double the number of pharmacists moving from community into PCN.' However, Dr Stretch did acknowledge that 'that oversimplifies things, because we have portfolio roles'.[85]

A qualitative study of the effect of ARRS found there were 'unintended consequences at system-wide levels, including large numbers of staff moving from other services to work in the scheme, which left some services depleted of their workforce'.[86]

Dr Zoe Anchors, a researcher at the University of the West of England and one of the authors of the study, says: 'The three things that were coming up in terms of concerns around the destabilising of NHS services were: pharmacists being taken from hospitals and community pharmacy; paramedics moving from emergency care services; and the impact on wider mental health service providers of including them in the ARRS. All of these were impacting NHS services. Some people said we are "robbing Peter to pay Paul".'

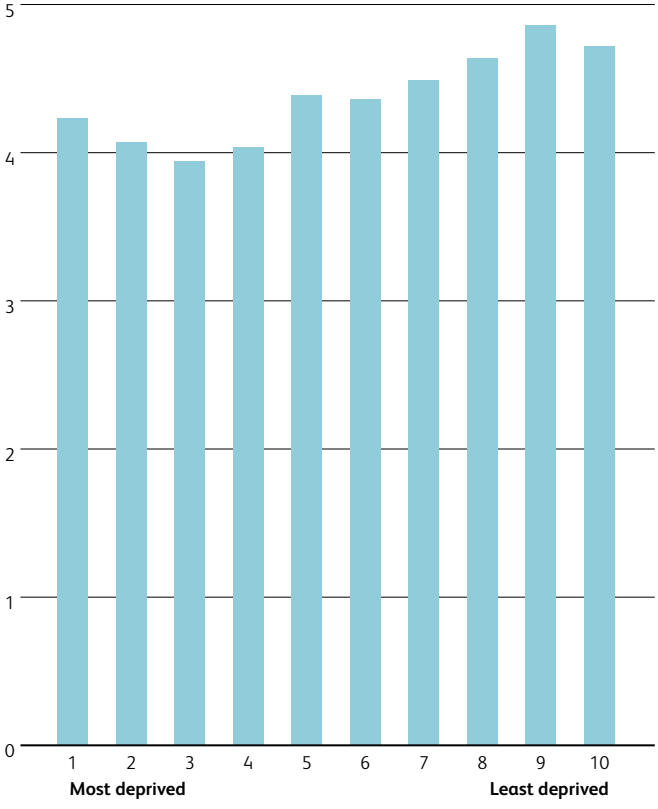
The practice characteristics shaping the skills mix

These issues around recruitment and unemployment are not uniform across the country. The local changes faced in an area – whether that be GPs out of work or problems with recruitment across professions – depend on a number of factors, such as geography (see map, page 24[87]), deprivation and funding levels. An analysis of data on every GP practice in England, using Cogora's 'Data Dashboard' tool, highlights these differences.

A striking finding is that practices in more affluent areas have a higher number of GPs and clinical staff per patient than those in the most deprived areas (Charts 26, 28). [88,89] Linked to this are vast differentials in staff based on ethnic population (Charts 31,32).[90,91]

Being located in a deprived area brings up a number of challenges for practices. The first is the health needs of the patient population. Even without including issues around access to healthcare, it is 'well established that deprivation... is associated with poorer health, including mental health'[92] and patients in deprived areas are more likely to develop 'serious mental illness, obesity, diabetes and learning disabilities'. Patients in the most deprived areas face the onset of multimorbidity 10-15 years earlier than those in the most affluent areas.[93]

Chart 26 GPs per 10,000 patients based on deprivation[88]



Case study

Surgeries in deprived areas like South Ilford, in east London, face critical and unique challenges, exacerbated by being in the lowest quartile of NHS-funded practices. These challenges include persistent workforce pressures, difficulty recruiting skilled professionals, and high staff turnover. Such systemic issues threaten the sustainability of care delivery and amplify health inequalities.

In Redbridge, where the doctor-to-patient ratio is approximately one GP per 2,700 patients – far higher than the national average of one per 1,900 – recruitment is a significant hurdle. The demanding workload, combined with the multifaceted health and social care needs of the population, makes these roles less appealing. We are a partner-heavy practice that relies on the goodwill and altruism of our partners to survive. There is a significant risk of burnout among the partners and our senior leadership team.

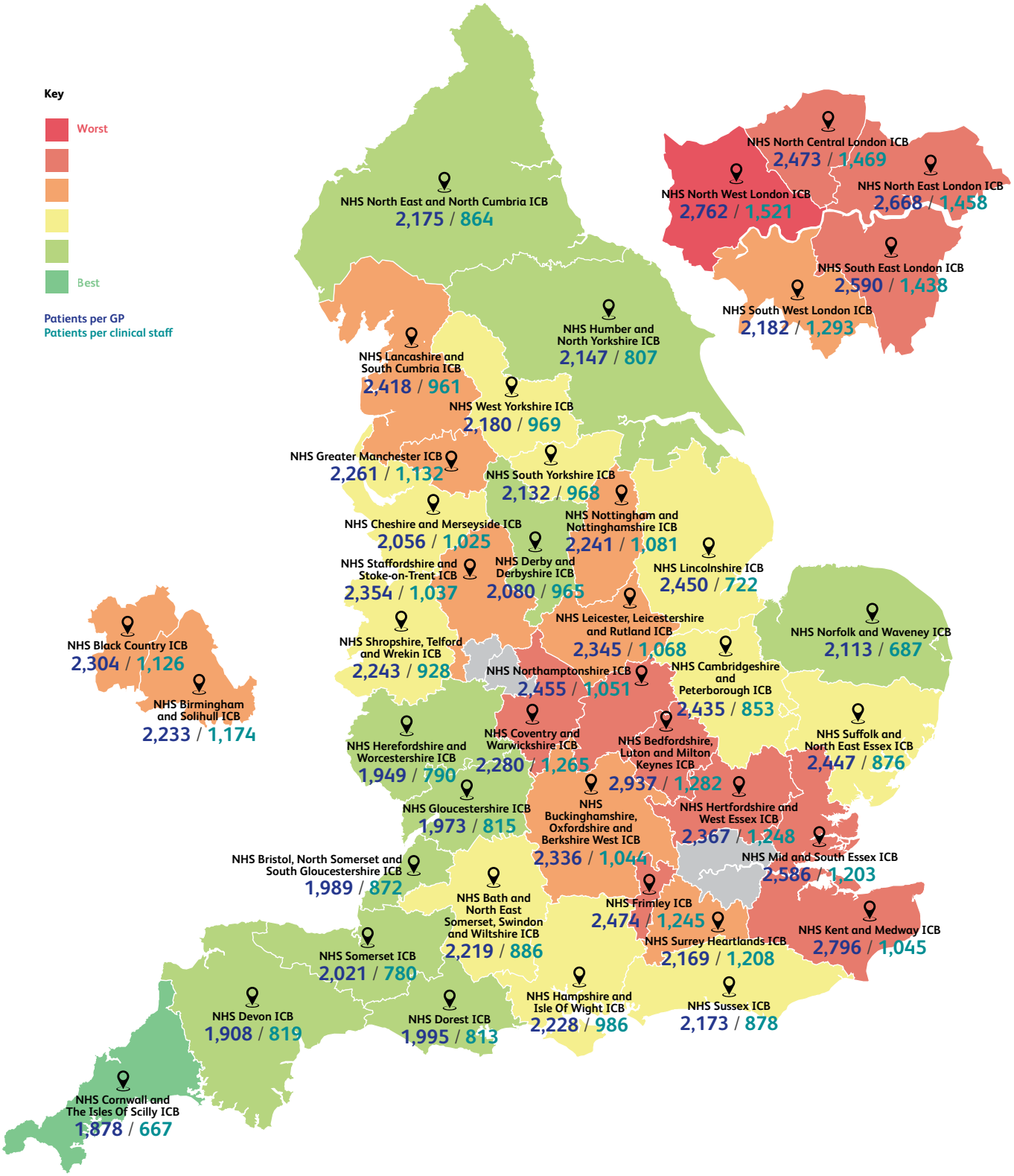
Similarly, nurse-to-patient ratios are well below national benchmarks, further straining resources. These staff shortages particularly impact deprived populations like those we serve, where patients often have complex medical conditions influenced by socioeconomic factors.

Retention is equally problematic, staff turnover is significant. Staff report high levels of stress and dissatisfaction due to the mismatch between patient demand and available resources. Limited funding restricts the ability to offer competitive salaries, invest in support systems or provide professional development, compounding these challenges. This underfunding creates a cycle of workforce instability, leaving remaining staff overwhelmed and communities underserved. The result is a deepening of health inequalities in already vulnerable populations. Add the burden of employer NI rises (our practice will be paying just under £40k according to the BMA calculator) and this becomes an existential threat.

Systemic change is urgently needed to address these challenges. Practices require equitable funding at the very least and a further £40 uplift to the capitation baseline as GPC England has asked for. Without decisive action, the workforce crisis will continue to undermine the provision of high-quality care, especially in deprived areas like Redbridge. Prioritising these interventions is essential for equitable and sustainable healthcare across the NHS.

GP partner in Redbridge

Map 27 Number of patients per GP and clinical staff at ICB level[87]



Practices in deprived areas attest to the problems around health needs (which are exacerbated by a lack of support services). The practice manager in Blackpool says: 'A large portion of our patient list has chronic diseases due to smoking, obesity, drug and alcohol abuse, etc. I believe Blackpool has the highest drug-related death toll in England. It is particularly difficult to manage these patients when they have poor living conditions, little money and no motivation to change their ways to improve their health. Our GPs, pharmacists, nurses and other staff all provide patient education to these patients, but we would ideally like to have more time with them. More GPs, nurses and pharmacists would mean we can bring them in more frequently and give them education on their illness and how to manage it.'

A GP in a deprived area of Hampshire says: 'We are by far the most deprived practice in our area, with a very young population, poor mental health and long-term conditions from a young age.'

This is where another problem for deprived practices comes in. The same GP adds: 'The town in general is relatively wealthy, but we cover three large estates of social housing. Our demographics have a significant part to play in our lower funding, which results in a low weighted list and thus lower remuneration.'

Because despite these extra health needs, deprived practices do not necessarily get paid more – and, in many cases, their deprivation leads to lower funding. The Carr-Hill formula was introduced in 2004 to calculate how much practices would receive per patient in the form of the 'global sum' – this forms the bulk of a practice's income. The formula is based on patient age and

Chart 29 GPs per 10,000 patients based on weighted funding[98]

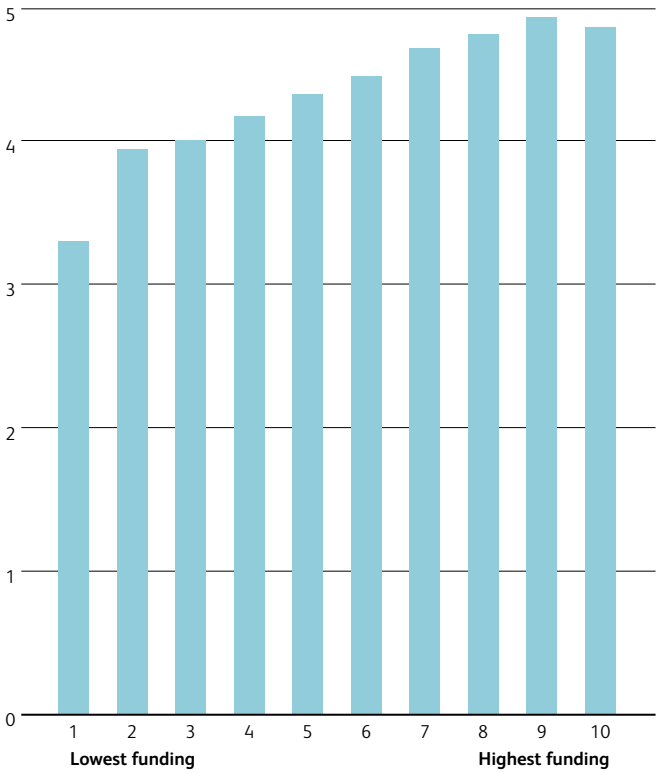


Chart 28 Clinical staff per 10,000 patients based on deprivation levels[89]

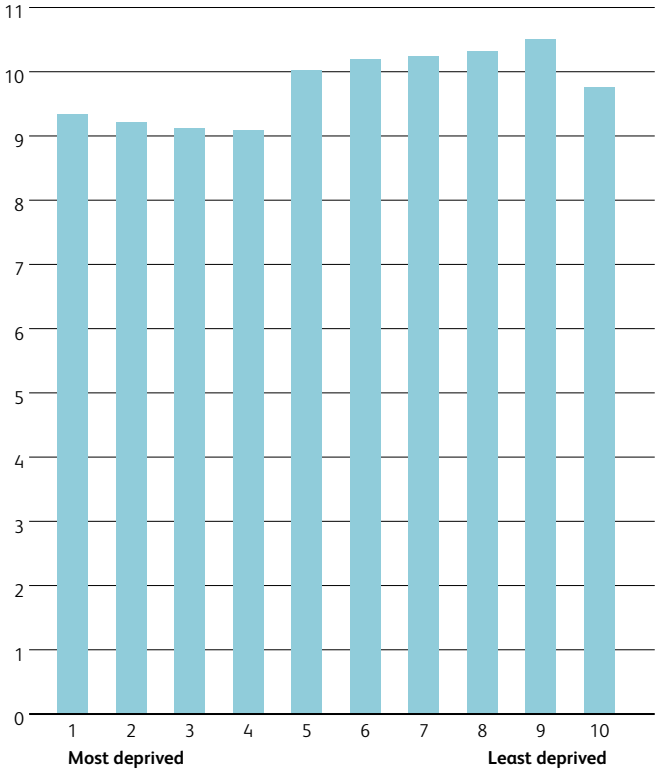


Chart 30 Clinical staff per 10,000 patients based on weighted funding[99]

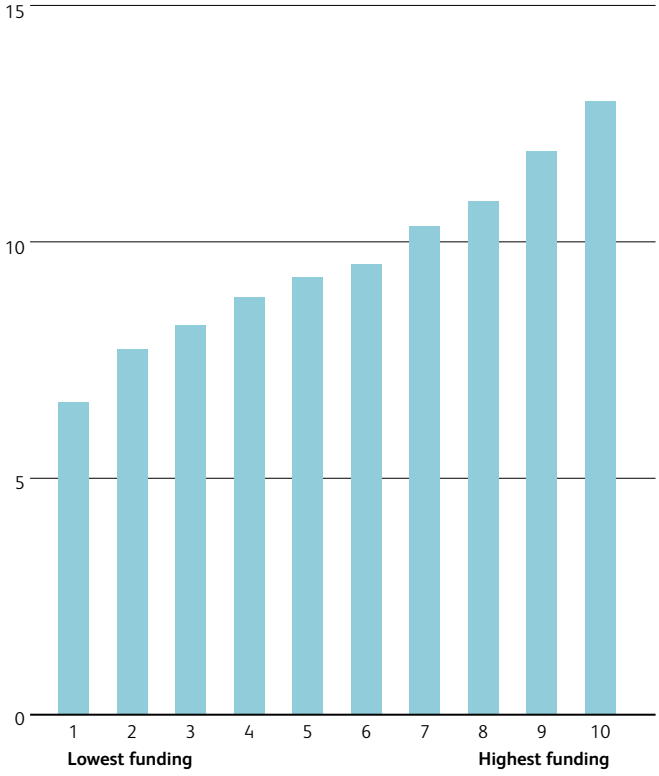


Chart 31 GPs per 10,000 patients based on ethnicity[90]

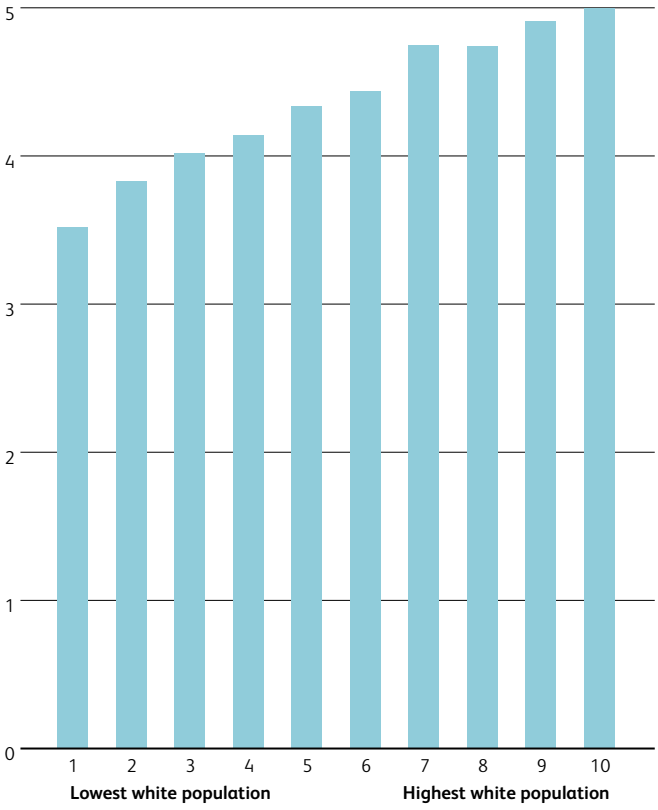
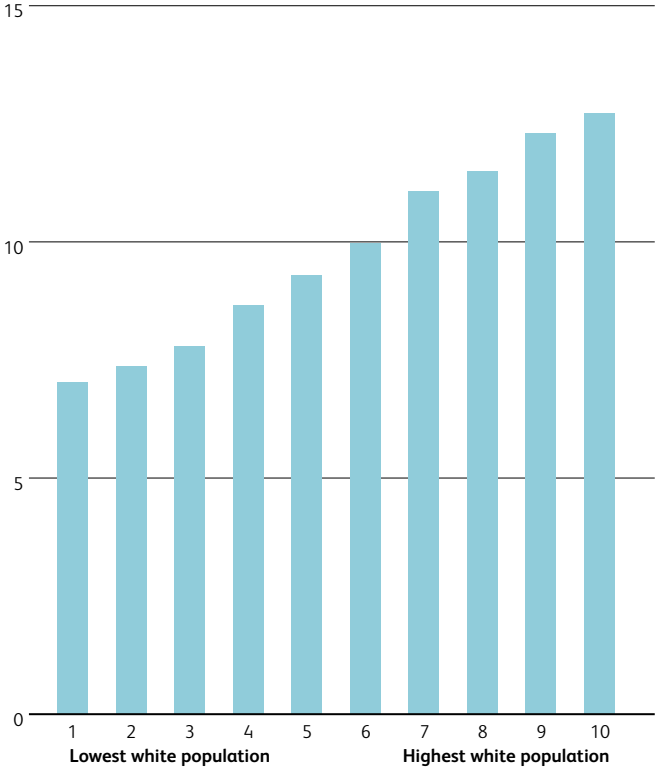


Chart 32 Clinical staff per 10,000 patients based on ethnicity[91]



sex, list turnover, rurality and 'staff market forces factor', which is based on geographical variations in staff costs.[94] Deprivation is not an explicit factor. There is another element – 'additional needs of patients' – which looks at mortality and illness before the age of 65 and does, to an extent, benefit deprived practices. But these additional needs are based on data from before 2000. As deprived practices tend to have younger populations, they often end up with lower-than-average global sums.

On top of this, practices receive income for extra services, such as via the QOF, which rewards performance against national clinical benchmarks, and enhanced services, which can be locally or nationally mandated. But the targets are harder to meet for practices in deprived areas. For example, one of the main sources of income is vaccination, which brings in money from the QOF and enhanced services. For childhood vaccinations,there are step increases for the final patients within the cohort they vaccinate. But for these practices, that is far harder to achieve. Their populations are more transient, more likely to have received their vaccinations overseas and more likely mistrust vaccination, especially minority ethnic families.[95]

An analysis of the Cogora Data Dashboard shows that practices with the top 20% most affluent patient populations receive £137.17 per patient (not including premises costs) compared with £135.93 for the 20% most deprived patient populations.[96] This has been a problem highlighted constantly in the 20 years since the pivotal 2004 GP contract was introduced, most recently by the Nuffield Trust.[97]

As well as specific health needs, and often lower income, deprived practices face another recruitment problem – they need to pay more to attract staff. One GP in Leicester says: 'I think it has been forgotten that the inner city is a completely different world to the suburbs. Certainly in our region, inner-city practices often have to offer higher salaries to attract staff like practice nurses, pharmacists and GPs. Hence there is less funding for other aspects and these higher-funded staff may in some cases be less committed to long-term improvements of inner-city practices.'

Recruitment problems bring other costs. The Hampshire GP says: 'We have struggled to replace a retiring partner but after over a year of advertising, finally recruited a partner. The lack of response to the usual adverts (before the current GP unemployment crisis) led to us needing to use agencies, resulting in high fees. We interviewed good candidates, who became salaried GPs rather than partners, but each appointment cost thousands of pounds, including locum fees. Some applicants specifically stated they wanted a more wealthy clientele.'

There is an even stronger correlation between a practice's funding per patient and its staffing levels, with those who receive the least funding having far lower levels of staffing (Charts 29, 30).[98,99] This is more explainable than the correlation between deprivation and staffing; the Carr-Hill formula is supposed to provide more funding for practices with greater demand, so in theory lower funded practices should have less need for staff.

But challenges not fully accounted for by the funding formula – including deprivation – cause particular problems with recruitment.

Case study

We are having to constantly balance staff morale and wellbeing with patient care and demand. This is more difficult when financially stretched. Our actual list is over 19,000 and weighted list is 16,000. We have unrecognised deprivation and are one of the highest practices for child protection. We have large numbers of patients with special needs, mental health issues and risky behaviours. There is unseen poverty, which is unrecognised.

In terms of staff, pharmacists get paid better elsewhere and don't want to accept the pay being offered by PCNs. There are locum agencies offering GPs for the PCN at £8,000 per session, but with holiday and CPD it is effectively £12,000. They may not enjoy working across three practices and essentially work as a locum so would be less helpful.

Our salaried GPs would like the 6% increase so we are trying to offer this while current practice finances stop us hiring new GPs, which can in the long run mean more spending on locums. Partners do the extended hours and evening duty. We only have six partners – one plans to retire in the next couple of years and three of us are now in our late 50s.

GP partner at practice in bottom 10% of income per patient

One GP partner, whose practice is in the bottom 20% when it comes to practice funding per patient, says: 'We used to use a remote pharmacist to support the practice when one of us was on leave (we have never 100% backfilled GP sessions as it has never been affordable).

'We now no longer do this, so when a colleague is on holiday, in addition to busier days, I have to do two hours or more in the evenings for repeat prescriptions. We took this decision after our profit share was down approximately £20,000 per partner from March 2022 to March 2023 (in hindsight, 2021-22 was artificially bolstered by Covid jabs).'

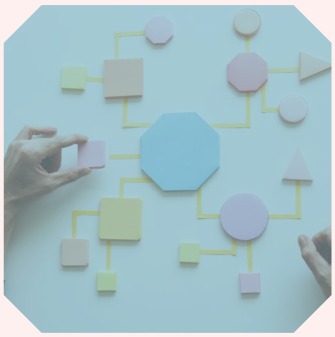
Another GP partner whose practice is in the 20% of lowest-funded practices, and is in a deprived area, says: 'We have a young, deprived population – highish workload but not reflected in the weighting system (fewer elderly than average, no nursing homes, and our homeless people's project is unfunded).'

The partner's situation highlights the differences across the country. 'Despite the talk of GPs being out of work, we recently had two days when we needed a locum at short notice and had difficulty finding one. We have just advertised an ARRS GP job with maximum flexibility, mentoring and scope for special interests, but the only two applicants were two recent ex-registrars from practices in our PCN.'

It is clear there are issues around workforce, with variations across the country, staff demoralised and out of work, and a number of issues with the ARRS scheme. So what is being done about it?

PART TWO

What plans are being put in place?



How the NHS intends to boost training in general practice

Training has understandably been seen as the priority when it comes to solving long-term workforce problems in general practice. In the context of this report, we have a specific definition of training.

Every healthcare professional continues 'training' until the day they retire. Fully qualified GPs, nurses and pharmacists need to demonstrate their continuing professional development for revalidation. There is also the potential for some healthcare professionals to upskill, by taking on prescribing responsibilities or advanced practitioner status, for example, or preceptorship courses, which smooth the way for fully qualified staff to enter general practice, or return from career breaks. All staff do their development training in conjunction with their routine work as part of the general practice team.

However, for the purposes of this report the term 'training' applies to professionals who are not yet fully qualified to practise without the necessary supervision within the team.

Currently, the only healthcare professionals for whom there is a requirement – or a national programme – to spend time training in general practice in order to qualify are GPs themselves (medical students effectively need to do rotations in general practice too). Other professionals are able to do training rotations within general practice but this is not essential for them to fully qualify, even for a career within general practice.

Practices have different financial incentives to train distinct groups of staff. This could be GPs – for whom rotations in general practice are compulsory – or other healthcare staff (including medical students), for whom general practice rotations are not compulsory. These incentives differ based on the staffing group and, in many cases, have been distorted by the ARRS. The picture is ever-changing – the incentives are constantly changing, and there may also soon be changes to the regulations. This is likely to have significant effects on the future general practice workforce.

We will look at the situation regarding the training needs for each healthcare profession, and in the next chapter we will look at the issue of the capacity within general practice to train all these staff.

Medic training

By far the biggest group of trainees in general practice is doctors. Most stakeholders agree that an increased number of trainees in general practice is essential to the future of the profession. These trainees include Foundation Year (FY) doctors and GP registrars.

The Foundation Year programme usually covers the two years following medical school, where graduates rotate around various clinical settings before starting specialty training. They are not required to do rotations within general practice, but more than half do.

GP speciality training normally takes three years, and GP registrars spend a minimum of one year in general practice – but ideally 18 months, and ideally the final 12 months in general practice.[100]

This could change. The NHS workforce report set goals to increase GP specialty training places from 4,000 to 6,000 by 2031, ensure all FY doctors do a rotation in general practice, and require GP registrars to spend the full three years in general practice.

These build on the success of Health Education England – since incorporated into NHS England – in increasing GP training places (Chart 33).[101]

There may be even more demand in terms of GP training. Wes Streeting's plans to revise the NHS workforce report will have 'a laser focus on shifting care from hospitals and into the community'. According to the announcement from the Department of Health and Social Care: 'The original workforce plan would increase hospital consultants by 49%, but the equivalent rise in fully qualified GPs would have been just 4% between 2021 to 2022 and 2036 to 2037.'[102]

Chart 33 Number of trainees entering general practice[101]

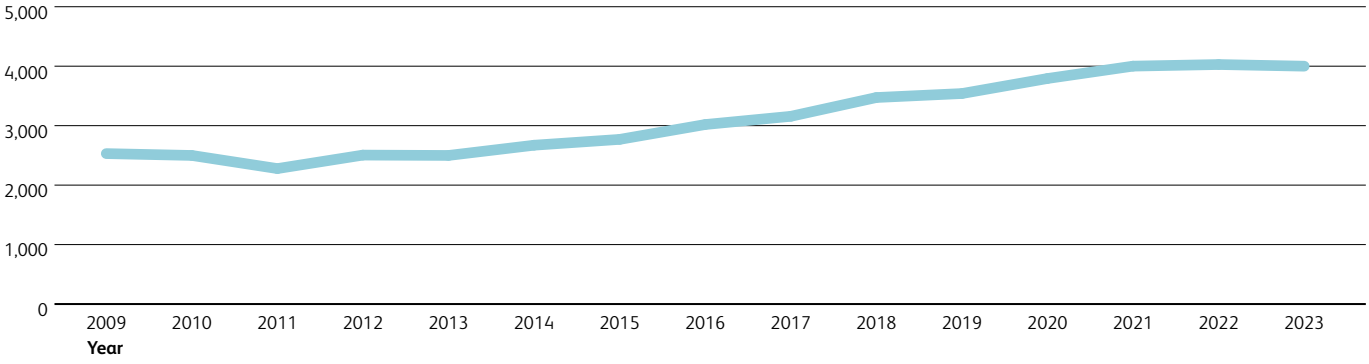


Table 1 The demand for training in primary care

Staffing group	Numbers in general practice, Oct 2024	Current and future demand
Medical students	Not known	There is no regulatory requirement for medical schools to do a placement in general practice, but general practice rotations are a part of every medical school course and it is unlikely a course would be approved with no general practice rotation. The median number of sessions that medical students spend in general practice throughout their degree was 108 in 2020[103], but is likely to be more now (see main copy). The NHS workforce report planned to double the number of medical school places. Newer medical schools are being encouraged to promote general practice, including more placements.
Foundation Year (FY) doctors	10,237[106] – including FY and GP registrars	No requirement for foundation year doctors to spend any time in general practice, but around 55% of FY doctors do a rotation in general practice.[107] The workforce report planned for all FY trainees to do a rotation in general practice. There are currently 7,940 trainers in England.[108]
GP registrars	As FY	For GP registrars, minimum requirement involves at least one year spent in general practice – but ideally 18 months and ideally the final 12 months spent in general practice.[109] The workforce report planned to double the number of GP speciality places, and for all GP registrars to spend the whole three years in general practice.
Nurse trainees	225[110]	There is a minimum requirement to spend two weeks in a community setting, but not necessarily general practice. They are employed on an ad hoc, local basis in general practice. As of 30 September 2024, there were 1,346 nurses with a general practice specialist practice qualification on the Nursing and Midwifery Council register.[111] This enables them to train but does not necessarily mean they are training. Around 40% of the 499 respondents to the *Nursing in Practice* September survey said they were a trainer.[112] There are no plans to increase nurses' exposure to general practice.
Pharmacist trainees	c.700	There are no requirements for pharmacists to train in general practice pre-registration. From 2025, prescribing skills will be mandatory for qualification, which are more easily learned in practice than in community pharmacy. There were 4,452 placements for 3,041 trainee pharmacists for July 2025. Of these placements, around 1,900 had a component in general practice.[113]
Nursing associate trainees	658[114]	There is a requirement to spend two years in clinical practice, which could include general practice. They can be trained by practices, and can be either supernumerary or part of the workforce, but with protected time for learning. There needs to be a named supervisor nurse or nursing associate.[115]
Physician associate (PA), physiotherapist, paramedic trainees	245[117] (includes all other trainees)	There is no requirement for any group to do compulsory training within general practice in order to fully qualify. The NHS workforce report aimed to increase the number of PAs in the NHS to 10,000 by 2036. There are currently around 2,000 in primary care. PA training is two years, and requires 1,600 hours of clinical training, including 350 hours in general hospital medicine and 90 hours in other settings including mental health, surgery and paediatric.[118] There are currently no requirements for physiotherapists to do any pre-qualification training in general practice, but there is likely to be more training as more care is delivered in general practice, the Chartered Society of Physiotherapy says. The Health and Care Professions Council considers it 'best practice' for paramedic training to include 'non-ambulance-based practice learning', but this is not a requirement.[119]

	Funding
	Practices receive £34,355 per student per year (although students don't spend a whole year in the same practice).[104] This translates to around £190 per day.[105]
	Trainees' salaries are covered by NHS England and are supernumerary. Per year and per trainee, practices receive £10,381 trainer grant, £750 CPD allowance and £250 educational supervision (pro rata).
	As FY
	The clinical tariff, which covers trainee nurses, is £5,519 per year. This works out at £30 per day.
	Practices and PCNs are now given training grants worth £26,500 per year to employ a trainee pharmacist.
	PCNs can employ nursing associates or trainee nursing associates under the ARRS. General practice receives £4,000 per year in addition for employing a trainee nurse associate, and £7,900 a year if they spent more than 50% of their time with patients with autism or a learning disability.[116]
	The clinical tariff, which covers paramedic and physiotherapist trainees, is £5,519 per year. This works out at £30 per day. There is no set tariff for training PAs. But practices in Manchester, for example, will receive £555 a week for their training.[120]

General practice also takes on medical students. There is no legislation stating that medical school courses need a rotation within general practice, but it is unlikely they would get approved by the GMC without it. A 2020 study suggested medical students spent a median average of 108 sessions in a general practice setting.[121] One of the study's authors, Professor Hugh Alberti, Professor of general practice education at Newcastle University, says this figure will 'no doubt' be higher now: 'Many traditional schools, like Newcastle, have increased our GP time since then and all the new schools have higher proportions.' Only 13% and 14% of Oxford and Cambridge graduates respectively go into general practice, compared with 34% and 32% of graduates from University of London (excluding UCL, King's and Imperial) and Leicester, respectively.[122] There have been several initiatives to redress this, including new medical schools that focus on general practice and financial incentives for universities.

The NHS workforce report planned to double the number of medical school places, which will likely see more demand from medical students for placements in general practice.

This comes as a time when the UK is relying far more heavily on international medical graduates (IMGs). In 2023, for the first time, international medical graduates outnumbered UK graduates among GP trainees (Chart 34).[123]

There is a question as to whether it matters that the majority of GP trainees are IMGs. RCGP chair Professor Kamila Hawthorne says the college has been campaigning to make it easier for IMGs to remain in the NHS as they are currently having to 'jump through hoops' in terms of visa requirements. However, she adds: 'We should not be reliant on doctors from overseas to ensure we have sufficient workforce – we also need to make significant efforts to train more GPs in this country and then retain them.'

Here it is worth touching on plans around staff and associate specialist doctors – predominantly sub-consultant doctors not working towards a CCT. There is also a high proportion of IMGs in this group. The GMC originally floated the idea of these doctors entering general practice to alleviate workforce issues in 2022.[124] The workforce plan committed to 'ensure that doctors other than GPs are more easily able to work in primary care', adding that the medical workforce 'is expected to change over the next 15 years', with more SAS doctors and doctors in training choosing different career paths including general practice.

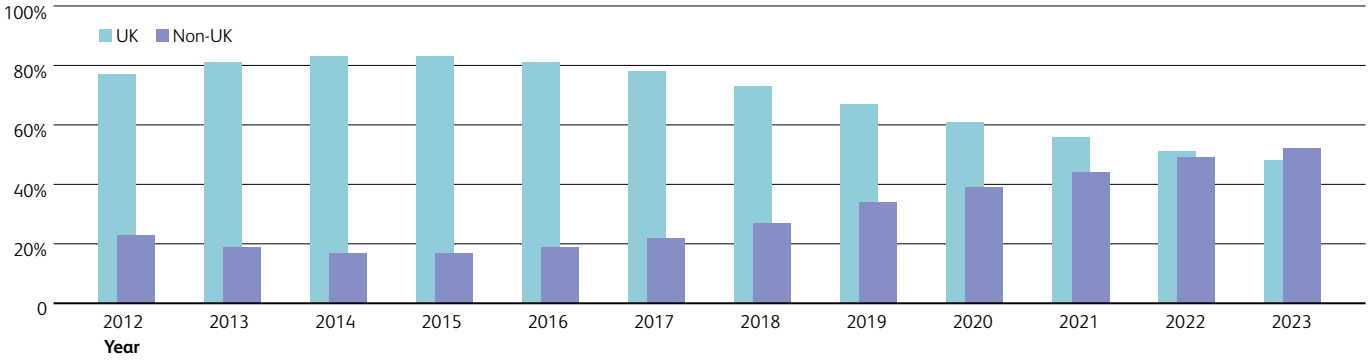
NHS England denied there were pilots involving SAS doctors in general practice, after GPC England chair Dr Katie Bramall-Stainer claimed they were 'colluding in the demise of the [GP] profession]' by promoting the idea of 'primary care doctors' in July 2024.[125] So far there have been no further developments.

Practice nurse training

There is at least an imperative to sort out training capacity for GPs. The regulations around the time they need to spend training in general practice, plus the Government's own targets (or revised targets with Labour's forthcoming workforce plan), mean there will be scrutiny around this.

For practice nurse training, this imperative does not exist. The NHS workforce plan included measures to increase nurse training

Chart 34 Percentage of GPs who are international medical graduates[123]



places from 30,000 a year in 2022 to 40,000 a year by 2028/29, and 53,500 by 2031/32, with an emphasis on community nursing. But this doesn't seem to be in general practice, with an emphasis on health visitors and little mention of practice nurses.

As described earlier in this report, practice nurses are experiencing low morale, and many are looking to retire in the near future (see chapter entitled 'What is being done to retain experienced staff?'). To revitalise the profession, there needs to be a steady influx of practice nurses. This will be helped by nurse trainees having exposure to general practice. Such exposure will also help with their induction into general practice.

But practice nurse training faces a number of problems. The number of nurses trained in GP practices has been static for the past seven years – 181 in March 2017 and 187 in October 2024.[126] Even including the 37 trainee nurses in PCNs, this represents barely any increase.

Trainee nurses are recruited on an ad hoc, local basis. The only requirement for nurses is they need to spend two weeks in a community setting – but not necessarily in general practice. The incentives seem to work against placing trainee nurses in general practice. First, from the universities' point of view, there is no obligation for nurses to spend time in general practice so it is far easier for them to place nurses in secondary care, which has the infrastructure to take on hundreds of students rather than the one or two that a GP practice can accommodate.

Second, practices have little incentive to take on nurse trainees; the clinical tariff a trainee nurse attracts is £5,519 – or around £150 a week, for what would be a two-week placement.

Asha Parmar, an ANP in North Central London, says: 'I've been trying to get a GP nurse trainee for two years across two practices and have had push back on renumeration of the nurse and lack of space with little room for flexibility on working patterns.'

As one practice nurse training co-ordinator puts it: 'What scares me as a practice nurse is whether there is a need for us at all. Is that why there is a lack of training and support provision for new practice nurses – as there isn't a role for us in the future?'

In the battle for training capacity, nurses seem a low priority.

Pharmacist training

The number of pharmacy trainees in general practice is not counted because there are no trainee pharmacists employed in general practice. However, in December 2024, regulations were changed to allow GP practices to act as the employer for trainee pharmacists (interestingly, this was an effect of Brexit, with the European Union not permitting GP practices to be counted as an employer of trainee pharmacists).

Practices are to be given a training grant of £26,500 a year from 2025/26 to employ trainee pharmacists in their one-year foundation programme.[127] This almost exactly covers minimum wage plus National Insurance contributions. Even before this change in regulations, there were around 700 trainee pharmacists in general practice, with practices partnering with community pharmacies or hospitals.

For 2025, this will all change. All pharmacists who qualify this year will be required to have prescribing skills, which will involve 90 hours of training from a prescriber.[128] For those pharmacists who train in secondary care settings, fulfilling this requirement will not be a problem. But it might prove a problem for pharmacists training in community settings, as there are currently not enough community pharmacists able to teach prescribing skills.

As a result, it is likely there will be more demand for training within general practice, which has the benefit of having not only pharmacist trainers, but also GPs and even ANPs, all of whom can provide training in prescribing.

It is not yet clear what the arrangements will be for this. It could mean more trainee pharmacists being employed by practices. Unlike trainee GPs, whose salaries are covered by NHS England on top of a training grant, trainee pharmacists will be on the open jobs market. Practices or PCNs that want a trainee pharmacist will be competing with community pharmacies and secondary care. At the same time, the tariff for hospitals to take in a trainee pharmacist has decreased and is now the same as the grant given to general practice, at £26,500. But, unlike pharmacies and general practice, acute trusts won't have scope to increase salary offerings. General practice will have the benefits of being able to offer prescribing training and, if partners and PCN clinical directors so wish, to offer topped-up salaries.

For practices and PCNs, the attraction is that the pharmacists can start consulting one-to-one with patients within about four months, according to Primary Care Pharmacy Association president Graham Stretch. They will require support within the practice but the consultations themselves will be unsupervised.

This will be financially sensible, he says, and will provide a pipeline of practice pharmacists at a time when they are in demand.

Danny Bartlett, a Royal Pharmaceutical Society England pharmacy board member, notes this implies more training capacity in general practice for pharmacists. He says this is 'a vital moment' when GPs and other trainers must be given 'time and space to develop as supervisors to be able to take trainee pharmacists'.

The new regulations may lead to community pharmacies reaching agreements with local practices to provide prescribing training for a fee, benefiting all parties.

In summary, general practice is likely to see rising demand for pharmacy training – and pharmacy trainees – in the year ahead.

Other allied healthcare professionals

There are currently more than 650 nurse associate trainees in general practice.[129] Their role involves clinical tasks including venepuncture and ECGs, taking blood pressure, temperature, respirations and pulse rate, and supporting patients who receive bad news, for example.[130] Nursing associates need a foundation degree, typically taken over two years, which usually takes the form of an apprenticeship.[131] The entry requirements for the degree are pass marks in maths and English GCSE or equivalent.

PCNs and practices receive funding to employ these trainees – a training grant worth £4,000 a year (£8,000 for the two-year course), or £7,900 a year if more than 50% of their time is spent with patients with autism or learning disabilities.[132] On top of this, their salaries are funded through the ARRS.

The aim of the role is partly to 'allow nurses to concentrate on more intricate clinical tasks'.[133] But as the nurse training co-ordinator put it: 'Many practice nurses feel under pressure to train our replacements.'

For physician associates (PAs), there is again no requirement to spend time training in general practice. However, they must do 1,600 hours of clinical training, including 350 in general hospital medicine.[134] But practices and PCNs are heavily incentivised on a local basis to take on training for PAs. For example, in the Greater Manchester Training Hub, they are offered £555 a week to take on a PA, compared with just £130.96 per week for a nurse.[135]

Equally, there are currently no requirements for paramedics or physiotherapists to do pre-qualification training in general practice. But the professional bodies of both are expecting an increase in demand. A Chartered Society of Physiotherapy (CSP) spokesperson says: 'To achieve CSP accreditation, students and apprentices are required to complete 1,000 hours of practice-based learning as part of their degree programme. Practice-based learning must be organised to reflect the increasing presence of physiotherapy services in primary care and community settings.' Meanwhile, the Health and Care Professions Council says: 'We consider it best practice that pre-registration paramedic programmes include non-ambulance practice-based learning.'[136]

There are other trainees in general practice – mainly employed by PCNs – including trainee clinical associates in psychology, talking therapy practitioners, health and wellbeing practitioners and pharmacy technicians. But these are in single figures across England. There is a larger group of apprentices (220), which confusingly includes roles such as apprentice nursing associates and apprentice registered general nurse trainees, according to NHS England. But, relatively speaking, these trainees don't take up much training capacity. Which is lucky, because capacity is scarce.

Why training capacity remains a worry

As we have seen, there are a number of different staffing groups that train within general practice. They differ in how lucrative their training is for practices, the requirements for training within general practice and how much they can contribute to the general practice team while training.

However, there is only so much resource and capacity for training. The NHS workforce plan only exacerbates the capacity issues, with Labour's version in 2025 expected to do likewise.

Modelling by *Pulse* in 2023 revealed the aims in the workforce report would require a doubling of training capacity for GPs alone within five years, and a trebling within a decade (Charts 35, 36).[137]

On the capacity for training, the workforce plan had this to say: 'Management of the number, spread and quality of clinical placements is a concern across healthcare education and training, and for learners. Growth in placements has been challenging for several years, usually attributed to a lack of capacity and supervision, and this restricts the breadth of learning opportunities on offer to students.

'We will work with stakeholders, informed by the issues we identified through a discovery exercise in 2022/23, to ensure clinical placements are designed into health and care services, and placement providers know what core standards they need to meet.'[138]

The workforce report includes an 'Educator Workforce Strategy'.[139] This lays out seven priorities for supporting 'educators' – a term that encompasses academic clinicians and trainers: ensuring educators' capacity is factored into workforce plans; protecting their time; introducing career frameworks; supporting their development and wellbeing; defining standards and principles; promoting equality, diversity and inclusion; and embedding evolving and innovative models of education. But details on the delivery will only be made clear in January 2025.

In the meantime, deaneries have also been tasked by NHS England with developing plans to increase training capacity.

We asked the seven deaneries across England what they were doing to address capacity issues. There were a few common strands. All the deaneries who answered pointed to the Blended Learning Programme, introduced during Covid and now adopted nationwide. This involves trainees combining technological and digital approaches to learning with practice-based training. In its report on blended learning, Health Education England makes a point of highlighting how it helps with capacity: 'Technology offers opportunities to support clinical placements and increasing the available capacity using techniques such as virtual ward rounds and the provision of remote supervision and mentoring.'[140]

Deaneries pointed to their accreditation of practices and PCNs as Unified Learning Environments (ULEs), enabling them to take on medical students or trainee doctors and healthcare professionals in a more streamlined fashion. Opening this up to PCNs has increased capacity, the East of England Deanery said. The Greater Manchester Training Hub has set up accredited ULEs for GP practices, PCNs and federations, allowing them to take on any trainees, attracting a tariff as a result.[141]

There are other innovations taking place elsewhere. The RCN's Kim Ball highlights a GP nurse training scheme at the Staffordshire Training Hub. The Staffordshire GPN Foundation School, launched in September 2023, states: 'The variability, instability, and optional nature of general practice nursing training have long been issues due to the lack of a structured pathway, unlike the established GP training programme for doctors.' The school says it was launched in recognition of 'the need for change' and modelled after the GP training scheme.[142]

But practices and PCNs are still having to prioritise, given the limited capacity. There is only so much physical space for each staffing group, as has been pointed out in previous chapters. Trainees may not always require their own space, but they certainly will if they are to contribute to service delivery and patient care alongside their training placements.

Chart 35 Total projected months spent in general practice by medical students and trainess across England[137]

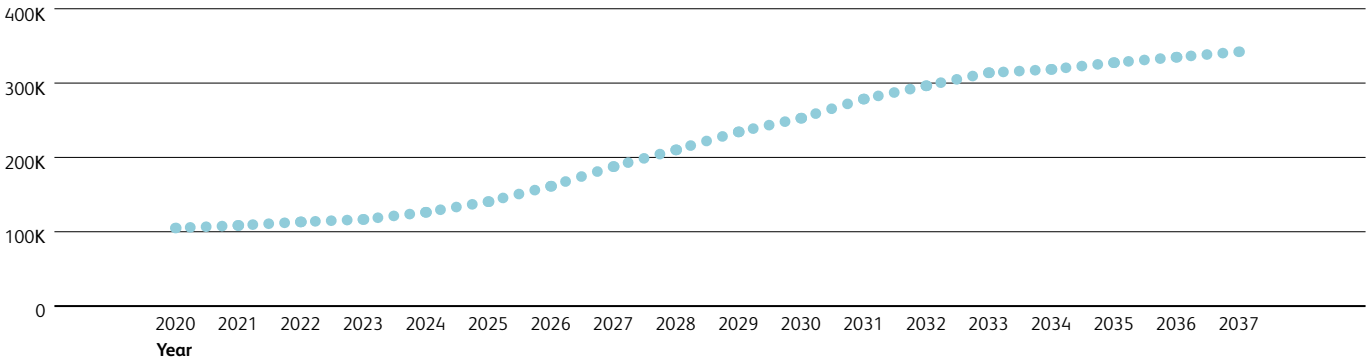
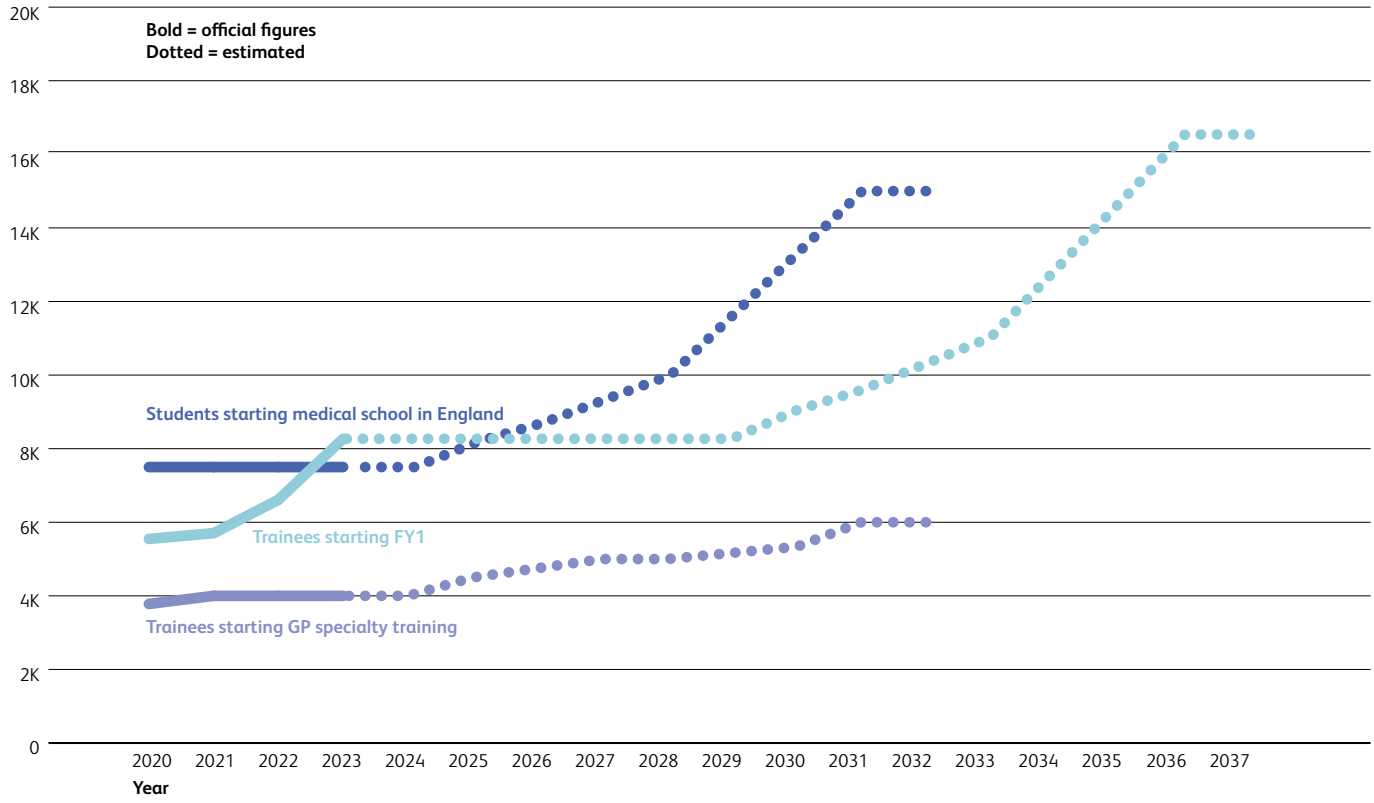


Chart 36 How the workforce plan increases trainee numbers[137]



A key problem is the number of trainers and their available time. GP, nursing and pharmacy trainees all need to be supervised by their senior equivalents. These same trainers will also be overseeing other allied healthcare professionals.

The data are patchy in relation to the number of professionals providing training within general practice. According to the GMC, there are 7,940 GP trainers in England.[143] The Nursing and Midwifery Council says there are 1,346 nurses on its register with a general practice nursing SPQ qualification who can provide training, but it does not have figures on how many are actually doing so.[144] The General Pharmaceutical Council says there are roughly 3,500 designated supervisors for trainee pharmacists, but cannot specify how many work in general practice.

NHS England's Educator Workforce Strategy found there were problems with service pressures eroding the time available for training, as well as an ageing educator workforce.

The surveys conducted by Cogora's brands provide a bit more cheer on this. As one nurse respondent put it, training can be 'one of the most rewarding parts of my work'.

Of the 830 GPs who responded to *Pulse*'s survey, 23% were trainers and 16% were considering becoming a trainer. It found that the average age of trainers was 49, compared with 52 for non-trainers, while the average age of those considering becoming a trainer was 45. Meanwhile, the average time they wanted to remain as a trainer was seven years. For the 198 nurse trainers who answered the *Nursing in Practice* survey, this figure was 5.7 years.

More trainers are needed, however. As RCGP chair Professor Hawthorne put it when addressing the Health and Social Care Committee hearing in December 2024: 'More and more people need to be trained in generalism, and the best place to do that is in general practice. And that's not just medical students and GP trainees. It's nursing students, it's physician associates, it's clinical pharmacists.

'The whole raft of the team needs to come out into general practice, and we don't have the room to train them properly, nor do we have the trainers.'

While the lack of capacity remains, practices need to prioritise. There are many non-financial benefits in taking on trainees of all types. But, with an ongoing funding squeeze, practices and PCNs are having to give greater weight to the financial aspects – whether that be preferring certain staffing groups because of the funding they attract, or avoiding other groups because of adverse cost-benefit analyses. Such choices do not necessarily translate to the longer-term benefits to the workforce; for example, there are now greater financial incentives to train PAs and nursing associates than there are to take on practice nurses or medical students.

This is an example of the GP contract being fundamentally broken, with incentives poorly aligned with long-term needs. The BMA and NHS England are currently discussing an overhaul of the contract, with a new version expected to be implemented in 2028. Training, and how it integrates with overall health of general practice, must be a key factor in to this.

What is being done to retain experienced staff?

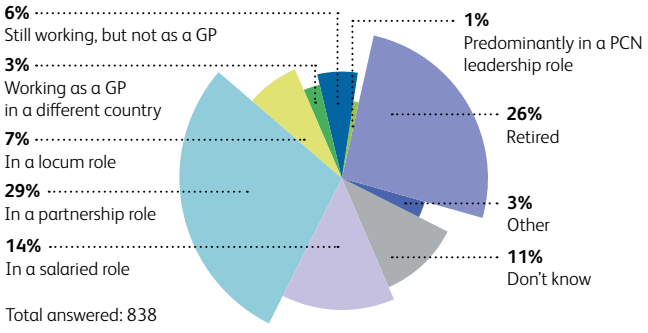
Retention remains one of the biggest problems within general practice, and this looks unlikely to change. Only 55% of GPs surveyed by *Pulse* said they expect to be working in UK general practice in five years. It is a similar case for nurses – just 36% said they see themselves in general practice in five years' time. Practice pharmacists are content, in comparison (Charts 37-39).[145 146 147]

There is a National GP Retention Scheme in place, which provides additional funding to both the practice and the GP. It sets three criteria: first, the GP is seriously considering leaving the profession for personal reasons, is approaching retirement, or requires greater flexibility; second, that a regular part-time role won't meet the GP's needs; and third, that practices ensure making time for educational supervision for the retainee.[148]

The GPs themselves are given expenses allowances worth £1,000 per year for every weekly session they undertake, up to £4,000, so a GP working three sessions per week will receive £3,000 per year. The practice is eligible for £76.92 per session, up to four sessions a week, worth up to £16,000 a year. This funding is available for five years per doctor. But as helpful as this scheme is, seven years after its introduction in 2017, only 289 GP retainees were practising in England as of October 2024.

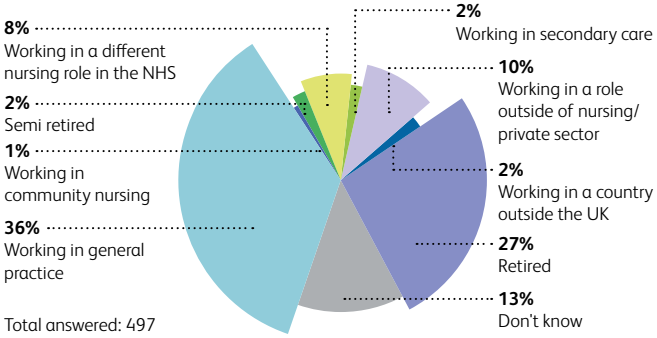
Another measure the previous Government enacted was changing rules around the taxation of pensions for doctors. The previous situation had seen GPs refusing shifts or retiring because working would have cost them money due to having exceeded either annual or lifetime tax-free pensions allowances. This change has had an effect, but not enough. BMA Pensions Committee deputy chair Dr Krishan Aggarwal calls the changes 'welcome but not a long-term fix'. He says the annual allowance has not been indexed to inflation, and there has been no 'meaningful' reform of the tapered annual allowance, which, in effect, 'is leaving senior doctors with an immediate risk of paying to work'.

Chart 37 GPs: Where do you think you will be in five years' time in terms of your career?[145]



Total answered: 838

Chart 38 Practice nurses: Where do you think you will be in five years' time in terms of your career?[146]



Total answered: 497

Other measures in the NHS workforce plan focused on cultural changes – aimed at making the NHS more inclusive for staff who are overseas graduates, or strengthening the freedom to speak out. Laudable though these initiatives are, they largely targeted the NHS as an employer – which, in general practice, it is not. For example, an emphasis on the 'freedom to speak out' is very different for small organisations like general practices compared with the wider NHS as an employer.

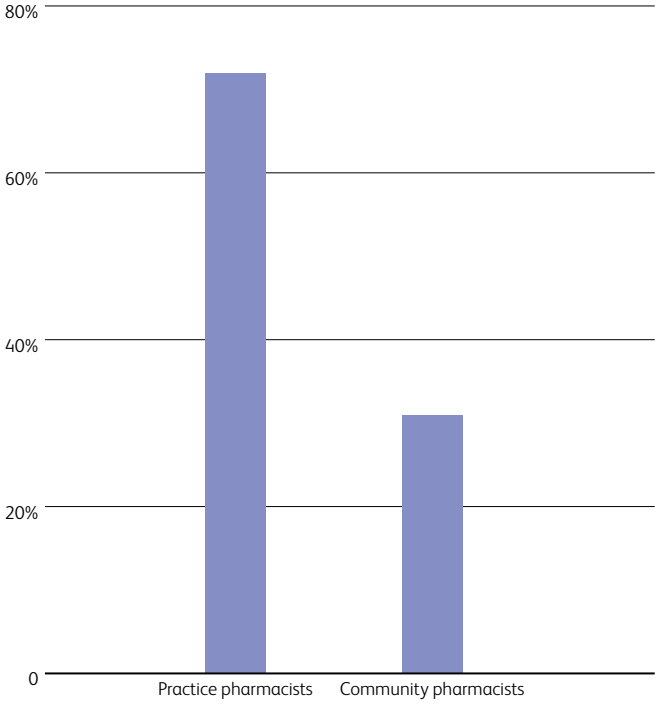
These measures do not appear to have been developed with the important goal in mind of stemming the flow of leavers from general practice.

For nurses, the situation is bleaker. NHS England last year cut funding for a fellowship scheme designed to improve retention.[149] Instead, ICBs will need to find this funding. At the time, Queen's Nursing Institute chief executive Dr Crystal Oldman said: 'There is a plethora of evidence of the benefits of the GPN fellowship in recruiting and retaining registered nurses in general practice, which should make continuing the funding via an ICB irresistible to the commissioners.'

Provisions for retention of practice staff were included in the May 2022 'Fuller Stocktake'[149a], led by Dr Clare Fuller, a GP who is now a medical director at NHS England – this was referenced in the workforce plan. The focus in the Fuller report was on the configuration of general practice, integrating services and improving same-day access. But there were a few recommendations around retention. It called for the 'NHS staff survey' – which at the time was being piloted – to be rolled out nationwide to general practice. The first results were obtained by *Pulse*, but were not published nationwide. Only 22 of the 42 ICBs participated, but the results showed that GP practices scored highest of all NHS bodies on their 'compassion and inclusivity'.[150]

However, the main problem with GP retention is burnout. The GMC's *Completing the Picture* report, cited in the RCGP's September 2022 *Fit for the Future: Retaining the GP Workforce*

Chart 39 Percentage of pharmacists who see themselves in their current sector in five years' time[147]



Total practice pharmacists answered: 128
Total community pharmacists answered: 116

report, found it was the second most common reason for GPs leaving the profession (43%) – not far off the proportion citing retirement (56%).[151]

The same is true of practice nurses. One ANP responding to NIP's September survey described how their workload had increased and become more complex, making it hard to take their unpaid lunch break. They now plan to take early retirement 15 months early due to stress and burnout and said they will be 'financially worse off' following this.

This was acknowledged by the Fuller report. It called for 'parity of access to system staff health and wellbeing hubs and occupational health services'. There is an established service for GPs seeking mental health support – the NHS Practitioner Health programme. It was originally for GPs only, but was later opened up to secondary care doctors and dentists. The programme is not open to staff in general practice and it looks unlikely to be extended any time soon – last April, NHS England withdrew funding for secondary care staff, despite the workforce plan's emphasis on wellbeing.[152] While NHS England reversed that decision, there are no signs it will widen access to the programme in the near future.

But treating the symptoms of burnout is not enough. What is most necessary is addressing the causes. This can only be done by making the jobs more tolerable, which will involve boosting workforce numbers. This may be a Catch-22, but it does suggest that retention will be improved once there are more of the right healthcare practitioners working in general practice.

Responsibility without power: ICB plans for the general practice workforce

ICBs are limited with what they can do to boost primary care recruitment. They don't negotiate the national contract, and they don't directly employ the workforce. However, despite these significant parameters, NHS England and successive governments have emphasised that they have the scope to improve recruitment and retention in general practice.

So what exactly are they doing? We asked every ICB in England to provide on-the-record details of what funding, schemes and challenges they have in regard to the GP workforce. We have summarised these on the table on pages 41-43.

There are a few things that come out of their responses. First, very few have particularly innovative schemes – or at least ones they were willing to share. Most are supporting practices through their training hubs. These training hubs are, on the whole, responsible for workforce issues in the ICBs, and are funded through both the local commissioners and NHS England. The hubs themselves help to support fellowships to help retain staff, support practices with Tier 2 visa applications, support apprenticeship recruitment directly, respond with advice when asked, aid newly qualified GPs in finding work, provide mentorship as well as upskilling existing staff. For example, Cambridgeshire and Peterborough ICB said their two-year fellowship programme for new GPs and nurses – run in conjunction with the training hub – has 'had a strong impact on retention' and has helped them retain staff at levels that are higher than peers across the region.

Second, those who have focused on general practice with targeted schemes seem to be seeing some limited success, such as Devon and Coventry. The focus in Devon on recruitment and retention of GPs has seen a shift in GP locums moving away from locuming in favour of seeking substantive posts, while Coventry has been building on its relationship with Warwick medical school and has developed programmes to support GPs on parental leave and locum workforce – this has helped them achieve some of the best staff-patient ratios in England

In Kent and Medway, a community educator facilitator team is based in each PCN – so far 125 practices and 17 PCNs have taken up individual workforce planning support and have used their population health data to make sure that each practice has the right workforce plans.

Black Country put in place a portfolio careers scheme which supported 93 individuals between 2018 and 2024. An evaluation conducted in early 2024 showed demonstrable impact on staff satisfaction (72% agreed) and retention (76% agreed). Others including Manchester are focusing on flexible careers.

Primary care directors off record

Cogora surveyed 15 of the 42 ICB primary care directors (or equivalents), and their answers were more illuminating than the official responses. We asked them to score statements out of five – with five being 'strongly agree' and one being 'strongly disagree'.

Further proving that there are dual crises in the general practice workforce, the average scores for 'Practices in my area are struggling to recruit GPs' and 'There is a problem with GP unemployment in my area' were broadly similar – 3.73 to 3.23 respectively.

They seem united in believing that general practice needs more funding. On the statement 'The Government should be investing a larger proportion of NHS funding into primary care', the average score was 4.92. Only slightly below this was their contention that 'ICBs should be investing a larger proportion of NHS funding into primary care', with a score of 4.43. And the statement 'GP practices need more funding to alleviate recruitment problems' scored 4.47.

Speaking on the condition of anonymity, one director said: 'One of the constraints we have is available funding to support practices' recruitment. Many are not able to increase their workforce because of this or estates constraints. We are supporting them locally to explore options, but there are some constraints which are not a quick fix.'

Another said: 'Sustainable primary care requires appropriate resource to be viable'. One respondent said there were systemic problems: 'The overall funding model is not creating equity and sustainability.' And a fourth said: 'Recruitment is clearly an issue - seems to currently be more about finance than staff.'

They don't blame practices for recruitment problems – the statement 'The GP practices who struggle to recruit have themselves to blame' got an average of 1.87. But equally, they don't feel they can do much about it; the statement 'ICBs can do a lot to alleviate issues in primary care recruitment' scored 2.87. One primary care director said: 'The ICB or training hubs are not resourced to provide recruitment and on demand support to individual practices. They are employers and the responsibility lies with them. ICBs can support but cannot "do", unless commissioned specifically by PCN and practices to do so.'

On the ARRS, they were mixed on how much it helps, although broadly positive: 'The ARRS scheme has been a success' scored 3.60, while 'The ARRS scheme has caused wider problems for general practice' scored 3.00. However, they were less positive that 'The emergency measure of GPs in the ARRS will help alleviate GP workforce problems' – which scored 2.67. One said: 'ARRS generally has been helpful... it would seem churlish to say it hasn't helped. But it probably has allowed PCNs to extend the range of what they do rather than directly provide traditional general practice.'

Another director was more downbeat: 'ARRS investment fell short of infrastructure and supervision, and placed employer burdens upon practices.' This has had an effect on ICBs, they added: 'ICBs are being left to supplement ARRS despite stiff efficiency targets and a lack of full oversight of ARRS.'

	Average score out of 5 (5=strongly agree)
GP practices in my area are struggling to recruit GPs	3.73
There is a problem with GP unemployment in my area	3.23
The ARRS scheme has been a success	3.60
The ARRS scheme has caused wider problems for general practice	3.00
GP practices need more funding to alleviate recruitment problems	4.47
The emergency measure of GPs in the ARRS will help alleviate GP workforce problems	2.67
The GP practices who struggle to recruit have themselves to blame	1.87
ICBs can do a lot to alleviate issues in primary care recruitment	2.87
The Government should be investing a larger proportion of NHS funding into primary care	4.92
ICBs should be investing a larger proportion of NHS funding into primary care	4.43

In Shropshire, Telford and Wrekin, a small team of GP leads support newly qualified GPs in finding work, and provide networking/resilience support for other cohorts of GPs, including female GPs, older GPs and GP partners. Other ICBs have talked about nurse support from experienced colleagues.

Third, while many ICBs stressed that growing the general practice workforce is a priority for them – retention as well as recruitment – a minority seem unclear what their primary care staff requirements are locally. Some responded that they didn't know where the shortages are.

For those who were able to identify shortages – or a lack of roles to recruit to – GPs remained the most in-demand role. But a high number identified a shortage in practice nurses – both in recruiting new nurses and retaining experienced staff. Several ICBs told us they had developed schemes and put in place specific support to address an ageing practice nurse workforce.

Funding pressures

Finally, of course, there is the issue of funding. ICBs themselves are strapped for cash, and are often under pressure to fund secondary care. The funding given to ICBs through service development funds (SDF) is additional to their baseline allocations from NHS England and is meant to be spent on primary care (Table 2). There are pots of ringfenced funding, including: £44m for general practice fellowship and supporting mentors schemes; £5m for 'new to partnership' payment schemes; and £13m for GP IT infrastructure and resilience.

There is also £127m available for 'primary care transformation'. But this now incorporates funding that had previously been ringfenced itself for general practice workforce issues, including local GP retention, training hubs, and recruitment and retention. The funding for digital-first primary care has also been included in the transformation fund.

Yet the transformation fund is not targeted on wider workforce issues – it specifies 'tackling the 8am rush and reducing the number of people struggling to contact their general practice [and] for patients to know, on the day that they contact their general practice, how their request will be managed'. Many ICBs said they would continue to use this funding for workforce issues (and ensuring general practice has adequate staff is clearly key to meeting aims around access). But crucially, this funding does not necessarily need to be spent on workforce.

In the case of Humber and North Yorkshire ICB, funding squeezes are having an effect on attempts to improve the general practice workforce. It had schemes in place around paramedic rotation, GP fellowships, supporting mid-career GPs to develop special interests to improve retention, and an international GP scheme in partnership with health authorities in Kerala, India among others.

GP and primary care workforce lead Dr Kevin Anderson says the ICB has 'created a supportive and collaborative system for innovative workforce development'. However, he adds: 'Unfortunately, due to well-publicised financial pressures in our system and wider NHS, some of the funding for primary care workforce we had been able to access in 2024 is unlikely to be available in 2025, which is disappointing given our achievements over the past 12 months.

'Sadly, this means many of our schemes may not have the funding to continue or have already ended.'

Table 2 Funding pots to ICB to support general practice

Primary care transformation (includes funding previously ringfenced for local GP retention fund, training hubs, recruitment and retention and digital first primary care)	£126.9 million
Additional centrally held funding for ARRS for ICBs to draw-down when needed	£534 million
General practice fellowship and supporting mentors schemes	£44.3 million
New to Partnerships Payments Scheme	£5 million
International GP recruitment programme (IGPR), return to practice programme (RTP) and international induction programme (IIP)	Funding available as part of broader workforce budgets
GP IT infrastructure and resilience	£13 million

Table 2 What ICBs say they are doing for the general practice workforce

We asked all 42 ICBs in England about the general practice workforce in their region: initiatives they have put in place, dedicated funding and particular challenges. All provided an answer. Many focused on standard programmes, such as training hubs and even the ARRS, suggesting a lack of local initiatives. However, we have faithfully summarised their answers.

ICB	What ICBs say about particular problems, solutions and funding
Bath and North East Somerset, Swindon and Wiltshire	• Third highest FTE GP staff per weighted 10,000 patients • Upskilling administration staff to support care navigation • ARRS roles utilisation is at 98% • Supply of newly qualified nurses wishing to be GPNs is higher than vacancies available in the ICB area
Bedfordshire, Luton and Milton Keynes	• Invested £197k to support recruitment, retention and education • Provides recruitment advice and advertising support, health and wellbeing resources, and a range of training, fellowships • Ringfenced CPD allocation from NHS England of £121k for nurses and AHPs.
Birmingham and Solihull	• Shortages in direct patient care roles in general practice, including nurses • Provides enhanced support for newly qualified GPs • Uses national general practice flexible staff pools scheme, GP mentors, New to Partnership payment scheme and GP retention scheme
Black Country	• Lowest leaver rate for GPs nationally, and eighth highest rate for GPs joining the workforce. Shortages include paramedics, general practice assistants and physician associates • Direct patient care staff now outnumber qualified GPs • Portfolio careers scheme supported 93 individuals between 2018 and 2024 • Still using SDF (service development funding – see main copy, page 40) for primary care workforce initiatives
Bristol, North Somerset and South Gloucestershire	• Struggling with recruiting practice nurses • Recently launched an 18-month project to review and improve non-clinical staff training • There is no formal funding for core general practice training or a general practice learning and development 'department'
Buckinghamshire, Oxfordshire and Berkshire West	• Works with partners to scope, review and prioritise support offers for primary care workforce • Fully utilises emerging national, regional and local support offers, such as GP improvement programme, GP retainer scheme, coaching and mentoring, flexible pool for nurses and GPs two-year new to practice fellowship programme and PCN learning environments
Cambridgeshire and Peterborough	• FTE GP numbers are above target, with an increase of 4.4% FTE in last 12 months and 11.4% since 2019 (compared to regional growth at 4.7%) • Two-year fellowship programme for new GPs and nurses has had a strong impact on retention and has helped retain staff at levels that are higher than peers across the region • Using ARRS budget to train, recruit and retain patient-facing staff in primary care
Cheshire and Merseyside	• Currently 44 GPs on the National GP retention scheme • 148 GPs currently on two-year fellowship programme, supported by 25 GP mentors • 56 nurses on fellowship programme • New cohort of 25 nurses commenced on nurse preceptorship programme
Cornwall and the Isles of Scilly	• The Cornwall Training Hub, delivered in partnership with Kernow Health CIC, receives primary care transformation funding through an SDF and utilises this to facilitate clinical and non-clinical workforce support across general practice
Coventry and Warwickshire	• Above-average number of GPs per 1,000 patients, partly due to high number of GP trainees. Strong relationships with Warwick Medical School has supported high retention • ICB continues to use SDF funding of £460k and further budget of £700k to commission support services including First5, last five, induction, wellbeing, mentorship and retention schemes • Comprehensive and integrated primary care workforce people plan with senior clinical and managerial input is being finalised to drive future work programme
Derbyshire	• All primary care professions have struggles. Dedicated budget around £1.6m, it is majority ringfenced and is delegated to the training hub • All of the national retention schemes are in place and the training hub offers a range of practical and wellbeing support to ensure staff can continue in their roles. Has an 'excellent' induction programme for new starters in the area
Devon	• Focusing on recruitment and retention of GPs. There has been a shift in GPs returning from locum service to look for substantive posts • There is a general practice nurse strategy with plans in place for a legacy mentoring scheme and other pilot schemes to aid retention and to support those new to general practice • Supporting recruitment by attending key recruitment events and careers fairs, and promote working in Devon
Dorset	• Shortages across all primary care workforce, scoping work being done – focus on pharmacy and optometry • Already in place are a GP retention scheme, a GP fellowship offer, a community of practice to provide peer support and education to GP nurses and ACPs, and looking to reinvigorate one for FCPs

Frimley	• Shortages of GPs and practice nurses • Comprehensive and integrated primary care workforce strategy with senior clinical and managerial input • SDF from NHS England is ringfenced. Projects include extensive fellowship programme
Gloucestershire	• GP partner numbers remain high compared with regional average, and practice nurse numbers are above national average • Some of ICB SDF allocated to the training hub to deliver programmes including practice nurse measures and GP retention • Local GP and GPN Fellowship scheme to replace the NHSE scheme, branded 'Spark' locally
Greater Manchester	• Reducing barriers for nurses entering general practice (pilot launched in Oldham) • Flexible, inclusive recruitment models at all levels and adopting hybrid roles • Equitable access to training and development • Created a central careers page for Greater Manchester • More support for international GPs to stay in practice
Hampshire and the Isle of Wight:	• Comprehensive and integrated primary care workforce strategy with senior clinical and managerial input • Annually allocate a ringfenced portion of the SDF for workforce-related programmes. This includes a continued commitment to fund the new to practice fellowship scheme
Herefordshire and Worcestershire	• ICB working closely with Herefordshire and Worcestershire Training Hub to invest in local workforce attraction and retention schemes such as First5, partnership development programme, nurse attraction and practice manager leadership
Hertfordshire and West Essex	• Primary care training hub activities include: developing strong relationships with universities and colleges; working with NHS England to support the international recruitment programme; offering practices support with gaining a visa sponsorship licence; running/attending primary care careers fairs; commissioning primary care careers and the National Association of Sessional GPs to support practices with recruitment • Range of GP fellowship programmes plus support (including conferences, networking, career conversations) for GPs and practice staff at various stages of their career and aspiring educators scheme for experienced GPs. Protected time to learn events in GP practices to set aside time for staff development
Humber and North Yorkshire	• Workforce and training hub was one of the first in the country • Examples of sustainable models for new roles (which don't destabilise other parts of the system) such as paramedic rotation scheme • Catalyst GP fellowship programme has vastly improved GP recruitment in the region • Phoenix fellowship programme designed to support mid-career GPs to develop special interest, improving retention and preventing burnout • Commissioned mentor programme for GPs, practice managers, nurses and other practice staff. Since 2021 this has provided more than 700 course places to practice staff and supported 225 mentees • Working with partners in Kerala, India to develop an international UK GP fellowship programme • However, schemes may be cut due to cost pressures – 'which is disappointing given achievements over the past 12 months'
Kent and Medway	• A large older population with multiple comorbidities and high under-14 population which places burden on primary care • 'It is the role of primary care contract holders to tailor their workforce to meet the needs of their patients depending on local needs. The ICB supports them in identifying and fulfilling their workforce needs through the Kent and Medway Primary Care Training Hub.' • To date, 125 practices and 17 PCNs have taken up individual workforce planning support • Funding for the skilled worker visa scheme has been provided and 61 practices now hold a sponsorship licence; 21 GPs, three paramedics and three pharmacists recruited so far
Lancashire and South Cumbria	• Below-average numbers of GPs, but PCNs have been more successful in appointing to ARRS roles than other ICB areas • The ICB funds retention and training of primary care staffing through the combined funding (with NHS England) of a training hub, whose remit is to deliver various workforce projects
Leicester, Leicestershire and Rutland	• Locally funding GP fellowships, mentorships and mentors for GP fellows • GP practices can widen their candidate search by utilising the LMCs' recruitment channel • Currently working up a local offer of support for newly qualified GPs following the cessation of the national fellowship scheme in March 2024
Lincolnshire	• Struggling to recruit clinical pharmacists, practice nurses, practice receptionists • Two subgroups looking specifically at retention and engagement for all multidisciplinary staff – introduced schemes such as the GP assistant programme
Mid and South Essex	• Range of schemes to recruit, upskill and retain the wider primary care team, including GP fellowship schemes, increasing the number of training practices, expanding the number of healthcare roles working in primary care, GP partnership courses, structured clinical leadership support and other learning and development opportunities
Norfolk and Waveney	• Shortages in nursing, physician associate and pharmacy roles, but improvements in GP training numbers • Additional budgets are utilised as part of workforce strategy, but these are not ringfenced and are aligned with broader system-wide priorities
North Central London	• People strategy includes dedicated primary care workstreams for training, recruitment and retention of general practice staff • Retaining SDF funding for training hub development, GP retention and nursing measures, despite ringfence being removed

North East and North Cumbria	• Two PCNs hosting People Promise managers as part of the national improving staff experience programme • Career start nurse and GP programmes in many areas, as well as GP trainer schemes, clinical skills training and other local retention schemes • Support practices to become training practices for medical students • Protected learning time for practice teams including PCN staff, with a range of training options • Active support for healthcare assistants who wish to become nurse associates and potentially registered nurses • A £35m three-year plan to improve health in most deprived areas is supporting steps to attract and retain more GPs to work in deprived areas, with extra training and support to encourage trainee doctors to build their careers in these practices
North East London	• Expanding approved training environments and placements • Supporting career development across all ages • Offering a wide range of training and educational opportunities
North West London	• Particular focus on practice nurses. Overall initiatives include SPIN fellowships; advanced clinical skills training; peer support networks; coaching; mid-career and health inequality fellowships; preceptorship programmes to support newly qualified GPs; mentorships and leadership training • Onboarding fellowships to support the PCNs in their embedding and training of GPs hired under the ARRS • Workshops to support development of the ICB's new workforce strategy
Northamptonshire	• 'Dedicated budget, which is made up of national funding'
Nottingham and Nottinghamshire	• Local new to practice offer for GPs to replace national scheme, which is stopping • Local new to practice offer for practice nurses • GP mid-career fellowship scheme • Multiprofessional support unit for ARRS staff
South East London	• Primary care workforce lower than national average as is the case across London. GP partners reducing year on year • Development, recruitment and retention initiatives in place for primary care led by the workforce and development hub
Shropshire and Telford and Wrekin	• Small team of GP leads support newly qualified GPs in finding work and provide networking/resilience support for other cohorts of GPs including female GPs, older GPs and GP partners • Anecdotally, many practices unable to recruit to GP vacancies due to financial pressures. Some challenges in recruiting experienced practice nurses
Somerset	• As part of broader primary care recovery strategy, there is a dedicated workforce plan but ICB is currently undertaking a detailed review of it • Alongside funding from NHS England, the ICB has commissioned a training hub for specific primary care workforce initiatives, investing £370,000 in 2024/25
South West London	• Alongside funding from NHS England, the ICB has commissioned a training hub for specific primary care workforce initiatives, investing £370,000 in 2024/25
South Yorkshire and Bassetlaw	• Training hub delivers a number of programmes to support roles in general practice, including a local fellowship programme, aspiring practice manager programme and nurse vocational training scheme
Suffolk and North East Essex	• Training hub delivers awardwinning programmes, including fellowship programmes for GPs and nurses, and preceptorship for nursing associates • Programme for student nursing placements – a hybrid model of taught sessions and clinical placements to relieve pressure on supervisors and estate • GP support hub provides recruitment support, peer support, coaching, mid-career development, education and training for all GPs in the region • Currently developing immersive training programme for key clinical system priorities including chronic pain, dementia delivered via VR headsets, laptops or mobile phones
Surrey Heartlands	• Has the largest GP FTE population per 100,000 patient, and has doubled GPs in training grades since March 2019. But the practice nurse population is lower than the regional average • Set up GP nurse forums, allowing them space to learn and share best practice, leading to increased job satisfaction and the safe delivery of quality care for the local population • Working with higher education institutions to promote general practice careers • Appointed a lead role for apprenticeships placed within the training hub
Sussex	• Primary Care Workforce Plan was published in November 2024, one of the first in the country • Best performing area on GP numbers with 11% increase in two years. Ratio of patients per GP, has fallen from 2,370 to 2,172 • The training hub runs initiatives such as mentoring services, fellowship and development opportunities, groups to support retention, and the new to primary care programme for newly qualified doctors and new clinicians. The latter scheme has so far supported 148 GPs and has expanded to the wider primary care workforce to include nurses and other patient-facing staff
Staffordshire and Stoke-on-Trent	• Two clinical workforce 'champions' in place at ground and system level to drive initiatives that support engagement, recruitment and retention of GPs • Six local GP retention initiatives in place • Collaborating with Staffordshire Training Hub to launch an 'innovative' General Practice Nursing (GPN) School • Developing a Staffordshire and Stoke-on-Trent general practice workforce strategy by 2024 looking on how to make their system an attractive place to work to ensure recruitment and retention
West Yorkshire and Harrogate	• Support has included fellowship programmes, mentorship for general practice staff, wellbeing education, group consultation training and maintaining access for West Yorkshire GP practices to a digitally enabled GP flexible pool

Taking control: innovative thinking in practices and PCNs

PCNs and practices are also limited in what they can do to address workforce problems. The coming together of practices in these networks has helped with co-ordinating both PCN-employed and practice-employed GPs and staff, backfilling roles when staff are sick, for example. This is a follow-on from strategies first implemented during Covid.

Since the addition of newly qualified GPs to the ARRS, some PCNs have been taking a longer-term view. Retention is one of the major problems for the GP workforce, and some PCNs are offering more responsibilities for newly qualified GPs who want this, such as helping them develop a speciality area, running a population health project or shadowing the PCN's clinical director.

Then there are initiatives to take the pressure off the existing workforce. For example, some PCNs are using ARRS-funded GPs to support practices that have a heavy care home workload by providing cover at the surgery. PCNs are also responsible for running enhanced-access clinics outside normal hours, which are open to all practices within the PCN allowing them a number of extra appointments at more flexible times.

Community initiatives

There are also softer measures that are in part designed to place GPs back at the heart of their communities. Some PCNs are using link workers to support patients with dementia cafes, or similar initiatives to alleviate loneliness. PCNs also run community wellbeing days offering health education and proactive, preventative care that, in time, should ease the burden on general practice. They support group consultations, with ARRS staff seeing 20-30 patients across a longer appointment session, and use care coordinators to manage patients with particular conditions to prevent exacerbations or decline. PCN pharmacists carry out structured medication reviews, while digital and transformation leads develop practice systems to increase automation and save time on tasks such as pill checks.

Practices have even more limited scope to put in place measures to increase recruitment. Some have started campaigns with their patients – for example, a town in Cornwall organised a flash mob and produced a music video to attract GPs to its surgery – and succeeded in finding a new GP.[153] Across the county border, a patient participation group at a GP surgery in Devon put out an advert for a GP, promising 'a great "lifestyle" choice for any doctor who thrives on the great outdoors and all the fabulous natural wonders this area has to offer.'[154] Meanwhile, a patients' group in Shropshire looked to buy its local GP surgery building, to save it from closure and make it more attractive to new doctors.[155]

These cases are, of course, uncommon. For most GP practices that responded to the *Pulse* and *Management in Practice* surveys, the keys to successful recruitment were being a training practice, longstanding reputations and structural factors, such as being in affluent, convenient locations.

Benefits for training practices

It seems that a combination of these factors is the best way to alleviate workforce issues. An anonymous practice manager in the North East says: 'We benefit hugely from being a well-regarded practice, in a modern building, in a popular market town within commuting distance of a major city and being a training practice. Half of our GPs were registrars here. So basically we are in a good position for recruitment and feel very lucky. I think beyond that we have a good team and fair working conditions. I don't feel we have had to do anything special when it comes to recruitment.'

One GP principal and trainer in Kent tells a similar story: 'We have been doing well in terms of recruitment, primarily because we tend to retain our resident doctors. We are in an area of high growth – in 2012, we were at 12,500 patients on our list but now it's 21,000 and we have had to consistently recruit as the list size has gone up. The ST3 year is pretty much a one-year interview that results in the residents staying.'

Berkshire GP Dr Rupert Woolley says his practice has a full complement of doctors. 'We have been very lucky with our staffing over the years. I think one of the big things is being a training practice. The last four appointments are doctors who trained here. Having trained here they know what to expect when they join and we know what we are getting. It also means they are people who are fairly settled and want to stay around here.

'We are a dispensing practice and own our building, so we are financially stable which makes it a more appealing prospect for partners. And the salaried doctors know there is a prospect of partnership as and when retirements happen.'

One point they all agree with is that they have benefited from happenstance. Dr Woolley says: 'I realise we have been lucky, I imagine a lot of practices have previously had similar stable models but it only takes one or two unexpected departures, through ill health or other personal reasons, to destabilise a situation and lead to a downward spiral where life is harder for the remaining team. This increases the likelihood of further doctors leaving and a reputation of high turnover or a difficult working environment makes it harder to recruit.'

The GP principal in Kent says: 'If we were not a training practice, things would probably be more challenging.' And the practice manager in the North East says: 'Other practices won't have those advantages and may struggle through no fault of their own.'

Case study

I think we may have just been lucky when we were looking for replacement GPs. We only advertised on our local LMC website and have managed to recruit from there. I do think that the last two GPs we have recruited have chosen us because we have done a lot of work on wellbeing in the practice and have won local awards (as well as Investors in People) and have started to be recognised locally for this. So what did we do?

- **We offer a mixed day of 15- and 10-minute appointments and we limit extras (squeeze-ins).**
- **We have a partner on duty every day who we call the 'mentoring GP' and who any clinician can 'interrupt' throughout the day for advice and guidance.**
- **Monthly one-to-ones with GPs and manager as well as an annual staff survey.**
- **We have all sorts of employee benefits, from an extra day off for their birthday to having a paid day off to volunteer.**
- **We have a weekly newsletter (issued every Monday morning) to keep everyone up to date, rather than a million emails).**
- **We also have a higher-than-average non-clinical team who reduce the admin burden for GPs, from a prescribing team, coding teams etc.**

We are certainly not perfect and, as with all other surgeries, we cannot meet the demand and expectations of our patients at all times. But what we can do is look after each other so that we can all be at our best to help our patients.

Practice manager in Kent

PART THREE

Conclusions and recommendations

Conclusions

- There is still a major need to increase the number of GPs. Practices in England may not have the same demand for new GPs as five years ago but they would still like to see a minimum 20% increase in the GP workforce.

- Other healthcare professionals have taken on some more of the work, and this has been valuable in cases such as nurses and pharmacists working at the top of their licences. But GPs have the skill levels and capability to take on the majority of the work in general practice and, in most areas of activity, are the only professionals who can take on the clinical responsibility. An increase in GPs would also mean less activity overall, because their experience and training mean fewer follow-ups.

- This need for more GPs exists alongside a situation where there are GPs out of work. The reason there are few job vacancies is not that there is less demand for GPs' services, but that practices lack funding and – increasingly – the premises space to house them. The ARRS has made non-GP practitioners a far cheaper option; not only are their salaries lower than those of GPs but they are largely paid in full by the NHS. These staff place more pressure on space-limited surgeries too.

- In many cases, these healthcare professionals are deployed inappropriately. Nurses and practice pharmacists report working above their correct level of clinical responsibility, and there is controversy about the responsibilities given to physician associates.

- Looking at the characteristics of practices around the country, it is also clear that clinical need isn't the sole driver of how medical teams are configured. A lower number of GPs and clinical staff per patient is associated with higher deprivation levels, lower funding and more non-white patients.

- Furthermore, there is no suggestion that things are improving. Many professionals in general practice don't see themselves still being there in five years' time.

- There are national plans to improve training and retention for all healthcare practitioners in primary care, and these are essential. But these plans all fall short; the training expansion hasn't accounted for an increase in training capacity. Meanwhile, moves to improve retention will fail if the day-to-day work in general practice is not improved, yet this can only be remedied through an expansion in the workforce.

- ICBs have tried to respond, but admit their ability to improve the problems is limited. The number of unemployed GPs should help PCNs and practices in dire need of staff with their recruitment problems. But unemployment and vacancies often don't overlap in a geographical sense. Some GPs face moving long distances for work but many have personal commitments that prevent this – indeed, for some, the flexibility of general practice for family life was the attraction in the first place. Equally, the funding available often isn't enough to tempt GPs to the areas of most need.

Recommendations

1 **More funding**

By now it is abundantly clear that the underlying crisis is one of funding, with severe knock-on effects on staffing and employment. There are staff available, and there are positions that need filling. The main barrier is the funding to pay for this. This has come from years of 2% funding increases at a time of huge inflation and more expenses. Successive governments have rarely delivered on promises to shift more funding into primary care. The one time this did happen to a significant degree – when the 2004 GP contract was first implemented – led to the modern golden age of general practice. There is no way of improving recruitment without more money. Wes Streeting's commitment in December 2024 is welcome, but with the increase in employer National Insurance contributions and the previous below-inflation increases, it is unlikely to be enough.

2 **More funding to deprived practices**

The way core practice funding is distributed needs to be reviewed. Currently the Carr-Hill formula, which dictates the baseline funding each practice receives per patient, doesn't take

enough account of deprivation, despite its adverse effects on health. As a result, deprived practices have less funding than those in more affluent areas that have an older population. This increases inequalities, in part by the effect on staffing levels.

There is a new major GP contract being negotiated, which is likely to be implemented in three to four years' time – GPC England has set a deadline for implementation as '2028 at the latest'.[156] This might completely overhaul the way practices are funded – potentially even move away from paying them based on the number of patients they have. Regardless, there must be a funding mechanism that passes a greater share of the budget to practices in deprived areas.

3 Remove restrictions from the ARRS

The introduction of GPs to the ARRS this year was a positive move but the effects are limited. There is uncertainty about long-term commitments and PCNs are only allowed to employ newly qualified GPs. But such restrictions no longer make sense. When the ARRS was first introduced, there was some justification for limiting the roles PCNs could employ, to protect other areas of the NHS from having staff taken away. The scheme originally promoted only those professions where there was deemed to be a surplus of staff (although community pharmacy has said that the inclusion of pharmacists has had a detrimental effect on that sector).

The time has come to give general practice owners free rein on who they now employ. Everyone agrees a strong general practice is essential for the NHS to function. If this requires a shift in staff, then so be it. There is also no reason this should be funnelled through primary care networks. It might be that practices feel this is the best way to organise themselves – but there is no reason it should be compulsory.

As well as increasing core funding and removing the restrictions on a staff reimbursement scheme, the Government should also consider increasing the proportion of the overall funding that is ringfenced for staffing costs. Governments have been reluctant to increase funding for practices in the past because they fear headlines about partners keeping the money for themselves. Increasing the ringfenced proportion would negate any such worries, and remove any concerns around increasing funding when it is necessary.

Again, Mr Streeting's announcement around practice nurses being added to the ARRS is welcome. But all restrictions should be removed from the scheme.

4 Expand premises and encourage training

The 2024 Budget committed £100m for expanding the premises of 200 practices. How this will be allocated has yet to be decided. But the majority of GP premises need to be improved. Pre-2015 buildings didn't take into account the expansion of non-GP roles that began around then; many practices are unable to accommodate new staff, whether that be GPs, nurses or other healthcare practitioners.

This has implications for long-term plans to increase the workforce, especially in terms of training. Training of any staff can't take place without the physical space. But alongside this, fresh incentives are needed for experienced staff to become trainers. Again, this may only be possible when the workforce is increased.

5 Promote general practice as a flexible career

It is true that one big reason for the fall in numbers of fully qualified full-time equivalent GPs is that more are working less than full time. But instead of seeing this as a weakness, all parties need to see it as a strength. The way to mitigate a shortfall of full-time GPs is to have a greater number of GPs coming into the system, and an effective way of doing this is to actively promote the positive elements of the job, such as flexible working.

Such a strategy might have implications for continuity of care. But continuity has been most affected by the lack of full-time GPs. With enough GPs – even working less than full time – strategies can be put in place to promote continuity. But without sufficient numbers, continuity will be impossible.

6 No short cuts

These proposed measures may seem obvious, and the biggest question is undoubtedly where the necessary funding will come from. But there are no short cuts to improving general practice workforce problems. Minor initiatives are no doubt well meaning, and may well bring about positive changes for a small number of practices. But they will not address the structural issues around the general practice workforce.

The fact that we have a recruitment problem and an unemployment problem running in tandem should be seen as a positive, because it provides fresh hope that we do have the staff available. But solving these twin crises will require a comprehensive, properly funded strategy. The time for sticking-plaster initiatives is over.

Scan the QR code to find all the references and methodology on the Cogora website or visit **tinyurl.com/cogworkforcerefs**

About Cogora

Cogora is one of the UK's leading data-led healthcare professional engagement and marketing services groups. At the heart of the business is a rich first party data set of more than 500,000 healthcare professionals spanning primary and secondary care in the UK and internationally. Through our market-leading brands and educational platforms, covering a range of therapy areas, we have cultivated and grown engaged communities of healthcare professionals, learning what they do, think and really need.

We pride ourselves on seamlessly integrating multiple data sets – first- and third-party data sources – to meticulously target and segment audiences according to our clients' unique requirements. This allows us to serve more relevant content, delivering impactful education and high-quality care to patients, resulting in further growth in engagement – all in a continuous loop. This audience-centric, data-led approach enhances our analytical capabilities, and insight into our community.

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Technology could play a pivotal role in reducing the strain on the primary care workforce

This report outlines key challenges in ensuring equitable access to healthcare. As primary care faces significant pressures from increasing demand, there is a risk of over-reliance on the workforce to meet these needs. By rethinking the role of existing and emerging digital technologies, we empower patients to access services more appropriately. This makes it possible to mitigate inappropriate demand on general practice and free up clinical capacity to focus on patients with more complex health needs.

Communities in deprived areas, often with high ethnic diversity, face an array of health and access disparities. These areas not only experience elevated rates of chronic illness and mental health issues but are also disproportionately impacted by shortages of GPs. Demand continues to outpace capacity, even in less deprived areas, and as a result, primary care services are having to be more reactive than proactive, increasing reliance on emergency services and driving up costs.

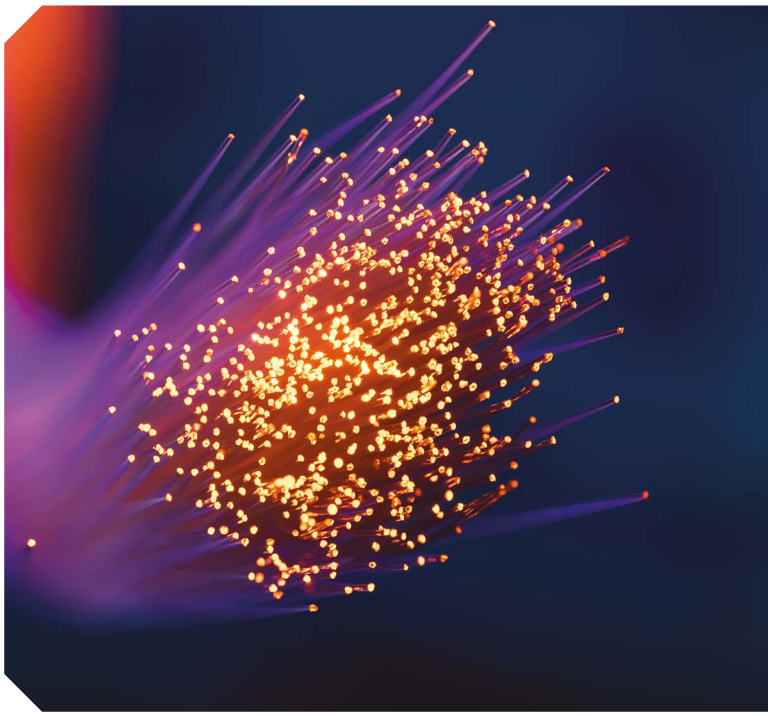
The difficulty in attracting clinicians to these high-need areas further intensifies these challenges. Under-resourced practices often experience higher turnover and burnout, creating a cycle that strains both patients and providers.

Digital poverty adds an additional barrier for many patients, limiting their ability to use online health resources and self-service options designed to reduce demand on primary care. This makes it harder for patients to access the very tools in place to provide faster, more convenient care.

Addressing these challenges requires making the most of existing digital infrastructure. We believe that by integrating technologies like cloud telephony, unified communications, and AI-enabled healthcare tools, practices can alleviate the pressure on GPs and other clinicians. These tools offer a streamlined approach to demand management, encouraging patients to self-serve for non-urgent needs while enabling clinicians to focus on more complex, preventive care. This shift supports better patient outcomes and helps balance demand across primary care services.

Remote or digital GP roles can also be highly effective in these contexts, especially when 'space in the surgery' is a barrier to recruitment. Unified communication systems and secure cloud-based telephony that are fully integrated into clinical systems, enable practitioners to facilitate phone and video consultations from anywhere. This approach requires minimal additional resources and provides patients with convenient access to care without needing to visit a practice in person.

Cloud-based telephony and unified communications solutions offer a cost-effective entry point to digital healthcare, especially



for those with limited internet access or digital literacy. By integrating voice and text interactions with online health systems, and offering translation services, these technologies create an inclusive digital pathway, making healthcare more accessible for diverse communities. This bridge between phone and online services helps patients become familiar with digital tools in a more gradual and supportive manner.

The continued crisis in recruitment invites the idea that existing technology can play a pivotal role in improving patient outcomes and reducing the strain on the primary care workforce when used well. While we accept that systematic change requires more, such as incentives for clinician recruitment in high-need areas, support for automated care navigation, and AI-powered triage, embracing technology would make a difference today. By harnessing available digital tools, practices can relieve some of the immediate pressures on the primary care workforce.

This article was provided by X-on Health who are a commercial partner of this white paper

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Methodology

Data Dashboard

The Cogora Data Dashboard was built using official data from 22 different official sources for general practice. The dashboard contains around 250 pieces of data for each practice in England. This includes data around patient demographics, appointments, funding, deprivation levels, QOF scores, disease prevalence, and CQC ratings among many others.

These data sources are (file names in brackets):

- General Practice Workforce – NHS England Digital (General Practice – Practice Level – Detailed.csv)
- Using CQC data – Care Quality Commission (CQC_Latest_ratings.xlsx)
- GP and GP practice related data – NHS England Digital (ePCN; epraccur.csv)
- Appointments in General Practice – NHS England Digital (GPAD_Annex1_Practice_Level_Breakdown_Summary.xlsx)
- Survey and Reports – GP Patient Survey (GPPS_Practice_results_(weighted).xlsx)
- Patients Registered at a GP Practice – NHS England Digital (gp-reg-pat-prac-all.csv; gp-reg-pat-prac-quin-age.csv; gp-reg-pat-prac-sing-age-female.csv; gp-reg-pat-prac-sing-age-male.csv)
- NHS Payments to General Practice, England 2022/23 – NHS England Digital (nhspaymentsgp.csv)
- Primary Care Network Workforce – NHS England Digital (Primary Care Networks – Individual Level.csv)
- Quality and Outcomes Framework – NHS England Digital (includes overall domain achievements, and all the disease areas: qof-prac-dom-ach.xlsx; qof-prev-ach-pca-cv-prac.xlsx; qof-prev-ach-pca-hd-prac.xlsx; qof-prev-ach-pca-ls-prac.xlsx; qof-prev-ach-pca-ms-prac.xlsx; qof-prev-ach-pca-neu-prac.xlsx; qof-prev-ach-pca-resp-prac.xlsx; qof-prev-ach-pca-vi-prac.xlsx)

The dashboard is updated monthly, and for this report, we pulled out the data on 15 December 2024, with all the data fully up to date at that point.

For the purposes of this report, we excluded all practices that had a blank value for number of patients, and blank value for numbers of GPs/nurses/direct patient care staff at a practice level.

We treated much of this data to provide more accuracy when discussing practice characteristics, as below.

Calculating staff at a practice level

To assign the number of GPs, nurses, direct care staff and overall clinical and non-clinical staff, we needed to combine the total practice staff with a share of the primary care network staff.

The PCN element of the staffing on a practice level was calculated by assigning PCN employed staff to practices, based on their member practices' relative patient list size within the PCN. This is imperfect, but we felt this was the best solution.

For each staff group, we used full time equivalent figures. Total numbers of GPs and nurses within the practice level and PCN level datasets are self-evidential, except:

For GPs, we used FTE excluding trainees. (TOTAL_GP_EXTG_FTE (column CJ of the General Practice Workforce dataset).

We counted job titles 'Nurse Dispenser', 'Nurse Specialist' and 'Advanced Nurse Practitioner' under nurses.

We counted the following job titles as 'direct patient care' in both the practice-employed and PCN-employed datasets. (We appreciate there is an element of subjectivity in this).

- Advanced Dietician Practitioner
- Advanced Occupational Therapist Practitioner
- Advanced Paramedic Practitioner
- Advanced Pharmacist Practitioner
- Advanced Physiotherapist Practitioner
- Advanced Podiatrist Practitioner
- Applied Psychologist – Clinical
- Applied Psychologist – Clinical (Mental Health Practitioner – Adult)
- Clinical Associate in Psychology
- Community Mental Health Nurse
- Community Mental Health Nurse (Mental Health Practitioner – Adult)
- Community Mental Health Nurse (Mental Health Practitioner – Children and Young People)
- NHS Talking Therapies Therapist
- Nursing Associate
- Paramedic
- Pharmacist
- Physician Associate
- Physiotherapist
- Podiatrist

Deprivation decile

We gave every practice an average deprivation score using the Patients Registered at a GP Practice, October 2024 – NHS England Digital dataset (Patients Registered at a GP Practice – October 2024: LSOA 2021 (all-persons-male-female)), which assigns all patients in a GP practice to a 'Lower layer Super Output Areas (LSOAs)'. We then matched LSOA codes to this data set: English indices of deprivation 2019 - GOV.UK, File 1: index of multiple deprivation, IMD2019 tab, Index of Multiple Deprivation (IMD) Decile (column F)

Calculated average score by multiplying the number patients in LSOA by each LSOA IMD score, then totalling practices' overall score and dividing by total number of patients.

Based on their average scores, we assigned each practice into a decile.

Payments per patient decile
We worked out total payments per weighted patient based on their total NHS income minus reimbursement funding. We then put each practice in a decile, based on the average payments per weighted patient.

Added together these funding pots:
- Global Sum
- MPIG Correction factor
- Balance of PMS Expenditure
- Total QOF Payments
- Childhood Vaccination and Immunisation Scheme
- GP Extended Hours Access
- Influenza and Pneumococcal Immunisations
- Learning Disabilities
- Meningitis
- Minor Surgery
- Out Of Area in Hours Urgent Care
- Pertussis
- Rotavirus and Shingles Immunisation
- Services for Violent Patients
- Medical Assessment Reviews
- Weight Management Service
- Local Incentive Schemes
- Seniority
- Doctors Retainer Scheme Payments
- Appraisal - Appraiser Costs in Respect of Locums
- Prolonged Study Leave
- PCO Admin Other
- Information Management and Technology
- Non DES Item Pneumococcal Vaccine, Childhood Immunisation Main Programme
- General Practice Transformation
- PCN Participation
- Prescribing Fee Payments
- Dispensing Fee Payments
- Winter Access Fund
- Other Payments

We counted these as reimbursable costs, so they did not factor into the calculations:
- Premises
- Total locum allowances
- Reimbursement of drugs

Divided this payment by 'average patients', then placed each practice into a decile.

Ethnicity decile
We placed practices in deciles based on what percentage of patients described themselves as '% White – English, Welsh, Scottish, Northern Irish or British' in the GP Patient Survey.

Surveys
We surveyed the readerships of our primary care titles using the SurveyMonkey tool:
- 966 GPs responded for Pulse (including 293 GPs who said they had a say in decisions made by their primary care network for Pulse PCN);
- 540 practice managers responded for Management in Practice;
- 552 practice nurses responded for Nursing in Practice;
- 274 pharmacists responded for The Pharmacist, including 128 who work in general practice, 127 who work in community pharmacy and 19 who work in both;
- 15 primary care directors of ICBs who we were able to verify responded to an anonymous survey for Healthcare Leader.

The surveys were open between 19 September and 18 October 2024 and were advertised to our readers via our websites and email newsletters, and promoted by the relevant professional bodies. Respondents were entered into a prize draw for vouchers as an incentive to complete the survey. The survey was unweighted, and we do not claim this to be scientific – only a snapshot of the populations.

Anyone who stated they were not from the relevant professional groups received a disqualification message immediately, and were not counted towards the total number of respondents. We also removed those who were obvious spam.

For the purposes of this report, we only counted those respondents from England, although respondents from the other three nations in the UK are included in the totals above.

For the 'Joint Pulse/Management in Practice survey', we included one respondent per practice. We asked all respondents to supply their practice code. If they supplied one that was inaccurate, we searched their practice name and then their name to find their practice code. For duplicates, we firstly removed those who supplied fewest answers; second, those who put the most 'don't knows' for the relevant questions; if this did not differentiate them, we removed the GP partner answers first; then whichever respondent responded first.

If you have any queries about the methodology, or want to know more about the Data Dashboard, please contact Jaimie Kaffash, Editor in Chief, Pulse at jaimiekaffash@cogora.com

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