**RECRUITMENT OF GENERAL PRACTITIONERS:**

**TIME TO TAKE ACTION FOR THE FUTURE WORKFORCE**

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**Objective:** This paper is produced by the authors for discussion at GPC in April.  It is intended that this document, with comments from the wider GPC, will inform the ‘Future of General Practice’ work stream.

**The time has come to declare that the workforce gaps in General Practice have reached crisis point. As younger members of GPC who achieved their CCTs under nMRCGP and who serve the GP Trainees Subcommittee, we felt a scoping paper written from the perspective of the ‘next generation’ and produced in the run up to the 2014 Conference of LMCs, could provide a mandate on behalf of the wider GPC membership for the Future of General Practice work stream to take forward, and to focus the negotiating position of the Executive Officers.**

Across the UK there is a clear need for more general practitioners, and the gaps that are visible should be a concern for government, the profession and patients alike. In 2012 there were recommendations that the number of GP training posts in England needed to increase from 2,700 to 3,250 by 2015. Unfortunately the latest recruitment figures show that despite an increased number of training places being made available, there was a significant drop in the number of applicants for GP training for 2014. This year across the UK only 5559 applications were received at round 1 of the selection process, which is the lowest number of applications to GP training in the UK since 2009[[1]](#footnote-1).

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Number of  applicants | | | Number of vacancies | | Number of  appointable candidates | | Fill Rate | | Total number of posts accepted |
| Round 1 | | Round 2 | Total | England only | Round 1 | Round 2 | Total | England only |
| Total | England only |
| 2015 |  |  |  |  | 3250 |  |  |  |  |  |
| 2014 | 5559 | TBC | TBC | 3486 | 2896 | TBC | TBC | TBC | TBC | TBC |
| 2013 | 6031 | 5231 | 863 | 3316 | 2816 | 3760 | 262 | 91% | 93% | 3237 |
| 2012 | 5915 | 5094 | 1424 | 3206 | 2687 | 3322 | 310 | 98% | 99% | 3152 |
| 2011 | 5590 | 4752 | 1144 | 3187 | 2672 | 3197 | 384 | 99% | 99% | 3144 |
| 2010 | 5654 | 4802 | 1468 | 3319 | 2732 | 3251 | 470 | 100% | 100% | 3372 |
| 2009 | 6200 | 5066 | 670 | 3342 | 2719 | 3410 | 175 | 96% | 96% | 3213 |

The first round of recruitment is what will largely determine how many posts are filled for each annual intake and the data about applications provide an early indication of what to expect: the latest figures suggest grave problems lie ahead. Immediate measures are required to address the recruitment and retention into general practice.

A significant barrier to wider understanding of the extent of the recruitment problem is the lack of a clear release schedule for recruitment data. Recruitment data following each stage of specialty training is released by the National Recruitment Office for GP training (GP NRO) to a number of organisations including Health Education England (HEE), and the Committee of GP Educational Directors (COGPED). We would like to see better communication between the NRO and GPC to allow us to help acting on recruitment data.

Within the GP workforce are a known large number of GPs approaching retirement age, but what is less known is the loss of an unpredicted number of GPs who are choosing to leave the profession in the UK. The retirement bulge will occur over the next few years; but in combination with current poor recruitment and concerns over a ‘brain drain’ the result will be a significant shortfall of GPs, a scenario that could be described as a ‘perfect storm’. There is also an unwelcome lack of certainty in responses to advertisements for partnerships and sessional roles. Overall the picture would suggest that practices around the UK are unable to recruit and replace GPs. We are dismayed at the deleterious effect of poor recruitment on the stability of practices and patient care. The remaining workforce will face an increasingly uncertain future and an unpleasant and unsustainable present. The effects on patients and profession alike will be catastrophic.

Who do we expect will be applying for General Practice Specialty Training in the future? Efforts that would use social engineering to mould the career choices of prospective medical students are a moot point, and years away from bearing fruit. Even so, medical schools have a responsibility to help match the aspirations of students to the needs of the future healthcare systems within which their students will be practising. The solution is not a simple turning on of a switch, but a complex, multifactorial change in culture and strategy within the NHS and government, to recognise the clear problem facing us all and implementing action with both immediate and longer-term effect.

Discussions about sustainable models of general practice should be a priority. We must try to retain those elements that have allowed general practice to be so adaptable and responsive to the needs of the people we provide care for. In an ever-evolving healthcare environment the independent contractor model has been at the heart of general practice’s flexibility and innovation, which has been vital for affordable NHS care. Governments of the past and present haven’t always appreciated the wide variety of activity occurring in general practice, and some legislation has had the effect of undermining efforts of GPs. The truth is that corporate bodies will want to fill the gap if practices start to fail. In turn, practices will fail if the profession itself loses confidence in its own future.

We outline below, some key areas where GPC has a central role to play in defending its constituents, while working to increase the appeal of general practice as a viable career option with allied organisations where appropriate:

1. ***Workload:*** We are aware of alarming increases in the level of stress felt by GPs while striving to deliver an effective service for patients. Almost half the GPs who responded to the recent GPC survey revealed that increasing workloads and rising pressures were becoming unmanageable or unsustainable “all of the time”[[2]](#footnote-2). Rising demand and the increasing provision of care delivered outside the hospital model means this crisis will only deepen. Patient safety is being compromised by unreasonable and unsafe demands being made of the profession. The single biggest issue reported by general practitioners is increased workload, driven by rising patient demand but without being matched by a proportionate increase in resources. In England, over 300 million consultations took place in general practice in 2009, over 80 million more than in 1995[[3]](#footnote-3). Today, many GPs report they have never known a time when the workload was so intense, and morale so low. The downward pressure on GP income has reached a nadir where the very infrastructure of practices is under threat. When practices fail to recruit, they are often forced into reducing the services that they offer to their patients. This is in no one’s best interests.
2. ***The 2004 Contract was negotiated over a decade ago:***  The commonly held misconception that the BMA managed to ‘get one over’ the Labour government in the creation of the 2004 contract, is an albatross that has hung around our collective neck with an annual tightening of the noose ever since. Despite repeated attempts to convince the media and Secretary of State for Health that the waiting times in accident and emergency are not solely a result of the contract changes placed upon family doctors a decade or so more before, and that GPs do provide 24 hour care, the rhetoric and propaganda does not seem to have changed significantly. The 2004 contract has become the whipping boy *de nos jours*. Again this is a matter of demonstrable respect for the profession and it is time for the government to display honesty and address the increasing pattern of underfunding in general practice compared with the NHS budget as a whole. The individual blaming of GPs must stop. Show respect to general practice and more will want to be a part of it, and share in its pride and value.
3. ***Working pattern preferences have changed:***  The younger generation of GPs have different expectations to our predecessors. Flexible career options are now essential to being able to attract and retain new doctors to the profession. Partnerships are no longer seen as the end point of a career in general practice, but now resemble an overburdened path due to the increased workload, bureaucracy and financial responsibility and uncertainty. Increased funding could assist practices to take on new GPs. Full time practice has lost its appeal among both men and women alike: sessions spent in portfolio roles offers both variety and ways of preventing burnout. The message needs to be clear that general practice needs a balance between both sessional GPs and GP principals. Younger GPs are hesitant to enter into partnerships in times of such financial instability, and yet what they fear most is a future where the only option is to be salaried to a corporate body. Where will the goodwill of the partners working over a hundred hours a week go then? Graduates from the 21st century will usually come encumbered with student loans and tuition fees, set against inflated house prices and the knowledge that their pensions will not deliver what was originally promised. This naturally creates a financially risk averse demographic, who prioritise quality of life in the present and balancing family responsibilities, often in dual professional households, against slaving away at ten sessions a week, for a lifestyle that is beyond their reach in any case. In essence we must expect the working patterns of the future will be different from those that have gone before.
4. ***The GP Training*** ***Curriculum needs to change and become fit for purpose:*** It can be argued that those of us who followed the nMRCGP curriculum left training woefully underprepared for life post-CCT as an independent ‘GP’. This curriculum focuses purely on the clinical to the detriment of the practical. Many young GPs cite a lack of readiness as a reason they wish to defer joining partnerships following the completion of their training. The transition from Specialty Registrar to locum or principal for example, is a challenge to many and may partially explain the high dropout rates in the early years post-CCT. The GP speciality training programme needs to be planned to suit the challenges facing a 21st century GP, who is only part clinician, but also manager; commissioner; employer; negotiator; educator and book keeper. The majority of GP training programmes currently have a clear focus on the clinical aspects of general practice and merely pay lip service to the administrative and management aspects of the job. These skills are essential for tomorrow’s GPs but instead of these being developed, these important aspects are taking a back seat, when they should be seen as the very life-blood of the sustainability of the role. It is often only after exit from training that people realise the importance of exposure to management aspects of practice. Generally speaking, training experiences are highly variable and often depend upon local enthusiasm and LMCs making attempts to engage their trainees. If the curriculum better represented the place of business skills and strategy in healthcare, this might attract recruits from other specialties who were not aware of the multiplicity and variety of challenges that GP brings. The issue of how the extension to training will be focused has been addressed in other GPC papers, although we should highlight the less discussed issue of a ‘fallow’ year where fewer GPs would exit training, temporarily compounding the already bleak environment of recruitment.
5. ***The Work: Life balance has been lost:*** Year on year, GPs are being asked to do more for less. Until recently a major part of the appeal of general practice, has been a perceived chance to have a positive work/life balance. Before entering GP specialty training many young doctors have enjoyed relatively fixed hours and a reasonably stable wage. Neither is guaranteed in GP partnership. As the levels of demand reach saturation, it is no wonder that part time clinical working has become acceptable to the majority of young GPs. The demand of a whole time commitment is not sustainable at this current level of intensity in the short term, let alone over a career of decades, without a significant risk of burnout. There is only so much ‘leftward shift’ and unfunded, unsustainable workload that general practice can take. If the workforce is pushed too far, then the generation who rent because they cannot afford to buy, will have the flexibility to simply pack up and head to pastures where GPs can work in more autonomous, stable environments. This is a common trend already, with many UK trained GPs leaving for Canada and the Antipodes in alarming numbers. British GPs see much more complexity and variety than their continental counterparts. The time has come to recognise us as a specialty in our own right, and to bring some pride back into the profession which has been denigrated as ‘just a GP’ from time immemorial: the easiest specialty in which to underperform and the hardest in which to practice well.
6. ***The GP of the future: female, flexible, fecund, formidable.***  Unfortunately, a minority of the profession believe difficulties have arisen on account of the increasing number of women in the workforce. The composition of our profession has changed and there are more female doctors now than ever before. Comparisons with how things looked in the past need to be meaningful, not nostalgic. These are capable individuals who we dismiss at our peril. It is time to start respecting the new workforce. Young women GPs may reasonably expect maternity entitlements and it is essential that GPC negotiates these reimbursements, for example affording principals at least parity with their GMS salaried counterparts, or else we stand to lose out on the talents of female partners. A partnership can provide the right conditions for more flexibility in one’s working arrangements and that will appeal to many. How is a female GP who chooses to work six sessions a week to give herself a balance in the duties of motherhood, for example, a burden to her practice any more so than a male partner who has additional portfolio roles outside of the surgery? We need to create environments where the new generations of both male and female GPs seeking different ways of working can flourish. Create more opportunities for flexibility and start that by engaging with this demographic and listen to what they say. A dedicated piece of work needs to be commissioned to explore the multifactorial complexities behind why 40% of female GPs have left the profession by age 40. Focus on the many ready-trained GPs who are prevented from returning into practice due to unnecessarily obtuse constraints placed upon their working arrangements. Support our returners and retainers: we need them to work. If Health Education England cannot be persuaded to reinstate the programme of workforce analysis – commission our own.
7. ***Reduced investment, increased work, rock bottom morale:*** By far the most important factor underpinning all the problems discussed thus far is underinvestment in general practice. We need more than nominal percentages or pilots affording temporary gimmicks to the minority of the UK population: substantial investment in premises must happen if all the GP surgeries in the country are to be brought up to a standard expected by 21st century Britain. Invest in education, GP training and support returners. All these cost money and in times of austerity it is not easy to find that money. But to choose not to invest will risk a greater loss of UK qualified GPs. The recent BMA GPC survey found that a staggering 6 in 10 GPs were “actively considering” leaving the profession. We are at a watershed moment.
8. ***GP ‘bashing’ is part of the recruitment problem:*** We welcome scrutiny by health journalists. Unfortunately there are some stories appearing in the media with anecdotal, often sensationalist reports of poor performance. We are saddened that there are even certain elements of the press that will persistently denigrate and criticise GPs without this bringing any benefits to patients. We need to challenge the expectations and perceptions presented in the media and celebrate the amazing work the overwhelming majority of the UK’s 63,000 GPs do every day. The perpetual ‘GP bashing’ only serves to fuel the flames and adversely impact an already burnt-out workforce. We have reached situation critical, and concentrating on a decade old contract and the incomes of the top 0.1% of GP earners is both irresponsible and foolhardy.

**Summary**

UK general practice is admired throughout the world but years of underfunding have caused untold damage. It is lost to the NHS at its peril. The hospital workforce has benefited greatly from a significant increase in the number of consultants over the last two decades. What the commissioners of medical education and training have failed to prepare for is the high volumes of continuing care that GPs will provide for complex patients and running complex businesses in an ever competitive environment.

The GP workforce crisis, which has been talked about in worried, hushed tones for the last few years, has finally arrived in 2014. We now have a demonstrable fall in applications for general practice specialty training, which has become the least popular speciality second only to psychiatry. Falling fill rates, low morale, increasing workload and resignations have found us at a tipping point. The time has come to embolden the profession and demand respect for UK general practice that is long overdue. We must start listening to tomorrow’s workforce to continue the path of innovation that has served us so well in the past, if we are to get out of this crisis and lead into the future.

It is still not too late to act. The government needs to back general practice, and show support now and in the run up to the next general election. It cannot afford not to. The profession has a window of opportunity. Without drastic steps of action taken now, UK general practice will suffer permanent damage. The impending 2014 Conference of LMCs will no doubt galvanise grass roots’ opinion further. It would be prudent for GPC to ready itself in terms of making preparations for an informed response demonstrating that it has awareness, foresight and is primed to act.

The time to act is now.

We therefore call on GPC to prioritise the work stream on GP recruitment, and commence a sustained campaign to inform public and political awareness of the issues highlighted above.

1. General Practice National Recruitment Office & HEE MWAG Specialty Recruitment Update, Feb 2014 [↑](#footnote-ref-1)
2. BMA GPC online workforce survey, 26 March 2014 [↑](#footnote-ref-2)
3. Health and Social Care Information Centre, Trends in consultation rates in general practice, 2 September 2009 [↑](#footnote-ref-3)