



**Securing the Future GP Workforce
Delivering the Mandate on GP Expansion**

GP TASKFORCE FINAL REPORT

March 2014

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Letter to Ian Cumming, Chief Executive Health Education England

Dear Ian

The GP Taskforce was established by Medical Education England (MEE) and the Department of Health (DH) to recommend how the system could achieve the longstanding workforce target for 3,250 trainees to enter GP training in England each year by 2015. To meet the terms of reference of the GP Taskforce (Appendix 2), this report identifies the blocks to progress, as well as considering other key factors affecting the overall size of the GP workforce, namely retention and retirement rates.

We have reviewed the evidence supporting the workforce target of 3,250, and whether this target remains valid when set against the forthcoming NHS England Review of Primary Care Services, and the need to develop wider community and primary care capacity and capability.

We offer a series of recommendations for realising the target, as well as recommending the review and promotion of GP “returner” schemes. Many of the recommendations will be welcomed by Health Education England and NHS England, but some are very challenging and will need very serious evaluation and then concerted and co-ordinated commitment to implement. However, the independent Taskforce has concluded that the recommendations we make are essential to secure the future GP workforce supply upon which the sustainability of our NHS depends.

Just before this Taskforce produced its final report, the Shape of Training Review (SOT) was published.¹ If our recommendations are implemented, the enhancement of GP training together with more flexible training pathways (as envisaged in the SOT review) should also be early deliverables.



Simon Plint, Chair of GP Taskforce

The statistics and recommendations in this report refer to England, unless specifically stated otherwise, but we hope that the recommendations will be useful for all UK nations.

¹ Shape of Training: securing the future of excellent patient care – final report of the independent review led by Professor David Greenaway (Autumn 2013)

Acknowledgements

I would like to acknowledge all the stakeholders of the GP Taskforce (see Appendix 2) for identifying the priorities for the review, but in particular I need to thank my colleagues Ben Brown, John Howard, Bill Irish, Mark Purvis and Abdol Tavabie for their expertise and dedication leading their individual workstreams, the members of the Steering Group for their commitment and guidance, especially Liz Hughes the Lead Dean for her personal support, and not least Fran Mead in the secretariat.

Executive Summary

Despite the longstanding Department of Health policy to increase GP training numbers in England to 3,250 per annum, GP recruitment has remained stubbornly below this target, at around 2,700 per annum, for the last four years. This cumulative recruitment shortfall is being compounded by increasing numbers of trained GPs leaving the workforce, most significantly GPs approaching retirement, but perhaps more worryingly women in their 30s. GP recruitment and retention is a much bigger problem in some parts of the country and often in those areas which have the worst health outcomes.

General Practice delivered around 309 million consultations in 2008 representing 90% of NHS contacts.²³ Securing the supply of healthcare professionals to meet this demand now and into the future is vital: even a marginal shift of patients away from primary to secondary care would put the whole healthcare system under unmanageable pressure.

GP numbers – the policy position

It has been the policy of successive UK governments to address the challenge of the growing healthcare needs of our ageing population by transferring care into primary and community settings.⁴⁵ To facilitate this shift, the DH has sought to increase the numbers of doctors training in General Practice. This policy has been reaffirmed in the Health Education England Mandate (2013) which sets the target of 50% of medical students becoming GPs by 2015.⁶ The Centre for Workforce Intelligence (CfWI) GP In-depth Review 2014 also concluded that increasing GP training numbers to 3,250 was a valid objective and reported that the existing workforce was under considerable strain and lacked the capacity to meet either current or future expected patient needs.⁷

The current situation

Having reviewed the evidence, the GP Taskforce fully endorses the DH policy to train more GPs.

The outcome of the review arising from the consultation by NHS England Review of Primary Care (Improving General Practice – A Call to Action) may well have fundamental implications for the future model of General Practice, along with the urgency of developing primary care

² Gregory S. General Practice in England: An overview. 2009. Briefing. Kings Fund.

³ QResearch 2008 and HSCIC 2012 surveys

⁴ Department of Health. Primary Care Delivering the Future. 1996.

⁵ Department of Health. The new NHS: Modern, dependable. 1997

⁶ Department of Health. Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2013 to March 2015. May 2013

⁷ Centre for Workforce Intelligence. GP In-Depth Review. 2014

nursing capacity and overall community and social care infrastructure.⁸ Nonetheless, the Taskforce has concluded that there is a GP workforce crisis which must be addressed immediately even to sustain the present role of General Practice in the NHS, let alone enable it to expand and meet the growing healthcare needs of our population, irrespective of future models of care.

The Taskforce considers it unfortunate that whilst there has never been a greater need for information about GP activity and workload, the last national survey of GP workload was undertaken back in 2007, and there is no longer any national vacancy reporting.

Disturbingly, evidence is also emerging from the NHS Information Centre that the GP workforce is now shrinking rather than growing. Whilst the number of GPs per 100,000 head of population across England increased from 54 in 1995 to 62 in 2009, it has now declined to 59.5.⁹ Just as concerning is the unequal distribution of these GPs across the country: areas of high deprivation, where healthcare needs are typically greater, have fewer GPs per head than the UK average. The Taskforce notes reports of the increasing problems patients are experiencing accessing GPs, a recent RCGP survey of GP workload reported that 85% of GPs consider the situation unsustainable.¹⁰ It is most concerning to note that 54% of GPs over the age of 50 are intending to quit direct patient care within five years.¹¹ There are also a disproportionate number of older GPs nearing retirement in the more densely populated urban areas, areas where unmet health needs are already a national concern.

Finally the GP workforce demographic is changing: we identified that 65% of GPs currently in training are women – and 40% of women who leave practice each year are under the age of 40, and we simply don't know how many of them rejoin the workforce.¹² There is an increased trend for both men and women to work part time and be salaried. So increases in headcount do not translate into increases in whole time equivalent GPs.

Reasons for the problem

There are multiple factors underlying the apparent inability to achieve the longstanding targeted expansion of GP training numbers.

⁸ NHS England, Improving General Practice – A Call to Action August 2013

⁹ NHS Staff 2002-2012. 2012. The Health and Social Care Information Centre.

¹⁰ RCGP 2013 <http://www.rcgp.org.uk/news/2013/june/85-percent-of-family-doctors-say-general-practice-in-crisis.aspx> Accessed 31.7.13

¹¹ Seventh National GP Worklife Survey. Mark Hann, James McDonald, Kath Checkland, Anna Coleman, Hugh Gravelle, Bonnie Sibbald, Matt Sutton <http://www.population-health.manchester.ac.uk/healthconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf> Accessed 30.9.13

¹² The Information Centre: NHS Staff 2002-2012. 2012. The Health and Social Care Information Centre

In 2013, GP specialty training had the third lowest competition ratio of all specialties, and even after a second round of recruitment, vacancies remained unfilled. Over the last 20 years, only 20-30% of UK graduates have indicated General Practice as their unreserved first career choice, with disproportionate numbers indicating their preference for over-subscribed hospital-based specialties.¹³ However, General Practice is often a 'tied' or a 'back-up' career choice. This suggests that if General Practice could be promoted more effectively as a career at school, throughout medical school and into foundation training, career preferences and recruitment levels might be improved.

Another major factor is a lack of training capacity; the number of doctors training in General Practice placements has more than doubled since the introduction of the foundation programme and the lengthening of GP specialty training placements from a minimum 12 to 18 months in 2006. Although the DH funded a £100m capital investment programme to develop training capacity in 2009, the system based on the trusted one to one apprenticeship model is now reported as saturated.¹⁴

Pressures on capacity are exacerbated by two significant developments in recent years: the increasing numbers of doctors requiring extensions to their training (around 15% in their final year); and the growing proportion of less than full-time trainees (around 15%) occupying a full-time placement, because of the challenge for practices of managing more than one trainee in one training 'slot'. Furthermore, although the proportions of less than full-time trainees are evenly distributed around the country, the rates of extensions are disproportionately concentrated in LETBs with higher proportions of international medical graduates – one LETB reported a 40% exam failure rate over recent years with around 20% requiring extensions – some LETBs have been forced to operate waiting lists for extensions to training.¹⁵

These capacity pressures are mirrored by financial pressures. The system – having already absorbed the costs of financing foundation placements, the lengthening from 12 to 18 months in General Practice, and the growing number of extensions to the three year training programme arising from remediation training – is now under considerable financial pressure. Secondly, the cost of fully supporting a GP trainee's employment costs, together with the GP trainer's grant, is perceived as comparatively expensive. Even though GP training is currently only three years, compared with up to eight years in other specialties, and it costs

¹³ Lambert T and Goldacre M. Trends in doctors' early career choices for General Practice in the UK: longitudinal questionnaire surveys. *BJGP*. 2011; 61: 397-403.

¹⁴ GP Taskforce COGPED census 2013

¹⁵ John Howard. Personal Communication.

the tax-payer less than half as much to train a GP than a consultant, there is a view that GP training costs are unsustainable.¹⁶

Solutions

First and foremost General Practice needs to be promoted as a positive career choice, starting in schools, and then through Medical Schools and Foundation Programmes. This will need a professionally-led marketing strategy to target a wide-range of audiences, including the general public, to promote a realistic and positive image of General Practice.

There is an imbalance between the level one entry numbers into hospital specialty training and GP training; in 2013, 4100 (60%) doctors entered hospital specialty training compared with 2800 (40%) doctors into GP training. The Health and Education National Strategic Exchange (HENSE) was commissioned by the government in 2011 to review whether current levels of medical and dental student intakes were in line with predicted workforce requirements. HENSE recommended that the number of students accepted to medical school should be reduced by two percent in England.¹⁷ The models suggested that demand for GPs would outstrip supply but that hospital doctors' supply would exceed demand, unless "rebalancing" from other specialties to General Practice occurred.

Unless the number of hospital specialty entry training opportunities is reduced, the Taskforce believes the system will not achieve the necessary expansion of the numbers of General Practice trainees.

The overall applicant pool is not big enough to support GP expansion without a proportionate reduction in specialty training numbers. At the time of publication of this report, although GP vacancies for 2014 have increased by 200, there has been no corresponding net reduction in the numbers of specialty posts, and GP applications are down by 15% compared with the previous year. The Taskforce believes these statistics highlight the direct connection between the total numbers of training posts in hospital specialty and GP, and underpin the key recommendation.

A reduction in specialty training numbers would be consistent with Government policy to shift care away from hospitals, with an accompanying shift of education investment. This will require an extremely sensitive and co-ordinated approach, within appropriate timescales, to

¹⁶ Curtis L, Unit Costs of Health and Social Care 2013, PSSRU, available www.pssru.ac.uk/project-pages/unit-costs/2013 accessed 27.1.2014

¹⁷ The Health and Education National Exchange (HENSE). Review of Medical and Dental School Intakes in England. November 2012

enable the reconfiguration of specialty training programmes to maintain quality placements and service delivery. The scale of the service reconfiguration needed cannot be underestimated, but we believe is necessary to ensure an overall NHS medical workforce with the right numbers in the right places, capable of meeting the developing needs of the population.

The Taskforce recommends that Health Education England should work together with NHS England to address the health inequalities which are linked to unequal distribution of GP trainees and trained GPs across the country. We believe there may be a case for differential financial allocations and incentive schemes to attract trainees and qualified GPs to work in 'under-doctored' areas.

General Practice should address the issue of training capacity not just for GPs but for the wider primary care workforce by developing federated models of training, where a number of primary care providers come together for multi-professional placements with block training approval given for the system. This model enables inclusion of current non-training providers, and the report gives examples of how this has encouraged the development of common training environments for different professional groups, which has been effective for increasing both GP trainees and student and practice nurse training capacity.

We recommend that research is undertaken to identify why doctors leave General Practice early, including whether current employment conditions are fit for purpose, and what are the barriers to their returning to practice. We believe that nationally funded GP Retainer and Returner schemes make good economic and strategic sense, and will improve retention of the workforce. We recommend that NHS England should seek consensus on the threshold for assessing a doctor's eligibility for re-inclusion on the Performers' List, and explore whether there can be flexibility in the managed return to practice. We also recommend developing innovative schemes to retain doctors considering retirement, for example via a "Twenty Plus" scheme to complement the RCGP 'First Five' programme for newly qualified GPs, and suggest that NHS England should consider the reintroduction of the Flexible Careers Scheme as a model for retaining doctors seeking to reduce their clinical commitment.

Summary of Recommendations

See pages 40 - 49 for full recommendations

The Taskforce recommends a professionally-led marketing strategy targeting a wide-range of audiences including the general public, to promote General Practice as an attractive and positive career choice to sixth formers, medical students and foundation doctors.

Undergraduate medical schools should be incentivised to increase the proportion of their graduates selecting GP (and other shortage specialties) as first choice careers, but without disadvantaging medical schools which already train more future GPs. **(9) (11)**

The Taskforce has identified major gaps in workforce information needed to underpin effective workforce planning. We reconfirm the recommendation of the Centre for Workforce Intelligence (CfWI) that the GP workload survey must be urgently re-commissioned, along with a more effective vacancy survey. We welcome the adoption by Health Education England of a simple existing workforce replacement ratio metric to assure security of future workforce supply. **(1)**

The Taskforce recommends an interim target of 3,050 GP training ST1 entry points for 2014 (an increase of 250), with a corresponding decrease of 250 hospital specialty training numbers and the final target of 3,250 GP training ST1 entry points achieved by 2015, requiring a further increase of 200 GP numbers and corresponding reduction of 200 hospital specialty training numbers. **(14) (15)**

The Taskforce recommends the long term target for GP training numbers is reviewed following publication of the NHS England Review of Primary Care - Improving General Practice – A Call to Action, along with the long term target for hospital specialty numbers. Health Education England will need to review whether further increases in GP training numbers, or further decreases in hospital specialty training numbers, should be made to achieve the 50-50 balance in the Health Education England mandate, but the Taskforce suggests the numbers should be evidence-based on future workforce need rather than on relative ratios. **(16)**

The Taskforce recommends the end-point of expansion should be the allocation of trainees on a weighted population capitation basis, which will also require that financial allocations to Local Education and Training Boards (LETBs) should be on a weighted capitation basis. Consideration should be given in the short-term to prioritising expansion in under-doctored areas, or incentivising trainees to train in under-doctored areas; both of these strategies would require differential allocation of financial resource to under-doctored areas. **(17)**

LETBs should review the capacity of their existing educational infrastructure to support further GP expansion. LETBs should explore the development of models such as the federated practice model to increase multi-professional placement training capacity, facilitate the management and supervision of multiple trainees more efficiently, and add value for other health professionals in primary care. The Taskforce recommends local LETB capital investment programmes (of around £10-20k per project) to recruit and develop new GP training capacity, based on the DH Advanced Practice Programme. **(24) (25)**

The Taskforce recommends research is undertaken to identify why doctors leave General Practice early and what are the barriers to their returning to practice. The Taskforce believes nationally funded Induction and Refresher (Returner) and Retainer schemes make good economic and strategic sense, and need to be refocused to support workforce provision and development in under resourced areas. This should involve collaborative work between NHS England and Health Education England. **(5) (4) (6)**

The system must design and develop specific schemes to support GPs approaching retirement age to encourage ongoing engagement in the GP workforce, for example a ‘Twenty Plus’ scheme to complement the RCGP ‘First Five’ programme. NHS England should consider the reintroduction of the Flexible Careers Scheme, and review whether the current employment model in General Practice is fit for purpose for all career stages. **(7) (8)**

GP Workforce - Overview

Policy Background

It has been the policy of successive UK governments to address the challenge of the growing healthcare needs of an ageing population, and to bring care closer to patients, by investment in primary and community care.¹⁸¹⁹²⁰²¹²²²³²⁴²⁵²⁶

More recently, the Health Education England Mandate has confirmed the present government's commitment to expand GP training numbers with the long-term recruitment target of 50% of specialty trainees choosing to enter General Practice training following Foundation Programme training.²⁷

General Practice in England

"Our analysis of the available evidence on the demand for GP services points to a workforce under considerable strain. The existing GP workforce has insufficient capacity to meet current and expected patient needs." **Centre for Workforce Intelligence, 2013**

General Practices are the first point of call and most frequent provider of services for most users of the NHS. General Practice delivers 309 million consultations a year representing 90% of NHS contacts.²⁸

A marginal percentage shift from primary care to secondary care has the potential to overwhelm other parts of the NHS. There are around 22 million contacts a year in A&E in England, and even a tiny percentage shift of the General Practice consultations to A&E

¹⁸ Department of Health. Primary Care Delivering the Future. 1996

¹⁹ Department of Health. The new NHS: Modern, dependable. 1997

²⁰ Department of Health. The NHS plan: A plan for investment A plan for reform. 2000, Department of Health

²¹ House of Commons Health Committee (2007) Workforce Planning: Fourth Report of Session 2006-07

available <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171i.pdf>

²² Department of Health. Our health, our care, our say: a new direction for community services: A brief guide 2006 Department of Health

²³ Department of Health. Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2013 to March 2015 2013 Department of Health Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203332/29257_2900971_Delivering_Accessible.pdf Accessed 31.7.13

²⁴ NHS Workforce Review Team. Workforce Summary - General Practitioners: 2008 NHS Workforce Review Team

²⁵ Department of Health. Next Stage Review: A High Quality Workforce. 2008 Department of Health

²⁶ Hansard 2012 NHS; General Practitioners, questions asked by Lord Laming to Earl Howe, the Parliamentary Under-Secretary of State, Department of Health. Available at

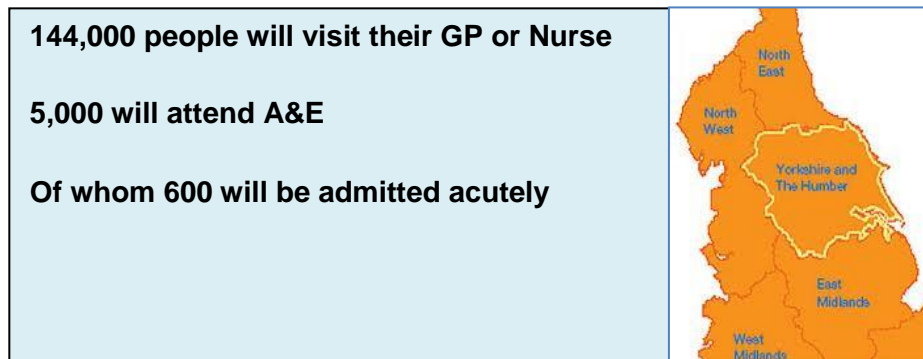
<http://www.publications.parliament.uk/pa/ld201213/ldhansrd/text/120523-0001.htm> Accessed 31.7.13

²⁷ Department of Health. Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2013 to March 2015. May 2013

²⁸ HSCIC Survey 2012-13

would be unmanageable. There is a significant risk to the entire NHS if we are unable to maintain security of supply of the primary care workforce.

Figure 1: Typical Day in Yorkshire and the Humber SHA 2008²⁹



Demand for GP Services

General Practice is the bedrock of the NHS. Good access to high quality primary care is essential for a cost effective, high quality NHS that meets the needs of the population.³⁰

International studies have shown that better supply of primary care doctors is associated with lower all-cause mortality and reduced health inequalities.³¹

Most presenting conditions are managed in primary care without referral to other parts of the NHS.³² Long term conditions and complex multi-morbidity are increasingly managed in primary care. Even when care is delivered by other parts of the NHS, care is often co-ordinated from General Practice which provides patients a 'medical home' in the communities where they live.

The largest growth in General Practice patient contacts has been witnessed in the elderly population. This segment of the population has grown 80% over the last six decades and is set to grow further. The number of people aged 65 and over is forecast to increase by 23 per cent from 10.3 million in 2010 to 12.7 million in 2018, and to reach 16.9 million by 2035.³³

Elderly patients have multiple morbidities with increasingly complex needs. This group of patients makes increasing demands on primary care. 85-89 year olds in 2008 had a median consultation rate of 14 per person per year, up from 6.8 per person per year for the same

²⁹ Mark Purvis. Personal Communication.

³⁰ Starfield B. Is primary care essential? *Lancet* 1994; 344(8930): 1129–1133.

³¹ Starfield B., Shi L. and Mackino J. Contributions of Primary Care to Health Systems and Health. *The Millbank Quarterly* 2005; Vol 83, No. 1, pp457-502

³² RCGP. The 2022 GP: Compendium of Evidence. 2013 Royal College of General Practitioners

³³ Rutherford T. Population Ageing Statistics. 2012. House of Commons Library Standard Note. SN/SG/3228

age band in 1996.³⁴ At age 75, 50% of the current population have three or more long term conditions. It is expected that by 2025, 18 million people in England will have at least one long term condition.³⁵

General Practice currently offers comprehensive coverage of the population, most of the population is able to register with an NHS GP. The small proportion of the population which is unregistered with a GP consumes a disproportionate amount of secondary care resource, and suffers worse health outcomes than patients registered with a GP. For example, homeless people each consume an estimated eight times more hospital inpatient services than an average person of similar age. Compared to the general public, they are 40 times more likely not to be registered with a GP and have about five times the utilisation of A&E services. 81% of GPs interviewed by Crisis, the charity for single homeless people, thought that it was more difficult for a homeless person to register than the average person.³⁶

Failing to secure the future GP workforce supply is therefore likely to have a disproportionate impact on hard to reach parts of the population who already have difficulty accessing primary care.

Supply of GP Services

General Practice has historically achieved high patient satisfaction and public trust ratings. However, the indications are that an increasing workload is compromising access to primary care. The Patients Association notes recent reports of increasing difficulties accessing primary care and states that: “almost two thirds of people (61%) have to wait longer than forty eight hours to book an appointment with their GP and more than half (57%) said the process was either ‘very difficult’ or ‘could have been easier’.”³⁷ This is reinforced by General Practitioners themselves, who report that they are working under increasing pressure. A recent GP survey reported: “85% of family doctors say General Practice is ‘in crisis’ and half say they can no longer guarantee safe patient care”.³⁸

³⁴ The Information Centre: Trends in consultation rates in General Practice 1995/6 to 2008/9: analysis of the QResearch® database. 2009 London: QResearch® and the Health and Social Care Information Centre and <http://www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf>

³⁵ Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet* 2012; published online May 10. DOI:10.1016/S0140-6736(12)60240-2.

³⁶ Social Exclusion Task Force. Inclusion health: Improving the way we meet the primary health care needs of the socially excluded. 2010. Cabinet Office and Department of Health

³⁷ The Patients Association. Primary Care: Access Denied? 2013 http://www.patients-association.com/Portals/0/PCR_Vol-II%20%28Access%20Denied%29_Final.pdf accessed 31.7.13

³⁸ RCGP 2013 <http://www.rcgp.org.uk/news/2013/june/85-percent-of-family-doctors-say-general-practice-in-crisis.aspx> Accessed 31.7.13

Increasing numbers of unfilled GP posts

With the suspension of the Health and Social Care Information Centre GP vacancy survey, we are reliant on vacancy data from elsewhere.

A snapshot survey in February 2013 of 220 practices, covering around 950 full-time positions, suggests that the number of unfilled GP posts has gone up fourfold in the last two years: “The results showed vacancy rates of 7.9% of all GP posts in January 2013 – almost double the 4.2% figure from the previous year’s survey in January 2012, which itself was twice the DH baseline figure of 2.1% from the last survey in 2010”.³⁹

This is reflected in qualitative evidence from GPs and providers of GP services.

GP, Surrey: “I have found it difficult to fill vacancies recently. The quality of applicants and the number has definitely fallen.”

“It is a sellers’ market. There have been instances where applicants have been offered another job at the same time elsewhere and it has become an arms race to get that applicant in the post by offering as attractive a proposition as possible.”

Provider in Hull: “I have been unable to fill one of our GP posts in Hull for two years.”

Large multi-site APMS provider: “I have difficulty filling GP posts in deprived areas...we offer the most competitive terms and conditions yet applicants expect higher pay than advertised and a half day off site for personal development each week.”

A survey of recently qualified doctors, undertaken by the Royal College of General Practitioners, showed that all 98% of doctors seeking employment were working, with many reporting that they were being asked to work more sessions than they wanted.⁴⁰

A situation of rising vacancies, positions remaining vacant for considerable periods of time, and virtually full employment among GPs points towards a general imbalance of supply and demand – a situation that is likely to push up labour costs and also create disturbing regional disparities in the provision of care.

Growing labour costs

As vacancies have risen the costs of labour, in particular locum labour, has also increased. A survey of 213 practices reported: “an average increase in locum fees of 9.5% during 2012,

³⁹ Kaffash J GP vacancy rates quadruple in two years. 2013. Pulse. Available at <http://www.pulsetoday.co.uk/your-practice/practice-topics/employment/gp-vacancy-rates-quadruple-in-two-years/20002034.article#.Ufkkn6xVKCI> Accessed 31.7.13

⁴⁰ Ashridge Communications Survey of GPs gaining a CCT between 1.8.11 and 9.5.13. Unpublished. Royal College of General Practitioners.

slightly up on the 9% increase seen in 2011.⁴¹ Some 59% of respondents said that they had seen locum costs rise during 2012, with 13% saying locum costs had risen by 25% or more". The World Health Organization cites rising labour costs, full employment of new entrants to the workforce and rising vacancy rates as indicators of workforce undersupply.⁴²

Access to GPs: local and regional differences

A recent paper reviewing the relationship between GP access and A&E attendance, concludes that moving practices from the lowest quartile access score to the highest quartile access scores could reduce A&E attendances by 111,739 in England.⁴³ There is a variation in availability of GPs of more than 40% between the most under doctored areas and the areas with most GPs. Our most under doctored areas tend to be those with most deprivation, and therefore with the highest incidence of health inequalities.⁴⁴ The Centre for Workforce Intelligence analysis shows that GP coverage is especially critical in the North West and North East, but there are localised areas underserved across the country.⁴⁵ These areas correspond with the recently published Public Health England heat map of reduced life expectancy.

Urban deprived areas are also more likely to have lower GP coverage and an older workforce than suburban, less deprived areas. GP workforce supply is therefore inversely related to population healthcare need, a phenomenon first described in 1971 by Julian Tudor Hart as the "inverse care law".⁴⁶

⁴¹ Lind S Practice locum costs rise 9.5% in a year. 2013. Pulse. Available at <http://www.pulsetoday.co.uk/your-practice/practice-topics/employment/practice-locum-costs-rise-95-in-a-year/20001676.article#.UfkkzaxVKCl> Accessed 31.7.13

⁴² Zurn P, Dal Poz M, Stilwall B and Adams O. Imbalances in the health workforce, briefing paper. 2002. World Health Organisation

⁴³ Cowling TE, Cevil EV, Sojak MA, Lee JT, Millett C, et al Access to Primary Care and Visits to Emergency Departments in England: A Cross-Sectional, Population Based Study. 2013 PLoS ONE 8(6) e66699

⁴⁴ Goddard M, Gravelle H, Hole A, Marini G. Where did all the GPs go? Increasing supply and geographical equity in England and Scotland. 2010. Journal of Health Services Research & Policy Vol 15 No 1, 2010: 28–35 available at: <https://www.york.ac.uk/media/che/documents/papers/WheredidalltheGPsgo.pdf> Accessed 31.7.13

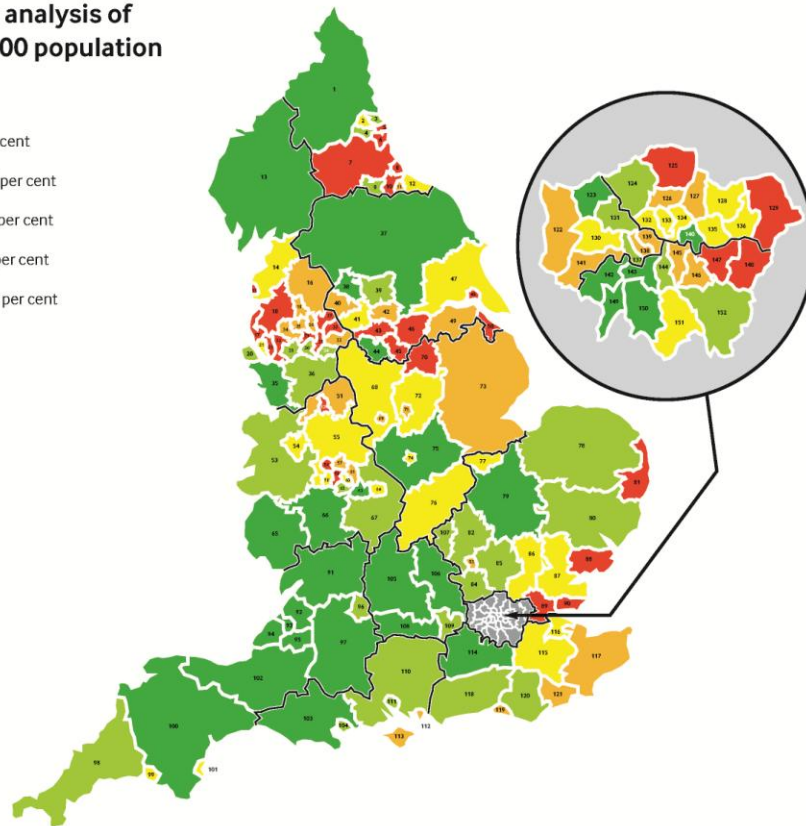
⁴⁵ Centre for Workforce Intelligence. GP In-depth review. 2014

⁴⁶ Julian Tudor Hart. The Inverse Care Law. 1971 The Lancet, Volume 297, Issue 7696, pages 405-412

Figure 2: PCT Map of GPs per 100,000 of Population

Local quintile analysis of GPs per 100,000 population (headcount)

- PCTs in top 20 per cent
- PCTs in second 20 per cent
- PCTs in middle 20 per cent
- PCTs in fourth 20 per cent
- PCTs in bottom 20 per cent



Source: HSCIC (2013) reproduced with permission CfWI
***Excluding GP locums, registrars and retainers**

Practice Nurse Workforce

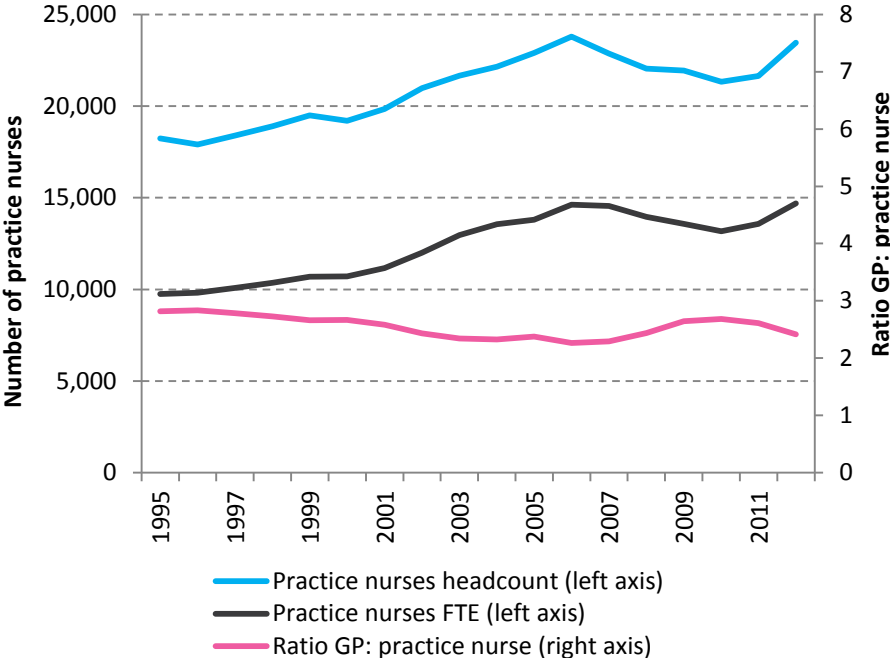
One third of General Practice face-to-face contacts are undertaken by practice nurses. The number of practice nurses in General Practice peaked in 2006, and 20% of practice nurses by LETBs across the country.⁴⁷ With growing demand for nurses in the acute sector, and the potential for an outflow of nurses from the UK, it is of concern to find 20% of current practice nurses or advanced nurse practitioners are likely to retire in the next 5 years.⁴⁸ There is little experiential learning with regard to primary care (long term conditions, health education and health promotion) for student nurses, most of whom do not currently have any primary care placements. Furthermore there is no career structure in primary care nursing and no established conversion courses for nurses leaving secondary care to move in to primary care. There is, therefore, as much concern about the future capacity and capability of

⁴⁷ GP Taskforce COGPED census

⁴⁸ Peter Sharp. The role of nurses in delivering integrated healthcare: workforce implications. Centre for Workforce Intelligence. 2012

nursing in primary care, as there is for the capacity of GPs to deliver an equitable service in the medium term.

Figure 3: Practice Nurse Headcount, FTE and GP:Practice Nurse Ratio



Source: HSCIC (2006, 2012 and 2013) reproduced with permission CfWI

The work of Barbara Starfield has demonstrated that a wide skill mix within primary care facilitates the delivery of high quality and comprehensive health care interventions across a registered population. Increasing the team working within the current model of primary care importantly reduces health care inequalities and reduces overall mortality within a population.⁴⁹ The current unmet need in the population, thought to be perhaps 40% of morbidity, could be addressed through the provision of alternative access points within practices, and also the promotion of increased access to community pharmacists.⁵⁰

Imbalanced growth GPs and Consultants

In the September 2012 NHS workforce census, there were 35,578 trained GPs (headcount) and 40,393 Consultants (headcount). There were 2,814 level one entry posts for GP training compared to 4,143 level one entry posts for a Consultant medical career.⁵¹ The ratio of level one entry points to CCT holders suggest that we are replacing 7.9% of the GP workforce annually compared to 10.3% of the Consultant workforce replaced annually.

⁴⁹ Starfield B., Shi L. and Mackino J. Contributions of Primary Care to Health Systems and Health. The Millbank Quarterly 2005; Vol 83, No. 1, pp457-502
⁵⁰ Department of Health, Primary Care Delivering the Future. 1996
⁵¹ Health Education England. Medical Workforce Advisory Group. 2014

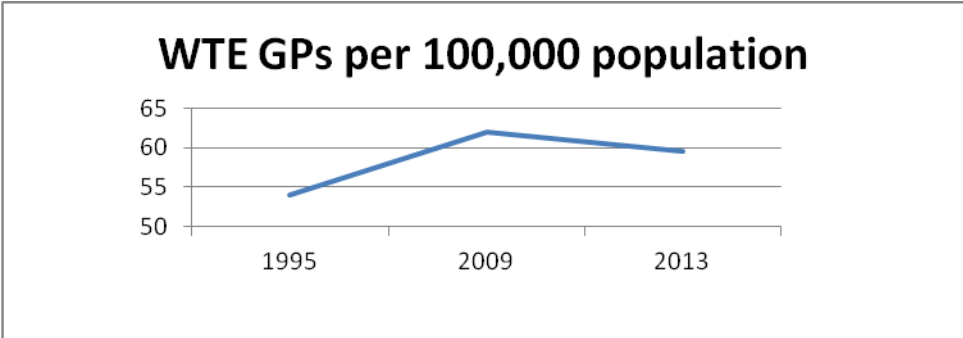
The Centre for Workforce Intelligence observes that there has been unbalanced growth in the England NHS medical workforce since the mid 1990's, with consultants more than doubling between 1995 and 2012, whilst the GP workforce only increased by 21%.⁵²

GP Retention

The Taskforce has identified major problems in retaining doctors in the primary care workforce.

The most significant but the least visible is the movement away from full time working, which means that although the overall headcount of GPs may appear to be increasing, the critical whole-time equivalent (WTE) workforce is actually decreasing. The number of WTE GPs per 100,000 registered patients in England increased from 54 in 1995 to 62 in 2009, but has now declined to 59.5.⁵³

Figure 4: Whole-time Equivalent GPs per 100,000 population



The National GP Worklife Survey, independent research commissioned by the Department of Health, has been looking at GP working conditions via regular surveys since 1998. The seventh survey, published in August 2013, reports the lowest levels of job satisfaction among GPs since the start of the series, with 36.5% of the current GP workforce hoping to reduce their workload.⁵⁴

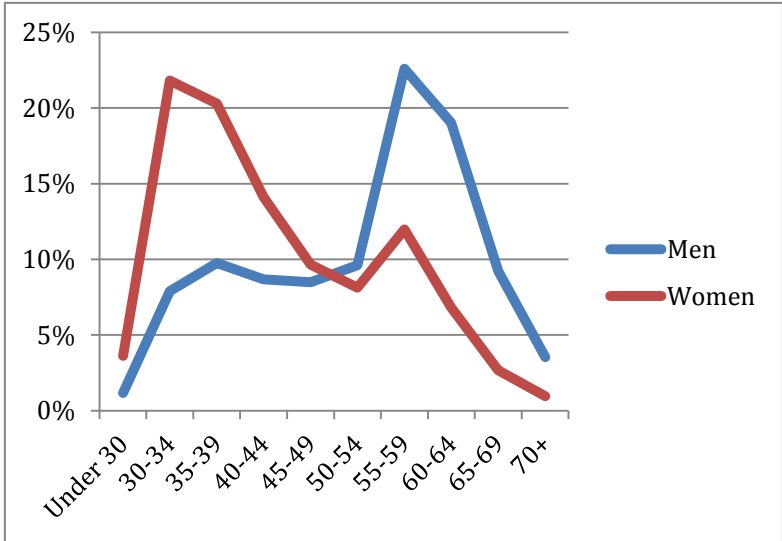
The survey also reported a substantial increase in the number of GPs intending to quit the NHS over the next five years. This number has been increasing over the last ten years, but the most concerning statistic is the 40% proportion of the women who leave the GP workforce each year who are under the age of 40 (around 400 doctors each year).⁵⁵ There is no subsequent bulge in the figures for joiners, suggesting that these doctors are lost

⁵² Centre for Workforce Intelligence. GP In-depth Review. 2014
⁵³ The Information Centre: NHS Staff 2002-2012. 2012. The Health and Social Care Information Centre
⁵⁴ Mark Hahn, James MacDonald, and others, available: <http://www.population-health.manchester.ac.uk/healthconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf> accessed 22.9.2013)
⁵⁵ The Information Centre: NHS Staff 2002-2012. 2012. The Health and Social Care Information Centre

permanently to the workforce. There is an increasing trend amongst both men and women who stay to work less than full time and to be salaried.

Although many doctors have chosen General Practice as a career because of the perceived flexibility around work life balance (see page 23), the Taskforce questions whether the models of employment in General Practice are indeed flexible enough to facilitate retention of women with young families in the workforce. In the next section we will be exploring underlying issues and making recommendations for further work.

Figure 5: Age of Leaving GP Workforce in 2001-2010



Source: NHS Information Centre for Health & Social Care 2012

Returns

The Health and Social Care Information Centre shows that 1,123 GPs under the age of 50 (representing 3.5% of the total) left the GP workforce between 2011 and 2012, the majority of them were women, and an important minority were academic GPs.⁵⁶

The Taskforce recommends urgent research to understand the factors behind this major loss from the workforce, but has already identified concerns around the difficulties doctors perceive “returning” to practice. The RCGP and the BMA both gave evidence to the Taskforce that they considered this a major problem and a priority for the system to address.

Under the 2004 Performers’ List regulations, those with responsibility for local licensing must ensure that a doctor joining the workforce has the competences expected of a GP.⁵⁷ This

⁵⁶ The Information Centre: NHS Staff 2002-2012. 2012. The Health and Social Care Information Centre
⁵⁷ Statutory Instrument 2004 No. 585. The National Health Service (Performers Lists) Regulations 2004

was reiterated by the House of Commons Health Select Committee report following the inquiry into the Daniel Ubani case.⁵⁸ The NHS England operating procedure quotes guidance from the Committee of General Practice Education Directors (COGPED).⁵⁹⁶⁰ This recommends assessment of a doctor after two or more years' absence from NHS General Practice, prior to re-entry into the GP Performers' List, in line with published data that shows that a significant proportion of such doctors are unable to demonstrate the necessary competences for return to independent clinical practice.⁶¹

The assessment requires doctors to demonstrate they have maintained up to date clinical knowledge by passing a clinical knowledge test (standard set by a group of subject experts with educational experience of helping GP returners) alongside a simulated surgery assessment and interview with an experienced medical educator. GP Directors will make recommendations to the Medical Director responsible for the Performers' List either for re-inclusion or for a bespoke period of "refresher" training. NHS England states that refresher training should be mandatory for doctors who have been out of clinical General Practice for five years.

Refresher training is provided through the Induction and Refresher (I&R) Scheme, which is designed for GPs who have been out of UK General Practice for more than two years and who have failed the above assessments, or for EU doctors whose training in General Practice in their own country is recognised by the GMC, but who are unfamiliar with the NHS. The scheme allows for a programme of between six weeks and a six-month full-time equivalent attached to an approved training practice. The outcome is assessed through workplace based assessment.

The Taskforce heard representations that there is a catch 22 in the system, because normally training practices are approved to provide the refresher training, but there has been no hypothecated funding for the training since the NHS Returner Scheme funded by the DH ended in 2006. Some LETBs have been able to fund a trainer's grant for a practice taking on a returner; some have found funding for salaries for limited numbers of returners, but many returners have agreed to retrain without any salary, to the great concern of the BMA.

⁵⁸ Response to the House of Commons Health Select Committee report. The use of overseas doctors in providing out of hours services. Crown Copyright, 2010. www.official-documents.gov.uk/document/cm79/7904/7904.pdf (accessed 25 Jul 2013).

⁵⁹ NHS England Policy and Standard Operating Procedure for Governing the Inclusion, Movement and Maintenance of Medical Performers in the NHS England's National Primary Care Performer Lists. 2013

⁶⁰ COGPED GP Induction and Refresher / Returner Scheme updated 2012
[http://www.cogped.org.uk/document_store/1354027303tyet_cogped_induction_and_refresher-returner_schemes_\(revised_nov_2012\).pdf](http://www.cogped.org.uk/document_store/1354027303tyet_cogped_induction_and_refresher-returner_schemes_(revised_nov_2012).pdf)

⁶¹ British Journal of General Practice, February 2013 (Morison, Irish, Main)

Although the Taskforce established that Medical Directors responsible for the Performers' List support a two year cut-off for assessment, there were further representations that the time limit out of practice should be extended and that the requirement for placement in a training practice may be an unreasonable restriction of trade.

Interestingly, the Academy of Medical Royal Colleges (AoMRC) cites the COGPED "retraining scheme" as an example of best practice.⁶² It recommends that all doctors (including GPs) who have been out of practice for **three** months or more should undergo an individual evaluation and learning needs assessment, and when appropriate a managed process for return to practice, which should be more robust the longer doctors have been absent.

The GP Retainer Scheme

The GP Retainer Scheme was specifically designed to retain doctors in the workforce, typically women with young families. It offers a financial contribution to a practice, approved by the local LETB, to employ a "retained" doctor for up to five years supervised practice with protected time for CPD and work-based support. It is available to qualified GPs who, for personal reasons, are unable to work more than four sessions per week. After five years the retained GP assumes the role of an independent practitioner having maintained their knowledge and skills as a GP.

The problem with the scheme is that there is no longer any hypothecated funding, responsibility having been devolved to PCTs and now to Area Teams, with the result that the total numbers of retained doctors in England has decreased dramatically from 1,110 in 2002 to 321 in 2012.⁶³

Analysis of the costs and benefits of the GP Returner and GP Retainer programmes makes a very powerful case for return on investment from funding these schemes, comparing "cost per productive year of work" with the cost of training new doctors for General Practice.⁶⁴

There is an opportunity to re-design and re-package an England wide scheme that is properly recognised and supported which will be covered in the recommendations later in the report.

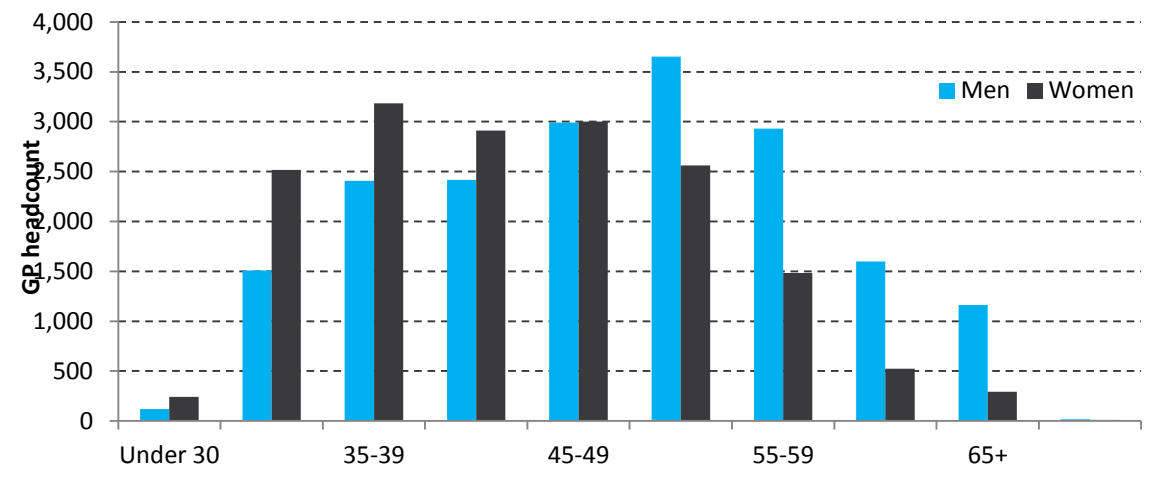
⁶² AoMRC Return to Practice Guidance April 2012

⁶³ NHS Information Centre Hospital and Community Health Service and General Practice Workforce 2012

⁶⁴ GP induction and refresher and retainer schemes: are they cost-effective? Harris M, Morison J and Main P. BJGP January 1, 2014 vol 64 no. 618 46-47

GP Retirement

Figure 6: GP Headcount by age band and gender 2012



Source: HSCIC (2013) reproduced by permission CfWI

22% of the GP workforce is over the age of 55. In some urban and deprived areas the percentage is as high as 40%. Two independent surveys report around 30% of all GPs intention to leave direct patient care within 5 years, including a rising trend of 54% of GPs over the age of 50, with the probability of under-doctored areas becoming even more disadvantaged.⁶⁵⁶⁶

Year	All GPs	GPs aged <50	GPs aged ≥50
1998	15.3%	5.6%	n/a
2001	23.8%	11.4%	n/a
2004	23.7%	13.1%	n/a
2005	19.4%	6.1%	41.2%
2008	21.9%	7.1%	43.2%
2010	21.9%	6.4%	41.7%
2012	31.2%	8.9%	54.1%

Source: 7th National GP Worklife Survey⁶⁷

⁶⁵ Health Policy and Economic Research Unit. National survey of GP opinion 2011. 2011. British Medical Association

⁶⁶ Mark Hahn, James MacDonald, and others, available: <http://www.population-health.manchester.ac.uk/health/economics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf> accessed 22.9.2013)

⁶⁷ Ibid

The drivers causing GPs to leave practice in their late fifties are a powerful combination of pension changes, perceptions about the new contract and medical revalidation, and the increasing volume, intensity and technical complexity of the job. These doctors describe being burnt out by “bureaucracy” and “workload”. However, most GPs who take their NHS pension before or at 60 still have much to contribute and many would be willing to continue to work if the circumstances were right.

The Taskforce has heard representations for the establishment of networks to support senior GPs (“Twenty Plus” groups), with proposals for tailored educational activities and matching senior clinical experience to local service needs; for example, GPs working with Emergency Medicine Departments, GPs with special interests, clinical work in Community Hospitals, or support for Nursing Homes to reduce inappropriate admissions. It was also proposed that there should be incentive payments for doctors who have retired to cover the professional costs of continuing to practise one or two days a week. In the longer term, it was suggested that a career pattern of perhaps 25 years as a settled GP will be preceded and followed by shorter spells in other primary care work.

The Taskforce will make recommendations later in the report for the reintroduction of the Flexible Careers Scheme which provided salary contribution and professional support for doctors working less than full time in General Practice.

GP Trainee Pipeline

GP National Recruitment Office data for the last five years show not only that target levels for vacancies have not been met, but just as importantly shortfalls in filling the vacancies. The cumulative shortfall in GP recruitment to replace the workforce is significant.⁶⁸⁶⁹

Table 2: GP Workforce Supply

Intake year	Applications	Vacancies	Accepted offers	Competition ratio	Fill rate
2009/2010	5,066	2,719	2,626	1.86	96.6%
2010/2011	4,802	2,732	2,800	1.76	102.5%
2011/2012	4,752	2,672	2,658	1.78	99.5%
2012/2013	5,094	2,687	2,669	1.90	99.3%
2013/2014	5,198	2,850	2,744	1.88	99.5%

Source: GP National Recruitment Office (2013) reproduced with permission CfWI

⁶⁸ GP National Recruitment Office Reports: Recruitment 2009, 2010, 2011, 2012. Available at <http://www.gprecruitment.org.uk/reports.html> Accessed 31.7.13

⁶⁹ Jaques H. Medical workforce is short of nearly 1000 GP trainees. 2012 BMJ Careers. available at <http://careers.bmj.com/careers/advice/view-article.html?id=20010122> Accessed 31.7.13

Insufficient numbers of Doctors want to become GPs

An insufficient number of UK medical graduates currently want to become GPs. In 2013, GP Specialist Training had the third lowest competition ratio of all specialties for its 2,850 training vacancies.⁷⁰ The 2014 recruitment round has seen a 15% reduction in the overall number of GP applications.⁷¹ In the UK, only around 20-30% of recent graduates indicate General Practice as their unreserved first choice career, a statistic that has remained relatively stable over the last 20 years.⁷²⁷³⁷⁴ Too many indicate preferences for over-subscribed hospital-based specialties, Switzerland, Canada, America, France and Greece have all described similar problems recruiting GPs.⁷⁵⁷⁶⁷⁷⁷⁸⁷⁹

According to Lambert *et al.*, 'many doctors simply do not consider General Practice as a career option in the first place'.⁸⁰ Perceived job content is the main reason for rejecting General Practice as a career (78% vs 32% in other specialties), whereas it is the main reason for choosing other specialties (73% vs 63% in GP). Those who do choose GP as a

⁷⁰ CfWI. GP In-depth review: Preliminary findings. London; 2013.

⁷¹ GP National Recruitment Office report to Health Education England. 2014

⁷² Svirko E, Goldacre MJ, Lambert T. Career choices of the United Kingdom medical graduates of 2005, 2008 and 2009: Questionnaire surveys. *Medical teacher* [Internet]. 2013 Jan 29 [cited 2013 Feb 5];1–11. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23360485>

⁷³ Jones L, Fisher T. Workforce trends in General Practice in the UK: results from a longitudinal study of doctors' careers. *The British Journal of General Practice : the Journal of the Royal College of General Practitioners* [Internet]. 2006 Feb [cited 2013 Aug 8];56(523):134–6. Available from:

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1828220&tool=pmcentrez&rendertype=abstract>

⁷⁴ Lambert T, Goldacre M. Trends in doctors' early career choices for General Practice in the UK: longitudinal questionnaire surveys. *The British Journal of General Practice : the Journal of the Royal College of General Practitioners* [Internet]. 2011 Jul [cited 2013 Aug 6];61(588):e397–403. Available from:

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3123502&tool=pmcentrez&rendertype=abstract>

⁷⁵ Buddeberg-Fischer B, Klaghofer R, Stamm M, Marty F, Dreiding P, Zoller M, Buddeberg C. Primary care in Switzerland--no longer attractive for young physicians? *Swiss medical weekly* [Internet]. 2006 Jul 8 [cited 2013 Aug 8];136(27-28):416–24. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/16862461>

⁷⁶ Bethune C, Hansen PA, Deacon D, Hurley K, Kirby A, Godwin M. Family medicine as a career option: how students' attitudes changed during medical school. *Canadian family physician Médecin de famille canadien* [Internet]. 2007 May [cited 2013 Aug 8];53(5):881–5, 880. Available from:

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1949175&tool=pmcentrez&rendertype=abstract>

⁷⁷ Biggs WS, Schmittling GT, Bieck AD, Crosley PW, Pugno PA. Entry of US medical school graduates into family medicine residencies: 2010-2011 and 3-year summary. *Family medicine* [Internet]. 2011 Oct [cited 2013 Aug 8];43(9):625–30. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/22002773>

⁷⁸ Lefevre JH, Roupret M, Kerneis S, Karila L. Career choices of medical students: a national survey of 1780 students. *Medical education* [Internet]. 2010 Jun [cited 2013 Aug 8];44(6):603–12. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/20604857>

⁷⁹ Mariolis A, Mihas C, Alevizos A, Gizlis V, Mariolis T, Marayiannis K, Tountas Y, Stefanadis C, Philalithis A, Creatsas G. General Practice as a career choice among undergraduate medical students in Greece. *BMC medical education* [Internet]. 2007 Jan [cited 2013 Aug 8];7:15. Available from:

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1899489&tool=pmcentrez&rendertype=abstract>

⁸⁰ Lambert T, Goldacre R, Smith F, Goldacre MJ. Reasons why doctors choose or reject careers in General Practice: national surveys. *The British Journal of General Practice : the Journal of the Royal College of General Practitioners* [Internet]. 2012 Dec [cited 2012 Dec 10];62(605):851–8. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23211266>

career do so because of expectations about working hours and conditions, the challenging variety of work, continuity of care, rewarding patient relationships, good work-life balance, and compatibility with domestic circumstances.^{81,82,83} Lifestyle factors are particularly important for female doctors, and are increasingly important for more recently qualified doctors.⁸⁴

Conversely, General Practice is the most popular 'back up' career choice after other specialties are rejected.⁸⁵ More recent medical graduates also tend to have more 'tied' first choice career preferences.⁸⁶ This suggests that if the attractions of General Practice are communicated more effectively, more graduates may be drawn to it.

Medical schools produce different proportions of doctors that are ultimately appointed to GP training – ranging from 11% at Cambridge to 39% at Keele [see Appendix 4 for table].⁸⁷ Undergraduate experiences appear to shape career choice; those who indicate GP as an unreserved career choice tend to have made their mind up by the end of undergraduate training, confirming this is an essential period to influence career choice.⁸⁸ Newer medical schools tend to produce more aspirant GPs than those of Oxbridge and London, and this is mirrored in GP Specialty Trainee appointment numbers when linked back to medical

⁸¹ Irish B, Lake J. When and why do doctors decide to become general practitioners? Implications for recruitment into UK General Practice specialty training. *Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors* [Internet]. 2011 Jan [cited 2013 Aug 9];22(1):20–4. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/21333127>

⁸² Watson J, Humphrey A, Peters-Klimm F, Hamilton W. Motivation and satisfaction in GP training: a UK cross-sectional survey. *The British Journal of General Practice : the Journal of the Royal College of General Practitioners* [Internet]. 2011 Oct [cited 2013 Aug 9];61(591):e645–9. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3177133&tool=pmcentrez&rendertype=abstract>

⁸³ Lloyd JR, Leese B. Career intentions and preferences of GP registrars in Yorkshire. *The British Journal of General Practice : the Journal of the Royal College of General Practitioners* [Internet]. 2006 Apr [cited 2013 Aug 9];56(525):280–2. Available from:

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1832236&tool=pmcentrez&rendertype=abstract>

⁸⁴ Lambert T, Goldacre R, Smith F, Goldacre MJ. Reasons why doctors choose or reject careers in General Practice: national surveys. *The British Journal of General Practice : the Journal of the Royal College of General Practitioners* [Internet]. 2012 Dec [cited 2012 Dec 10];62(605):851–8. Available from:

<http://www.ncbi.nlm.nih.gov/pubmed/23211266>

⁸⁵ Ibid

⁸⁶ Svirko E, Goldacre MJ, Lambert T. Career choices of the United Kingdom medical graduates of 2005, 2008 and 2009: Questionnaire Surveys. *Medical Teacher* [Internet]. 2013 Jan 29 [cited 2013 Feb 5]; 1-11. Available from : <http://www.ncbi.nlm.nih.gov/pubmed/23360485>

⁸⁷ UK Foundation Programme Office. National F2 Career Destination Survey (2012) <http://www.foundationprogramme.nhs.uk/index.asp?page=home/keydocs#fpar>

⁸⁸ Irish B, Lake J. When and why do doctors decide to become general practitioners? Implications for recruitment into UK General Practice specialty training. *Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors* [Internet]. 2011 Jan [cited 2013 Aug 9];22(1):20–4. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/21333127>

school.⁸⁹⁹⁰ The Taskforce has commissioned research in partnership with the Medical Schools Council to explore what factors may contribute to expressed career preference at the end of medical school training.

There is evidence to support clinical exposure to General Practice as a positive influence on career choice. Those who choose GP training are more likely to have undertaken a Foundation Programme including General Practice – though this does not necessarily imply causation.⁹¹ Research in the UK, Germany and Netherlands has suggested that more medical students choose General Practice as a career after undertaking it as a clinical attachment.⁹²⁹³⁹⁴

The proportion of doctors preferring a career in General Practice increases with time from qualification.⁹⁵⁹⁶⁹⁷ This may reflect changing clinical abilities such as comfort with clinical uncertainty – an essential competence for General Practice – but may also be due to perceived work-life balance issues rather than vocation to become a GP. The Taskforce has

⁸⁹ Svirko E, Goldacre MJ, Lambert T. Career choices of the United Kingdom medical graduates of 2005, 2008 and 2009: Questionnaire Surveys. *Medical Teacher* [Internet]. 2013 Jan 29 [cited 2013 Feb 5]; 1-11. Available from : <http://www.ncbi.nlm.nih.gov/pubmed/23360485>

⁹⁰ UK Foundation Programme Office. National F2 Career Destination Survey (2012) <http://www.foundationprogramme.nhs.uk/index.asp?page=home/keydocs#fpar>

⁹¹ Irish B, Lake J. When and why do doctors decide to become general practitioners? Implications for recruitment into UK General Practice specialty training. *Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors* [Internet]. 2011 Jan [cited 2013 Aug 9];22(1):20–4. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/21333127>

⁹² Deutsch T, Hönigschmid P, Frese T, Sandholzer H. Early community-based family practice elective positively influences medical students' career considerations--a pre-post-comparison. *BMC family practice* [Internet]. 2013 Jan [cited 2013 Aug 6];14:24. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3605291&tool=pmcentrez&rendertype=abstract>

⁹³ Howe A, Ives G. Does community-based experience alter career preference? New evidence from a prospective longitudinal cohort study of undergraduate medical students. *Medical education* [Internet]. 2001 Apr [cited 2013 Aug 9];35(4):391–7. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/11319005>

⁹⁴ Maiorova T, Stevens F, Scherpbier A, van der Zee J. The impact of clerkships on students' specialty preferences: what do undergraduates learn for their profession? *Medical education* [Internet]. 2008 Jun [cited 2013 Aug 9];42(6):554–62. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/18435712>

⁹⁵ Jones L, Fisher T. Workforce trends in General Practice in the UK: results from a longitudinal study of doctors' careers. *The British Journal of General Practice : the Journal of the Royal College of General Practitioners* [Internet]. 2006 Feb [cited 2013 Aug 8];56(523):134–6. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1828220&tool=pmcentrez&rendertype=abstract>

⁹⁶ Lambert T, Goldacre M. Trends in doctors' early career choices for General Practice in the UK: longitudinal questionnaire surveys. *The British Journal of General Practice : the Journal of the Royal College of General Practitioners* [Internet]. 2011 Jul [cited 2013 Aug 6];61(588):e397–403. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3123502&tool=pmcentrez&rendertype=abstract>

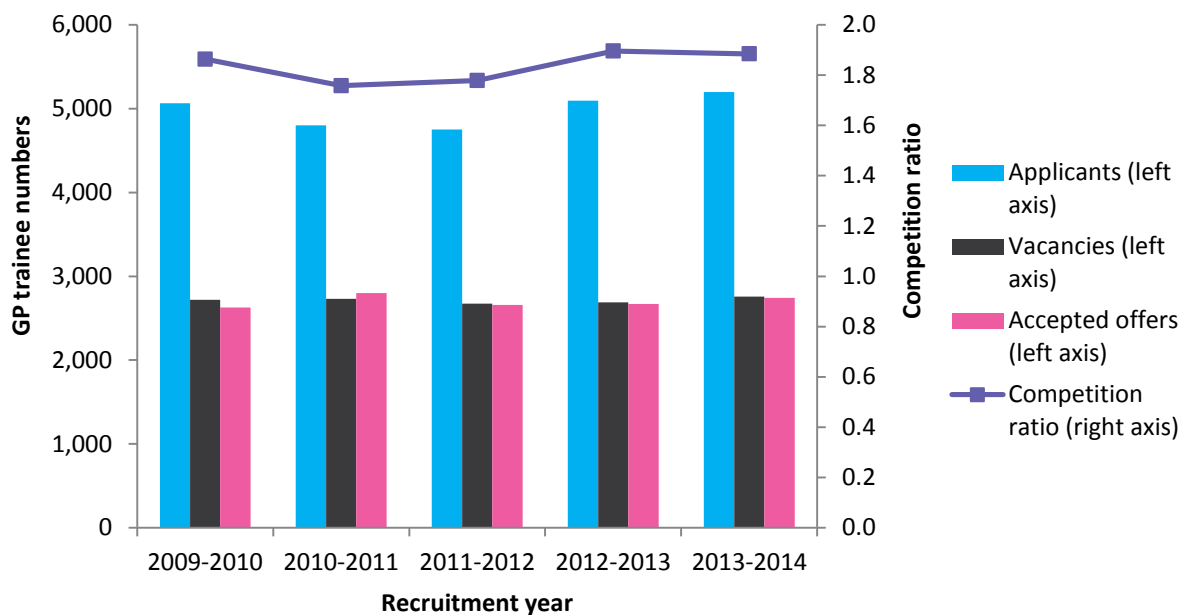
⁹⁷ Lambert T, Goldacre R, Smith F, Goldacre MJ. Reasons why doctors choose or reject careers in General Practice: national surveys. *The British Journal of General Practice : the Journal of the Royal College of General Practitioners* [Internet]. 2012 Dec [cited 2012 Dec 10];62(605):851–8. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23211266>

heard concerns about the inflexibility of the system to recognise prior training experience for doctors who wish to change career direction.

Insufficient numbers of doctors pass the GP Selection Process

GP national recruitment is an internationally recognised competency based selection process, with high predictive validity for successful completion of GP training.⁹⁸ Concerns have been expressed that its exclusion of past achievement and academic excellence, and only assessing performance in the selection process, may give the impression that the General Practice is non-academic. However, the far greater concern is the failure to fill all vacancies, despite a competition ratio around 1.8 over the last five years. A proportion of doctors who are offered training places will choose other specialties where they have been successful over General Practice. However, around 25% of applicants each year, including doctors who will successfully complete foundation programme training, are deemed lacking in the required competencies to undergo GP training.

Figure 7: GP Postgraduate Trainee Recruitment, England



Source: GP National Recruitment Office (2013) reproduced with permission CfWI

This raises questions around whether the Foundation Programme prepares doctors appropriately for training in General Practice, or whether the assessment process excludes

⁹⁸ Plint S, Patterson F Designing a selection process for postgraduate medical training: the case of UK General Practice Postgraduate Medical Journal 2010;86:323e327

too many applicants. The GP National Recruitment Office have predictive validity data which support the standard set for entry into GP training, with strong evidence that lowering the standard would result in unacceptable numbers failing to complete GP training successfully. The remaining explanation is that the assessment process appropriately selects those doctors suitable for successful completion of GP training, and the solution is to increase the quality of the applicants for General Practice training.

Increasing training numbers doesn't necessarily improve under-doctored areas

Previous expansions in GP numbers have not resulted in a more equitable distribution of GPs. The insufficient pool of quality applicants to fill all the national vacancies, differentially impacts the less popular areas within regions which are already the under-doctored areas.

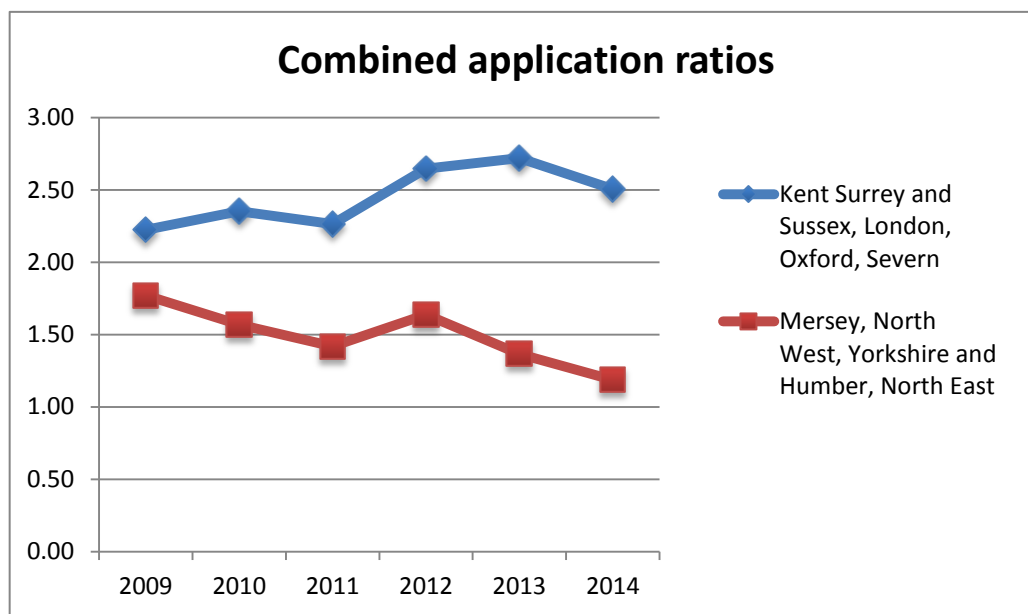
This phenomenon is not only played out within LETBs, but also at national level. Increasing vacancies uniformly across all regions has resulted in greater competition for the LETBs in regions which are relatively over-doctored across the South of England, and lower competition for the LETBs in regions which are relatively under-doctored (most notably Northern, North West, Mersey and West Midlands LETBs), with the perverse outcome of potentially exacerbating the fill rate in the areas of highest need.

Table 3: UK Deanery Competition Ratios 2013 Recruitment ⁹⁹

Deanery Competition Ratios	Round 1 2013
London	3.8
Northern Ireland	2.6
Severn	2.1
Oxford	1.9
East of England	1.6
Kent Surrey and Sussex	1.6
North Western	1.6
East Midlands	1.5
Scotland	1.5
Wales	1.5
West Midlands	1.5
Yorkshire & Humber	1.5
SW Peninsula	1.4
Wessex	1.4
Mersey	1.1
Northern	1.1

⁹⁹ GP National Recruitment Office. Round 1 recruitment for August 2013.

Figure 8: North versus South Competition Ratios over last 6 years¹⁰⁰



Training more doctors in popular areas would not be a problem if there was evidence of mobility amongst newly trained GPs, linked to a preparedness to seek work in under-doctored areas. The RCGP survey of recently qualified GPs reveals that there is, in fact, very limited mobility, with 97% indicating their willingness to commute within an average distance of 19 miles, and only 19% willing to relocate over 60 miles.¹⁰¹ The evidence is that doctors tend to stay in the area local to where they trained, and that they are much more likely to choose to work in areas with low unemployment and good amenities.¹⁰² The core strategy to improve the number of GPs in under-doctored areas is therefore to encourage postgraduate training in the areas of greatest workforce need.

GP Training Capacity

The number of doctors training in General Practice placements has at least doubled since the introduction of the foundation programme and the extension of GP specialty training placements from a minimum twelve to eighteen months in 2006. The current training programme now incorporates eighteen months in secondary care posts, and eighteen months based in General Practice. At the same time, medical schools have also been

¹⁰⁰ Harris M, Irish B. Analysis of NRO competition ratios by Deanery submitted for publication BJGP

¹⁰¹ Ashridge Communications Survey of GPs gaining a CCT between 1.8.11 and 9.5.13. Unpublished. Royal College of General Practitioners

¹⁰² Goddard M, Gravelle H, Hole A, Marini G. Where did all the GPs go? Increasing supply and geographical equity in England and Scotland. 2010. Journal of Health Services Research & Policy Vol 15 No 1, 2010: 28–35 available at: <https://www.york.ac.uk/media/che/documents/papers/WheredidalltheGPsgo.pdf> Accessed 31.7.13

increasing the time medical students train in General Practice. Although the Department of Health funded a £100m capital investment programme to develop training capacity in 2009, the system is now reported as saturated.¹⁰³

GP Taskforce Census

The GP Taskforce undertook a census of all LETBs in March 2013 requesting data about GP training and capacity for expansion. The census contained both quantitative and qualitative data.

The census reported that there were 3271 training practices in England, which represents approximately 40% of the practices in England, and 6337 GP Trainers or Associate Trainers representing nearly 20% of the total numbers of GPs (excluding GP Retainers and GP Registrars).

Table 4: GP Taskforce Census March 2013 – Infrastructure

GP Training Practices		3271	
GP Trainers	5360		
Associate Trainers	977		
Total GP Trainers		6337	
GP Associate Directors (2012)		105	(average 3 sessions)
GP Programme Directors (2012)		538	(average 2 sessions)

Source: UKCEA Workforce Survey 2013

There were a total of 8174 trainees, of whom 15% were training less than full-time and 9% were out of programme for either maternity or sickness leave. 5% of the total numbers of trainees were undergoing extensions to training, which effectively represents 15% of the final year of training requiring remedial training for typically an additional 3-6 months.

¹⁰³ GP Taskforce COGPED census 2013

Table 5: GP Taskforce Census March 2013 – Trainees

Total Trainees			8174	100%
LTFT		1205		14.7%
Extensions		430		5.3%
OOP (Maternity)	623			
OOP (Sickness)	119			
OOP (Total)		766		9.4%

GP training capacity is saturated

All LETBs reported that their training capacity was saturated, many also reported difficulties finding sufficient GP placements for their foundation programmes.

The General Practice apprenticeship model of training has demonstrated its effectiveness in the development of independent practitioners through graded exposure to increasing complexity of care in an uncertain environment. Whilst the model is effective, it is at the same time a significant factor limiting overall training capacity; the one to one model is apparently at odds with more than one learner per trainer. There are three other exacerbating factors limiting capacity: doctors requiring extensions to training because of unsatisfactory progress, doctors in less than full-time training, and doctors rejoining training from out of programme.

The 15% of trainees who cannot complete training in the three year programme are not evenly distributed. Typically the LETBs with higher competition ratios at recruitment attract stronger applicants who are more successful in their training and don't, in general, require extensions. Some LETBs are affected much more by extensions, one LETB with high numbers of international medical graduates with high failure rates in the MRCGP clinical skills assessment exam, reported last year an exam failure rate over the last few years per cohort of 40% of their final year.¹⁰⁴ LETBs with these high extension rates report great difficulty in maintaining morale in training practices, the impact of a "failing" trainee on a small organisation already experiencing growing service pressures should not be underestimated.

The impact of extensions is compounded by the majority being required in August, at the end of the three year programme. Extensions invariably need to be placed in General Practice,

¹⁰⁴ Howard, John. Personal Communication 2013

because this is the context for their clinical skills assessment exam failure or work-place based assessment failure. LETBs have to “double up” on capacity, because the next cohort of trainees is progressing into the final year. Training practices struggle to manage an additional trainee requiring focussed remedial training at the same time as a new trainee. Several LETBs have found themselves having to operate a “waiting-list” for trainees to undertake their extensions to training.

The 15% of doctors in less than full time General Practice training also causes capacity problems; this proportion is growing. Whilst the hospital based training component of GP training has become increasingly successful with “slot-sharing” of training posts, General Practices report much greater difficulty managing two doctors at the same time, which results in the inefficiency of one less than full-time trainee occupying a full-time training slot. The continuing payment of a full trainer’s grant to a practice with a less than full time trainee appears an anomaly which does not incentivise multiple placements.

The 9% of trainees who have been ‘out of programme’, either for maternity or sickness leave, also pose a logistical problem when they rejoin training programmes. Frequently they return to programme out of synchronicity with available secondary care posts, or they have already completed their hospital posts, and they are most easily placed back in practice where GP programme directors have more control over placements.

This model of General Practice training needs significant marginal capacity (around 10%) to manage the extensions to training and the less than full time placements. Total capacity is limited not just by the availability of sufficient trainers but also by premises capacity such as additional consulting rooms. The DH capital investment initiative in 2009 invested £100m in developing advanced training practices, largely focussed in under-doctored areas of England, increasing national training capacity by 600. Further investment will be needed for GP expansion, alongside the development of new models of training which can accommodate multiple trainees, which the report addresses later.

The attractiveness of GP training

The census collected qualitative data from the LETBs about GP training. As well as reporting the demoralising effect on practices and trainers of managing high numbers of trainees in difficulty, it also highlighted the rising service demand and additional responsibilities, such as clinical commissioning, which have all increased the pressure on some general practitioners, to the point where they question the value to the practice of training. This will appear counter-intuitive to everyone outside General Practice, with the perception that a GP trainee

who is fully funded and supernumerary to establishment must be a bonus. Nonetheless, there are increasing reports of training practices considering whether they will continue to train GPs.

Reassuringly there were still reports of the perceived status of a training practice as one of excellence in the profession, and GPs being motivated to teach their craft and recruit the next generation of GPs to the locality. Many were also excited by the development of a multi-professional training environment to develop the wider future primary care workforce.

GP Directors suggested that trainer numbers might be incentivised by increasing the GP Trainer's grant and funding capital grants to expand practice premises to train. They also identified the need to increase the quality of trainee applicants to minimise the numbers having difficulty completing training. Some reported openness to changing the current time-intensive model of training; all reported the desire to manage workload in primary care more effectively.

Emerging Primary Care Training Models

LETBs have previously tried a variety of models of training in General Practice to try and increase flexibility and the commissioning of more efficient models of training. These have included:

- A “hub and spoke” model where training or non-training practices clustering around a practice, developed as a primary care education centre, contribute additional training capacity and resources. This has been difficult to sustain as there have been few incentives for practices to work together in this way and the current statutory basis for the management of training acts as a barrier to shared payment systems
- The use of named clinical supervisors in General Practice (Associate Trainers) who with honorary contracts with the training practice can be in the same or other practices. This has been pioneered by some LETBs and will be legitimised by the current introduction of the GMC Trainer approval system
- A large primary care polyclinic (Darzi) model which trains enhanced numbers of trainees and other professions on one site. A lack of available investment and coordination with service strategy has meant that this is an uncommon occurrence
- Innovative integrated training posts, where trainees are based in practice and released to secondary care, have generally not been used as this is an expensive model. However, where there are community provided ambulatory care services with out-reach into primary care, there is no reason why trainees based in community

posts should not be released for part of the week into General Practice, reducing the cost of General Practice placements

The Taskforce has found that only the associate trainer model has made any significant impact, and it does not address wider primary care training capacity. LETBs have signalled that any solution for GP capacity issues must also address the training of nurses and other professions allied to medicine in primary care.

The Taskforce has reviewed emerging models of GP training which do also provide solutions for quality assured training for the wider primary care workforce.

The model which is generating the most interest is the “**federated model**” or educational network, which creates an approved training environment model. Here a number of the primary care providers come together for multi-professional placements with training approval given as if it was one system. This may include current non-training providers. In this model, block approval is given to the system, so that the organisation and allocation of trainees and students is left to the local provider, with the LETB providing approval and quality management in the normal way. Formal recognition and payments can still be made to individuals satisfying current regulations. This is similar to the situation in secondary care. The system is suitable to apply across professions and encourages the common development of clinical educators so that they can work with different disciplines.

A number of actual and potential changes within the system support the development of the federated model:

- The introduction of a tariff for all health care clinicians in training
- The grouping of primary care providers together into Clinical Commissioning Groups (CCGs)
- The introduction of NHS England Area Teams (ATs) who commission primary care services
- The introduction of a Learning Development Agreement (LDA) between LETBs and their ATs. This means that models such as the federated or educational network for creating an approved training environment could operate. Essentially this is a service level agreement across a wide area for the delivery of education and training in primary care, exactly as happens with Foundation and other Trusts

The Taskforce explored these models in a series of workshops and focus groups, which were overwhelmingly positive about the development of a federated structure for training in primary care.

Federated Model of Community Education Providers network

Health Education South London and Health Education Kent Surrey and Sussex

The combination of greater pressures on clinical and educational workload in primary care, and the need for more local and responsive workforce planning for development of primary care and clinical services, as well as the need to incorporate education and training provision to improve population health outcome has led us to propose the development of community-based educational provider networks (CEPNs).

CEPNs are envisioned as collectives or networks of primary and community provider organisations working collaboratively to enhance educational delivery in local geographic contexts. There is no pre-defined size for CEPNs though experience from clinical networks (e.g. Waltham Forest) suggests that a patient population size less than 50000 may prove challenging.

Common to all potential CEPNs are GP training practices which will act as the orchestrating unit for community based education provision, in varying degrees, encouraging local organisations to work collectively and develop ownership of local educational provision; extend the benefits of teaching to non-teaching organisations in the community; encourage innovation in educational delivery and diffusion of best practice; provide training and educational experiences to professional groups that are a priority for local workforce development; broaden the types and range of organisations involved in the delivery of community based education; and encourage organisations unused to working together to collaborate around education.

With the pressure experienced by primary and community care organisations, it will be essential to ensure that the emergent CEPNs have time to consider their development, and the resources (both human and financial) needed to build their capacity and relationships. The LETBs, in partnership with local primary care educational providers, have a critical role to play in supporting their development with adequate seed funding and project management support.

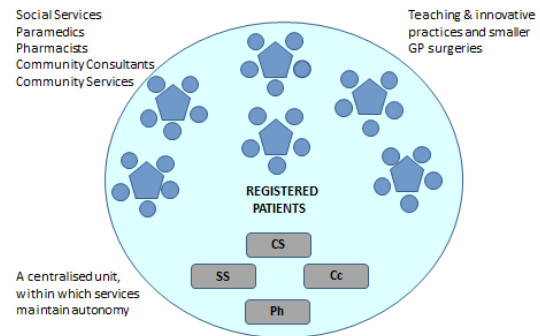
Health Care professional regulators (e.g. the GMC, NMC and others) have an expectation of educational providers (both practitioners and venues for delivering education) to meet exacting standards. There is a need to work with the regulators to ensure an approach to educational governance that meets the requirements of the regulators whilst preventing the nascent CEPNs from becoming stifled by established regulatory regimes. There is an opportunity for co-production and innovation in doing so. The Royal Colleges will also need to collaborate to ensure that competencies related to inter-professional and collaborative practice are reflected in curricula.

Critical to the success of CEPNs as vehicles for improving workforce planning and development is a key role for CCGs as service commissioners and offering leadership to support the identification of local clinical service priorities and workforce needs. Both LETBs

are working with universities, community providers, CCGs and GPs to create and support local federated models (CEPN) to increase placements in primary care based in General Practice for GP trainees, medical students, nurse students, health care assistants.

The Federated System of Community Providers offers all students, trainees, staff and the public a new exposure to population based healthcare, a multi-professional education and training, and promote inter-professional working and learning.

It is our view that CEPNs offer a model for developing better workforce planning and development, tackle the challenge of improving population health outcomes, and speeding innovation in primary and community care. Their development will require partnership that spans clinical and educational commissioners, as well as education and service providers. The AHSNs are likely to be critical facilitators in supporting their development. We firmly believe that GP education has a central and critical role to play in this emerging landscape. The CEPNs will provide opportunities for GP expansion and extension while they will provide placements for nurse students to appreciate the role of GP practices in delivering high quality services for patients with long term conditions.



13

Advanced Training Practices (ATP)

A route to increasing Practice Nursing capacity in Health Education Yorkshire and the Humber

Eight ATP hubs have been chosen as co-ordinators based on their diversity and location across Yorkshire and the Humber. There are a further 55 training practices involved as spokes to these hubs. The ambition over the next three years is for each hub to recruit 20 spokes.

Local Clinical Commissioning Groups (CCGs) are key stakeholders and we have been successful in encouraging CCG investment.

How does it work: groups of practices that are already accredited to provide undergraduate and post-graduate multi-professional training placements, work together to deliver an integrated learning ethos. The Learning and Development Agreement is used as the standard quality framework for all involved.

The key factors of this model are:-

- Education, training and development is the core part of everyday work
- Integrated learning is supported both inter-professionally and between different staff groups (learners) at different stages of their learning journey to give a greater understanding of the roles of colleagues

- *Practice training placements that offer opportunities for learners to develop the competencies needed to work competently following completion of training in primary and community care settings*
- *Local networks, made up of a group of practices support trainers through: mentorship; problem solving; CPD opportunities; administration of the placements*
- *Greater opportunity to ensure an appropriately training workforce for the implementation of services to support national policy and demographic trends*
- *Robust partnerships between placement providers and educational institutions (HEI's and Medical Schools)*
- *Opportunity for service to invest in education and training infrastructure in a way that offers economies of scale whilst maximising roll out of best practice educational governance for placements across primary care GP providers.*

The benefits are:-

- *Increased capacity of practice placements within General Practice*
- *Ability of ATP to influence the development of related curricula*
- *Involvement in forecasting future workforce needs within their own organisation and the wider health community*
- *Since its inception, eleven nursing graduates have obtained their first employment in General Practice as a result of this initiative*
- *The ATP model can be flexed for other staff groups, to address future regional priorities. The priority for us is on providing placements for undergraduate nursing students, in order to address the regional shortage and high retirement numbers anticipated of Practice Nurses*

GP trainee costs perceived as comparatively expensive

The systems for managing, employing and funding GP training in secondary and primary care are different, including different terms and conditions of employment, and salaries which are supported in hospitals by service contribution but not in General Practice. Although GP training is currently only three years, compared with up to eight years in other specialties, and net costs are actually half that of training a consultant, the cost of fully supporting a GP trainee's employment costs, together with the GP trainer's grant, is often described as "unsustainable".¹⁰⁵

We have described how LETBs with lower competition ratios in the more difficult to recruit geographies have higher extension rates; this results perversely in higher net costs for

¹⁰⁵ Curtis L, Unit Costs of Health and Social Care 2013, PSSRU, available www.pssru.ac.uk/project-pages/unit-costs/2013 accessed 27.1.2014 [Postgraduate training costs for GP £247,455 and for consultant £493,026]

training doctors in under-doctored areas where they are most needed. The report addresses later the case for redistribution of funding.

Some Local Education and Training Boards (LETB) have adopted a host or lead employer model for General Practice trainees, to standardise the employment contract and practices during the three year period. This is not yet universal and still requires full quality management of placements in practice, but changes the role of a training practice from being an employer to being an organisation which provides a training placement. Those LETBs who have adopted this model report economies of scale in purchasing indemnity insurance for trainees in General Practice, avoiding potential multiple changes in employer and all the associated human resources costs, as well as providing trainees with the associated continuity of employment rights and more consistent expertise managing HR problems.

Limited secondary care posts

GP training programmes also depend on the availability of secondary care posts. This is not simply a question of availability but also a question of the suitability of posts to deliver the GP curriculum. There is also competition with foundation and specialty training programmes for the posts, and in some specialties like paediatrics competition for the generalist posts. Unless there is high level support within the LETB and agreement across the specialties, GP schools have experienced difficulties expanding their programmes because of these competing priorities.

The availability of secondary care posts in some of the LETBs with the biggest expansion targets is limited by their overall stock of hospital training posts being disproportionately lower; these LETBs argue that historical funding allocations have disadvantaged them which need to be corrected.

These issues will be addressed through specific recommendations later in the report.

Recommendations

Better informed for workforce planning

We agree with the CfWI who have identified major gaps in workforce information required to underpin good workforce planning.¹⁰⁶ *“The CfWI is concerned by major gaps in the evidence base on GP activity, workload and practice workforce. Despite the scale and importance of primary care in the NHS, surprisingly little is known about what GPs do. The most recent workload survey was in 2006-07 and the latest data on activity and consultation rates is from 2008-09”.*

(1) We reconfirm the recommendation of the Centre for Workforce Intelligence (CfWI) that the GP workload survey must be urgently re-commissioned, along with a more effective vacancy survey. We welcome the adoption by Health Education England of a simple existing workforce replacement ratio metric to assure security of future workforce supply.

The Taskforce believes there has never been a greater need for accurate and comprehensive information about GP activity and workload. The distributed nature of General Practice – large scale service provision by many, diverse, small sized providers, does not lend itself to aggregation of organisational data.

The Taskforce has seen evidence that motivated practices, who were engaged in workforce planning issues, could supply useful workforce information, including qualitative data such as perceptions of future workforce risk. We observed how web based systems that could be updated in real time could produce secure aggregated data useful for workforce planners.

Data on workload supplied by QRisk was extracted from GP clinical record systems. GP clinical record systems are accurate, data is entered in a timely way, every staff member in primary care is logged onto a clinical system whilst undertaking clinical work in the surgery setting.

(2) The Taskforce recommends that Health Education England and NHS England work together so that in the long term workforce data, including productivity data, can be extracted from GP clinical computer systems and the anonymised data aggregated for workforce planning purposes

Workforce data is required in three broad areas:

¹⁰⁶ GP In-depth Review 2014

- (I) Demand – current levels of demand including consultation frequency, consultation length, consultation complexity, demographics of the patient case load, other demand drivers/moderators (including technology)
- (II) Supply – covering three domains: capacity (the number in the workforce), capability (the skills and abilities the workforce has to meet the needs of the patients and population they serve) and availability (whether the right people with the right skills are available at the right location / time to meet predicted or anticipated need)
- (III) Risk – foreseen risks in changes to demand/supply, mitigation of risk and impact

Promoting Retention and Enabling Return

The Taskforce believes that a nationally funded GP Returner scheme makes good economic and strategic sense. It has the further advantage of providing a robust mechanism for ensuring patient safety and an effective planned (re-)introduction to NHS healthcare delivery.

(3) The Taskforce recommends that NHS England should seek consensus on the threshold for assessing a doctor’s eligibility for re-inclusion on the Performers’ List, and explore whether there can be any flexibility in the managed return to practice.

Whilst all doctors should have the opportunity to return to General Practice, the Taskforce believes that it is reasonable for the system to direct funding for return to practice programmes to the localities which are relatively under-doctored. Returners may therefore have to travel reasonable distances for a funded programme.

(4) The Taskforce recommends that NHS England and Health Education England should work together to provide and fund a GP Returner programme, prioritising the funding for GP returners to train in under-doctored areas.

The Taskforce believes there is a good economic as well as moral case for maintaining the GP Retainer scheme, or a successor programme aimed at maintaining general practitioner skills during periods of significant caring responsibility, to address the issue of retaining young female GPs in the workforce. The system needs to understand why so many young female GPs leave the workforce, and address an inflexible employment model as potential underlying cause.

(5) The Taskforce recommends research is undertaken to identify why doctors leave General Practice early and what are the barriers to their returning to practice.

(6) The Taskforce recommends renewed financial support and promotion of the GP Retainer scheme (or successor scheme), prioritising the funding for GP retainers to work in under-doctored areas.

This report has highlighted the risk to the NHS of losing really significant numbers of GPs over the age of 50 from the workforce, either through reduction in working hours or retirement.

(7) The Taskforce recommends NHS England and Health Education England and the RCGP should work together to establish networks for senior GPs (“Twenty Plus” groups) providing tailored educational and support activities, and facilitating opportunities for portfolio careers and balancing clinical with non-clinical commitments. For example, system leadership and management responsibilities would provide an incentive for some senior doctors to develop and contribute to the NHS later in their careers.

(8) The Taskforce recommends NHS England review whether the current employment model is flexible enough to retain doctors towards the end of their careers. It should consider the reintroduction of the Flexible Careers Scheme which provided salary contribution and professional support for doctors working less than full time in General Practice, as a model for retaining doctors seeking to reduce their clinical commitment.

Promoting General Practice as a Career Choice

The Taskforce has concluded there is need to promote General Practice in a concerted and professionally-led campaign to the general public as well as target audiences from secondary school through medical school and foundation training.

(9) The Taskforce recommends a professionally-led marketing strategy to target a wide-range of audiences, including the general public, should be introduced to promote an accurate and positive image of General Practice.

This should be informed by the existing literature on career choice and additional empirical background research. The campaign could co-ordinate a number of organisations including the BMA, Royal College of General Practitioners (RCGP), and the Society of Academic Primary Care (SAPC). Such organisations may also wish to expand or promote more widely

their GP membership eligibility to secondary school and medical students, Foundation Doctors and non-GPs. Medical school GP societies may also be an effective national network to provide direct access into every UK medical school. The campaign should encompass a variety of media and may wish to consider:

- educational events, summer schools, conferences, or academic competitions and prizes for students and foundation doctors.
- the promotion, central coordination and funding of provision of work experience in General Practice for secondary school students.
- impartial career guidance at all career stages from secondary school to post CCT-qualification in other specialties.
- GP career-guidance mentors for medical students and Foundation Doctors.

(10) The Taskforce recommends further research with the Medical Schools Council into the factors that influence the observed differences in proportions of students from different medical schools choosing General Practice as a career.

The research should explore medical school selection policies, culture and role models, curricula and clinical placements.

(11) The Department of Health should consider incentivising medical schools to increase the proportion of their graduates selecting General Practice (and other shortage specialties) as first choice careers without disadvantaging currently well-performing universities.

The Taskforce has heard arguments that medical schools with greater proportions of graduates selecting General Practice as a career have a number of potential causal explanations. These include more teaching (including the basic clinical sciences) by GPs in community settings, more opportunities for special study modules and electives in primary care, and more GPs holding senior managerial and academic positions within medical schools. These hypotheses need to be tested in the preceding recommendation for further research and translated into practice if found to be true.

(12) The Taskforce recommends that the proportion of General Practice posts in foundation programmes should be increased, ensuring that 100% of foundation doctors have exposure to General Practice or community based experience.

These placements must be designed to ensure they provide appropriate support structures for newly qualified doctors and avoid isolation from colleagues. General Practice topics

should be integrated into the regular teaching programmes for Foundation doctors, and GPs should be included in the management structure of the Foundation schools.

(13) The Taskforce recommends raising the profile of General Practice as an academic discipline through promotion of integrated clinical academic training programmes in General Practice during foundation and specialty training, in addition to the afore-mentioned marketing campaign.

The timing of higher academic training in General Practice usually happens after completion of GP training, which raises issues regarding equity of funding with other specialties and for doctors returning to practice. This work should be explored further with funders of medical research in addition to organisations that promote the academic discipline of General Practice including SAPC and the RCGP.

Expanding the GP Trainee Pipeline

The CfWI was tasked specifically with reporting whether the target of 3,250 GP trainees per annum was the right number for England, and reports “*there is a clear risk of a major supply-demand imbalance emerging by 2020 unless there is a significant, sustained and immediate boost to GP training*”.¹⁰⁷ It recommends an increase in GP training numbers of between 20 and 40 percent is needed, the lower figure equating to 3250.

(14) The Taskforce recommends an interim target of 3,050 GP training ST1 entry points for 2014 (increase of 250), with the target of 3,250 (increase of further 200) achieved by 2015.

There is an imbalance between the level one entry numbers into hospital specialty training and GP training; in 2013, 4100 (60%) doctors entered hospital specialty training compared with 2800 (40%) doctors into GP training. The Health and Education National Strategic Exchange (HENSE) was commissioned by the government in 2011 to review whether current levels of medical and dental student intakes were in line with predicted workforce requirements. HENSE recommended that the number of students accepted to medical school should be reduced by two percent in England.¹⁰⁸ The models suggested that demand for GPs would outstrip supply but that hospital doctors’ supply would exceed demand, unless “rebalancing” from other specialties to General Practice occurred.

¹⁰⁷ Centre for Workforce Intelligence. GP In-depth Review 2014

¹⁰⁸ The Health and Education National Exchange (HENSE). Review of Medical and Dental School Intakes in England. November 2012

The key recommendation of the Taskforce relates to redressing this imbalance. At the time of publication of this report, advertised GP vacancies for 2014 have been increased by 200, but there has been no overall net reduction in hospital specialty training numbers, and GP applications are 15% down on the previous year. The Taskforce believes this reinforces the evidence over the last few years, that there is an upper limit to the overall applicant pool and with General Practice already unable to fill all its vacancies, simply increasing vacancies without any corresponding reduction in secondary care vacancies will not achieve any increase in recruitment numbers.

As well as increasing the pool of potential GP applicants, the reduction in secondary care training programmes will also enable the transfer of educational investment from secondary care into the community to support GP training.

(15) The Taskforce recommends that the expansion in GP training numbers should be matched by a concomitant reduction in ST1 or CT1 hospital specialty entry points (decrease of 450) – particularly in those specialties known to be over-producing CCT holders.

Health Education England will need to review whether further increases in GP training numbers or further decreases in hospital specialty training numbers should be made to achieve the 50-50 balance in the Health Education England mandate, but the Taskforce suggests the numbers should be evidence-based on future workforce need rather than on relative ratios.

(16) The Taskforce recommends the long term target for GP training ST1 entry points is reviewed following publication of the NHS England Review of Primary Care along with the long term target for hospital specialty numbers, as part of the implementation of the Shape of Training.¹⁰⁹

We welcome the inclusion of a “replacement ratio” in the Health Education England workforce plan which shows output from training programmes as a percentage of the consultant and GP workforce.¹¹⁰ Specialties which are expanding or have high numbers of CCT holders approaching retirement, or high training attrition or low participation level post CCT, may need a higher ratio compared to other specialties. We believe, however, that this

¹⁰⁹ Shape of Training: securing the future of excellent patient care – final report of the independent review led by Professor David Greenaway (Autumn 2013)

¹¹⁰ Investing in People for Health and Healthcare Workforce Plan for England Proposed Education and Training Commissions for 2014/15 Health Education England

metric will give an indication regarding the rate of replacement and could be a useful indicator for assuring security of supply.

(17) The Taskforce recommends the end-point of expansion should be the allocation of trainees on weighted population capitation basis, but consideration should be given in the short-term to prioritising expansion in under-doctored areas, or incentivising trainees to train in under-doctored areas. Prioritisation and incentivisation must be joint initiatives between education and service (Health Education England and NHS England).

Unless the pool of applicants to GP training is significantly increased, there is a risk that increasing GP expansion across the whole of England will *reduce* the pool of applicants to GP posts in the least popular units of application, which match the areas that are most under-doctored by GPs.

LETBs have previously attempted to alter the distribution of trainees in a number of ways. These range from the establishment of academic training programmes in areas of high social need, differential funding of training, and even mandatory trainee distribution. In order to address the vital issue of the differential distribution of health inequalities in our society, a coordinated approach between education and service commissioning is required. Increasing primary care capability in under-doctored areas with high morbidity and mortality must be an aim of any investment in the training of more primary health care clinicians.

(18) The Taskforce recommends that financial allocations to LETBs for GP training should also be on a weighted capitation basis to match the allocation of trainees. The short-term priority of prioritising expansion in under-doctored areas, or incentivising trainees to train in under-doctored areas, will require short-term differential allocation of financial resources to under-doctored areas.

Health Education England will also need to consider differential allocation of resources to those LETBs incurring additional costs because of increased proportions of international medical graduates, who will require more focussed and supportive training to ensure successful completion of training.

(19) Health Education England and the GP National Recruitment Office will need to review the reasons why 25% of applicants to GP training are considered unappointable.

The review should include a revalidation of the person specification against the contemporary role of the GP, and whether the standard for appointability is set at the right level to predict success in GP training. It should also review whether the foundation programme prepares doctors appropriately for application for GP training.

(20) General Practice should encourage doctors from other specialties to switch to GP training with greater flexibility to recognise prior training and career progression.

Currently, doctors changing specialty are required to re-enter the GP training programme at ST1 level, whatever their prior experience. The Taskforce recognises that greater flexibility is one of the key recommendations of the Shape of Training, and anticipates that the introduction of enhanced GP training *including* greater flexibility of training will be one of the early deliverables.

The Taskforce has considered whether it should recommend the promotion of international recruitment of appropriately trained GPs. Given the NHS Plan ambition that the UK should become self-sufficient in training its NHS workforce, it has concluded that this would not be an appropriate recommendation.¹¹¹ However, with freedom of movement and rights to employment within the expanding European Union, the Taskforce believes there should be funding for a mandatory Induction and Refresher training programme.

(21) The Taskforce recommends that eligible doctors, who have not previously worked in General Practice in the United Kingdom, should undergo a mandatory period of fully funded Induction and Refresher training, and assessment of successful completion prior to inclusion on the GP Performers' list.

Increasing GP Training Capacity

The recommended increase of 450 GP trainees by 2015 will require 675 years of suitable specialty training posts and 675 years of GP training posts (providing 18 months in specialty and 18 months in GP training).

Decommissioning the recommended 450 specialty level 1 entry programmes would potentially liberate funding ranging from a minimum of 900 posts (from 2 year core training programmes) to a maximum of 3600 posts (from 8 year core plus higher specialty training programmes).

¹¹¹ The NHS Plan: a Plan for Investment, a Plan for Reform. July 2000

With successful co-design with Trusts the 675 specialty training posts required for GP hospital based training expansion could be rebadged, minimising disruption to service delivery. The remaining 675 GP training posts at 100% Multi Professional Education and Training (MPET) funding would either require new funding at around £40m, or the decommissioning of 1,350 specialty training posts (GP posts will cost twice as much as hospital posts under the new MPET tariff arrangements unless GP training funding arrangements are changed).

(22) The Taskforce recommends that funding the training posts required for GP training expansion could be cost neutral to Health Education England if 2,025 specialty training posts are decommissioned.

These posts should come from a combination of core training, run through programmes higher training programmes (each programme eventually releasing the same number of posts as the length of the programme). The Taskforce does not underestimate the short term impact this change would have on service delivery, but believes what is effectively a transfer of educational investment into the community must accompany the transfer of care into the community, to ensure an overall medical workforce which is fit for future purpose. To put this shift into perspective, the Taskforce has identified a total number of hospital training posts recorded in the Health Education England Stocktake around 45,000, and the decommissioning of 1350 posts to fund the 675 GP training placements would represent a 3% reduction in the overall number of hospital training posts.¹¹²

(23) The Taskforce recommends the Postgraduate Dean or an Associate Dean from specialty background should lead the process for the LETB of decommissioning and rebadging specialty training posts. GP Schools will need this high level specialty leadership to support the GP expansion.

(24) The Taskforce recommends LETBs should explore the development of the federated practice model to increase multi-professional placement training capacity, facilitate the management of multiple trainees more efficiently, and add value for other health professionals in primary care.

The potential for placing trainees using a federated model could be the vehicle to enable the increase in capacity required to train the effective 15% increase in GP training numbers. The use of such a model in deprived areas, possibly with additional incentives such as enhanced premises, is likely to mean that health inequalities will decrease. In addition, it is expected

¹¹² Aggregated PMDE Stocktake October 2013 Health Education England

that it will improve the recruitment and retention of the whole workforce due to increased high- quality training opportunities locally which will enhance morale.

Unless new models are adopted, a pro-rata increase of 15% in current capacity would require an additional 950 trainers and 500 training practices. Although LETBs would look to maximise marginal capacity, there would also need to be some increases in programme administrators and training programme directors and associate directors.

Even with the federated model, we anticipate the need for new trainers and training practices, given the priority for primary care to develop training capacity not just for more GPs but also student and practice nurses. New training practices would require grants to cover costs of creating additional consulting rooms and becoming accredited.

(25) The Taskforce recommends local LETB capital investment programmes (of around £10-20k per project) to recruit and develop new primary care training capacity, based on the DH Advanced Practice Programme.

Table 6: Estimated Additional Resources Required for GP Expansion

Requirement	Number	Opportunity Cost	Financial Cost
GP Trainees	450 trainees	450 specialty trainees	
Hospital Posts	675 posts	675 specialty posts	
GP Posts	675 posts	1350 specialty posts (3% of total hospital posts stock)	(or) £40m per annum
New practices	500		£10m non-recurrent capital investment grant
New Trainers	950		Trainers grant included in GP posts cost
Named clinical supervisors	150	Availability to specialty trainees	Additional SPA if new clinical supervisor
New TPDs* @2 sessions	80	Availability to clinical practice	£1.4m incl on-costs
New ADs** @3 sessions	16	Availability to clinical practice	£0.5m incl on-costs
New Administrators (wte)	30		£1.1m incl on-costs

Source GP Taskforce Census responses and pro-rata calculations against existing numbers

**Training Programme Director **Associate Director*

Summary of Recommendations

<p>1. We reconfirm the recommendation of the Centre for Workforce Intelligence (CfWI) that the GP workload survey must be urgently re-commissioned, along with a more effective vacancy survey. We welcome the adoption by Health Education England of a simple existing workforce replacement ratio metric to assure security of future workforce supply.</p>
<p>2. The Taskforce recommends that Health Education England and NHS England work together so that in the long term workforce data, including productivity data, can be extracted from GP clinical computer systems and the anonymised data aggregated for workforce planning purposes.</p>
<p>3. The Taskforce recommends that NHS England should seek consensus on the threshold for assessing a doctor's eligibility for reinclusion on the Performers' List, and explore whether there can be any flexibility in the managed return to practice.</p>
<p>4. The Taskforce recommends that NHS England and Health Education England should work together to provide and fund a GP Returner programme, prioritising the funding for GP returners to train in under-doctored areas.</p>
<p>5. The Taskforce recommends research is undertaken to identify why doctors leave General Practice early and what are the barriers to their returning to practice.</p>
<p>6. The Taskforce recommends renewed financial support and promotion of the GP Retainer scheme (or successor scheme), prioritising the funding for GP retainers to work in under-doctored areas.</p>
<p>7. The Taskforce recommends NHS England and Health Education England and the RCGP should work together to establish networks for senior GPs ("Twenty Plus" groups) providing tailored educational and support activities, and facilitating opportunities for portfolio careers and balancing clinical with non-clinical commitments. For example, system leadership and management responsibilities would provide an incentive for some senior doctors to develop and contribute to the NHS later in their careers.</p>
<p>8. The Taskforce recommends NHS England review whether the current employment model is flexible enough to retain doctors towards the end of their careers. It should consider the reintroduction of the Flexible Careers Scheme which provided salary contribution and professional support for doctors working less than full time in General</p>

Practice, as a model for retaining doctors seeking to reduce their clinical commitment.
9. The Taskforce recommends a professionally-led marketing strategy to target a wide-range of audiences, including the general public, should be introduced to promote an accurate and positive image of General Practice
10. The Taskforce recommends further research with the Medical Schools Council into the factors that influence the observed differences in proportions of students from different medical schools choosing General Practice as a career
11. The Department of Health should consider incentivising medical schools to increase the proportion of their graduates selecting General Practice (and other shortage specialties) as first choice careers without disadvantaging currently well-performing universities
12. The Taskforce recommends that the proportion of General Practice posts in foundation programmes should be increased, ensuring that 100% of foundation doctors have exposure to General Practice or community based experience
13. The Taskforce recommends raising the profile of General Practice as an academic discipline through promotion of integrated clinical academic training programmes in General Practice during foundation and specialty training, in addition to the aforementioned marketing campaign
14. The Taskforce recommends an interim target of 3,050 GP training ST1 entry points for 2014 (increase of 250), with the target of 3,250 (increase of further 200) achieved by 2015
15. The Taskforce recommends that the expansion in GP training numbers should be matched by a concomitant reduction in ST1 or CT1 hospital specialty entry points (decrease of 450) – particularly in those specialties known to be over-producing CCT holders
16. The Taskforce recommends the long term target for GP training ST1 entry points is reviewed following publication of the NHS England Review of Primary Care along with the long term target for hospital specialty numbers, as part of the implementation of the Shape of Training
17. The Taskforce recommends the end-point of expansion should be the allocation of trainees on weighted population capitation basis, but consideration should be given in the short-term to prioritising expansion in under-doctored areas, or incentivising trainees to train in under-doctored areas. Prioritisation and incentivisation must be joint

<p>initiatives between education and service (Health Education England and NHS England)</p>
<p>18. The Taskforce recommends that financial allocations to LETBs for GP training should also be on a weighted capitation basis to match the allocation of trainees. The short-term priority of prioritising expansion in under-doctored areas, or incentivising trainees to train in under-doctored areas, will require short-term differential allocation of financial resources to under-doctored areas</p>
<p>19. Health Education England and the GP National Recruitment Office will need to review the reasons why 25% of applicants to GP training are considered unappointable</p>
<p>20. General Practice should encourage doctors from other specialties to switch to GP training with greater flexibility to recognise prior training and career progression</p>
<p>21. The Taskforce recommends that eligible doctors, who have not previously worked in General Practice in the United Kingdom, should undergo a mandatory period of fully funded Induction and Refresher training, and assessment of successful completion prior to inclusion on the GP Performers' list</p>
<p>22. The Taskforce recommends that funding the training posts required for GP training expansion could be cost neutral to Health Education England if 2,025 specialty training posts are decommissioned</p>
<p>23. The Taskforce recommends the Postgraduate Dean or an Associate Dean from specialty background should lead the process for the LETB of decommissioning and rebadging specialty training posts. GP Schools will need this high level specialty leadership to support the GP expansion</p>
<p>24. The Taskforce recommends LETBs should explore the development of the federated practice model to increase multi-professional placement training capacity, facilitate the management of multiple trainees more efficiently, and add value for other health professionals in primary care</p>
<p>25. The Taskforce recommends local LETB capital investment programmes (of around £10-20k per project) to recruit and develop new primary care training capacity, based on the DH Advanced Practice Programme</p>

Terms of Reference for GP Taskforce *agreed by Medical Programme Board*

Background

The CfWI report “*Shape of the Medical Workforce: Informing Medical Training Numbers*” (August, 2011) has been used as a baseline for the Joint Working Group (JWG) to work with SHA Workforce leads, Deans and Speciality Advisory Committee Chairs to determine the annual recruitment training numbers for each specialty and geography.

In 2009, £100m of capital expenditure was invested to create additional GP training capacity; mainly focussed on enhancing practice facilities in areas where GP numbers was low compared to national norms. It was expected that this would contribute significantly to an increase in training capacity, and we have seen GP recruitment numbers grow from c.2,200 to 2,800 places by 2012. However, this still falls short of the target for England of 3,250 GP training programmes required to maintain historical levels of GPs.

The strategy required to increase the GP training number capacity is complex, with a range of issues affecting the system including:

- GP places are, on average approximately 1.5 times more costly per year than other specialty training places. This is due to trainee salary costs and GP trainer grants and infrastructure costs (even though at the present time it takes half the time to train a GP compared to the other main acute specialties)
- The national number of total medical training places per year needs to remain static at 6,500 to prevent an oversupply of CCT holders (GP and specialties) and to match the predicted Foundation Programme output
- To increase GP training numbers will inevitable mean a reduction in other specialty training posts which needs to be carefully managed so as not to destabilise clinical services in any given year. The potential for destabilisation varies to a significant extent by geography due to historic MPET funding arrangements
- The competition rates for GP training places is not high, so if additional posts were made available there is a question as to whether sufficient candidates will be available to fill them
- The new Health Education England landscape provides LETBs with more local autonomy to decide their priorities, which may conflict with previous national

direction. However, Health Education England will need to review LETB plans from a national perspective before agreeing the final national agreements with LETBs

- GP training needs to be organised as close as possible to predicted workforce demand for GPs as trainees generally continue to work, post CCT, close to where they trained
- There is not the necessary immediate training capacity available in primary care in all areas where GP numbers need to increase
- There is a changing landscape for GP employment with fewer partnerships being made available to newly qualified doctors leading to expectation gaps

Proposal

This is a complex multifactorial issue. In discussion between the DH Director of Medical Education, METP team with SHA Cluster Leads, DH workforce and Deans in England, it was recommended that a General Practice Taskforce (similar to the other two national priority Taskforces in Emergency Medicine and Psychiatry) be established to coordinate and manage a programme of initiatives that will improve the current position.

The Taskforce will need to work across the new education and training landscape and ensure local priorities and needs are taken into account whilst ensuring that changes are made that will provide direction to ensure the 3,250 target for GP training places is met by 2015.

Terms of Reference

- To review the current national employment environment including vacancies, retirement trajectory, retention, attrition and participation rates by LETB
- To review how improvements can be made to GP workforce data collection
- To assess the changing options available for the General Practice employment in the light of recent changes to the wider NHS commissioning landscape, including career progression
- To review the historical average time of GP training to CCT by LETB
- To review the current training capacity by LETB and assess where immediate opportunities are available and undertake a gap analysis of where need is most required

- To assess and understand the cost of GP training in its constituent parts and to review alternative options
- To assess and cost by LETB of a three year plan to reach national GP training levels with mitigation for lost specialty numbers in other specialties
- To understand the motivation factors and barriers of trainees to want to work in General Practice
- To review what factors might boost interest and fill rates into GP training positions
- To undertake a stocktake of good practice for using a range of other professionals as part of the primary care team and plan a coordinated plan for spreading good practice
- To make recommendations to the Medical Programme Board covering workforce, education and training, cost and timescale for delivering the national training numbers required by 2015
- To note any implications of a four year GP training programme to the above (whilst recognising that such a change is not approved)

Representative Group

- Director of Medical Education DH
- DH Workforce Lead
- Senior Clinical Advisor DH
- SHA Cluster Workforce Lead representative (to March 2013)
- 3 Clinical Commissioning Group representatives
- 3 LETB representatives
- 3 Deanery representatives
- 2 COGPED representatives
- RCGP representatives
- 2 GP trainees
- BMA (GPC) representative
- NHS employers
- CfWI representative
- Academy of Medical Royal Colleges representative
- DH METP Team representatives
- Lay representative

Membership of GP Taskforce

Member	Title	Organisation
Abdol Tavabie	Dean of Postgraduate GP Education	KSS Deanery
Alistair Blair	Chief Clinical Officer	NHS Northumberland CCG
Amanda Howe	Honorary Secretary of Council	Royal College of General Practitioners
Andrew Matthewman	Policy Manager	Department of Health
Barry Lewis	Director of GP Education	North West Deanery
Benjamin Brown	GP Trainee	Royal College of General Practitioners
Bill Irish	Director of GP Education	Severn Deanery
Bill McMillan	Head of Medical Pay and Workforce	NHS Employers
Chris Jeffries	Interim Director of Workforce and Education	North West SHA
Claire Loughrey	Director of Postgraduate GP Education	Northern Ireland MDTA
David Eadington	Deputy Dean	Yorkshire and the Humber Deanery
Davinder Sandhu	Postgraduate Dean	Severn Deanery
Elizabeth Hughes	Postgraduate Dean	West Midlands Deanery
Fiona Erasmus	Head of Professional Standards	Royal College of General Practitioners
Ian Hammond	Lay Representative	
John Howard	Postgraduate GP Dean	East of England Deanery
Kirsty White	Head of Education Quality Assurance	General Medical Council
Krishna Kasaraneni	Chair	BMA GP Trainees' Subcommittee
Liz Kidd	Senior Policy Manager	Department of Health
Malcolm Lewis	Director of Postgraduate GP Education	Wales Deanery
Mark Purvis	Director of Postgraduate GP Education	Yorkshire and the Humber Deanery
Nathan Nathan	Chair	Medway CCG
Neil Jackson	Chair, Postgraduate Training Board	Royal College of General Practitioners
Paru Patel	Senior Analyst and Project Manager	Centre for Workforce Intelligence
Simon Plint	Postgraduate Dean	Wessex Deanery
Stephen Welfare	Director of Workforce	NHS East of England
Tom Black	Chair	BMA GP Committee

Sponsor

Patrick Mitchell, Director of National Programmes, Medical Education, Department of Health

Secretariat

Tom Clayton and Fran Mead, Health Education England

GP Taskforce Steering Group

Member	Title	Role
Abdol Tavabie	Dean of Postgraduate GP Education	GP Training Capacity Lead
Benjamin Brown	GP Trainee	Promoting GP Career Choice Lead
Ian Hammond	Lay Representative	RCGP Representative
John Howard	Postgraduate GP Dean	GP Training Capacity Lead
Amanda Howe	Honorary Secretary of Council	RCGP Representative
Elizabeth Hughes	Postgraduate Dean	English Postgraduate Deans Representative
Bill Irish	Director of GP Education	Promoting GP Career Choice Lead
Mark Purvis	Director of Postgraduate GP Education	GP Workforce Data Lead
Simon Plint	Senior Clinical Adviser Department of Health	Chairperson

Risk Analysis

The recommendations of the Taskforce need to be set within the national policy context. NHS England in its Mandate from Department of Health placed emphasis on the five domains of the National Outcomes Framework as a framework for the NHS.¹¹³¹¹⁴ These can be summarised as:

1. Reducing premature mortality
2. Improving the Quality of Life for people with Long Term Conditions
3. Enhancing recovery from illness or injury
4. Improving the patient experience
5. Ensuring patient safety

All of these domains can be affected by the quality of primary care locally; for example, there is a correlation between high rates of premature mortality in areas which are also under-doctored. There is clear evidence that increasing primary care physician numbers increases access and equity of access to health services, while also increasing performance in terms of delivery of preventative care and an overall reduction in population mortality rates.

Key to the patient experience is the ability to access services. The Government is emphasising the importance of encouraging people to care for themselves, with the help of advice lines like the new NHS111 services. However, it is also important for patients to be able to access services and it is government policy to promote care closer to home, rather than to use acute hospitals (inappropriately and expensively) for their care.¹¹⁵ However, there is evidence from NHS England that patients are increasingly using A&E departments rather than going to their GP because of they are easier to access – hospitals are open 24/7.

¹¹⁶

It is also particularly important for the NHS to develop services which are sustainable and represent value for money. This will require the development of new models of care, all of

¹¹³ A mandate from the Government to the NHS Commissioning Board, Department of Health, 2012

¹¹⁴ NHS Outcomes Framework 2013 to 2014, Department of Health, November 2012

¹¹⁵ Department of Health 2008 Delivering care closer to home: meeting the challenge

¹¹⁶ A&E quarterly statistics since 2004, NHS England, July 2013

which will have a significant primary care element. There has been a tendency in the past for the education and training implications of service change to be overlooked or addressed in isolation and this goes some way to explain why implementation of change can be problematical.

The Taskforce prepared a risk assessment which highlighted the risks of failure to train, recruit and retain sufficient numbers of high quality GPs, particularly in under-doctored areas. We considered the relative likelihood and severity of each risk, and how it might be mitigated. This thinking has informed our conclusions and recommendations. The key risks are summarised below. Those we judged to be of highest risk (i.e. both very serious and very likely) are marked with an asterisk.

Risks to Patient Outcomes

- Failure to reduce premature mortality
- Failure to improve the quality of life of people with long term conditions (LTCs)
- Failure to enhance recovery from illness or injury
- Failure to improve the patient experience
- Failure to keep services safe (Francis report)

Risks to achieving wider DH Policy objectives

- Inability to meet waiting time targets in A&E
- Inappropriate services for patients with co-morbidities, hampering integrated care
- Failure to reduce health inequalities*
- Continuation of financially unsustainable service models*

Risks of not achieving target numbers of trainee GPs

- Insufficient numbers to replace current numbers of GPs*
- Insufficient WTEs, because of less than full time GPs*
- Insufficient GPs in under-doctored areas
- Insufficient GPs to lead primary healthcare teams and develop new services
- Insufficient resource and training capacity in secondary care
- High cost and Insufficient physical training capacity in primary care
- Adverse reaction from secondary care – inability to staff acute rotas
- Inadequate information on which to plan workforce
- Increased numbers of conventionally trained GPs dilute flexibility and enhanced capability of GP workforce

- Inability to tackle cultural change issues
- Adverse societal/media response through poor appreciation of need for change
- Change impeded by low morale, silo inertia, protectionism and change fatigue

GP Career Choice by Medical School

Career preferences one year after graduation: percentages (numbers) of graduates who specified General Practice as their choice of future career, grouped by clinical medical school attended ¹¹⁷

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Medical school	Untied first choice for GP% (n)	Any first choice for GP% (n)	Any choice for GP% (n)	Total N
England				
Oxford and Cambridge				
Cambridge	13.0 (56)	21.1 (91)	34.5 (149)	432
Oxford	10.9 (46)	17.7 (75)	36.2 (153)	423
Total Oxford and Cambridge	11.9 (102)	19.4 (166)	35.3 (302)	855
London				
Imperial College	18.1 (140)	23.3 (180)	41.3 (320)	774
King`s College	17.5 (167)	24.9 (237)	44.9 (427)	952
Queen Mary and Westfield	22.2 (123)	30.8 (171)	49.0 (272)	555
St George`s	21.0 (110)	30.3 (159)	48.9 (256)	524
University College	19.8 (173)	26.1 (228)	45.0 (393)	874
Total London	19.4 (713)	26.5 (975)	45.3 (1668)	3679
Other English schools				
Birmingham	25.5 (198)	34.3 (266)	55.2 (428)	776
Bristol	18.0 (95)	27.3 (144)	45.6 (241)	528
Leeds	27.8 (166)	37.6 (225)	56.0 (335)	598
Liverpool	26.0 (139)	36.1 (193)	53.6 (287)	535
Manchester	22.3 (219)	30.5 (300)	50.6 (498)	984
Newcastle	22.6 (149)	31.6 (208)	50.9 (335)	658
Sheffield	24.1 (162)	33.6 (226)	50.4 (339)	673
Nottingham	22.2 (144)	31.2 (203)	48.9 (318)	650
Southampton	24.3 (121)	33.1 (165)	51.6 (257)	498
Leicester	20.9 (107)	29.7 (152)	47.9 (245)	512
Total Other English	23.3 (1500)	32.5 (2082)	51.2 (3283)	6412
New English schools				
Peninsula	31.4 (37)	40.7 (48)	55.9 (66)	118
Brighton and Sussex	29.0 (31)	35.5 (38)	57.9 (62)	107
Hull York	30.4 (34)	43.8 (49)	65.2 (73)	112
East Anglia	19.1 (17)	34.8 (31)	61.8 (55)	89
Warwick	27.1 (56)	43.0 (89)	64.3 (133)	207
Total New English	27.6 (175)	40.3 (255)	61.5 (389)	633
Total England				
Scotland				
Aberdeen	24.0 (114)	33.5 (159)	50.9 (242)	475
Dundee	27.0 (111)	34.8 (143)	51.1 (210)	411
Edinburgh	14.9 (107)	23.2 (167)	39.2 (282)	719
Glasgow	18.9 (122)	28.6 (184)	46.1 (297)	644
Total Scotland	20.3 (457)	29.0 (653)	45.8 (1031)	2249
Wales (Cardiff)	23.5 (166)	33.9 (240)	55.6 (393)	707
Northern Ireland (Belfast)	23.7 (128)	33.5 (181)	47.5 (257)	541
Total	21.5(3238)	30.2 (4552)	48.6 (7323)	15076

¹¹⁷ Trends in doctors' early career choices for General Practice in the UK: longitudinal questionnaire surveys. Trevor Lambert and Michael Goldacre BJGP July 2011

National F2 2012 Career Destination Survey ¹¹⁸

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Appointment to specialty training, GP and psychiatry by medical school

Medical school	Total % appointed to ST (incl. GP) in UK	Total % appointed to GP in UK
Aberdeen (University of), School of Medicine	65.1%	25.7%
Barts and The London School of Medicine and Dentistry, Queen Mary, University of London	74.1%	29.4%
Birmingham (University of), School of Medicine	75.8%	32.7%
Brighton and Sussex Medical School	44.9%	20.4%
Bristol (University of), Faculty of Medicine	48.6%	15.5%
Cambridge (University of), School of Clinical Medicine	86.4%	11.2%
Cardiff University, School of Medicine	58.8%	24.5%
Dundee (University of), Faculty of Medicine, Dentistry and Nursing	60.3%	19.9%
Edinburgh (The University of), College of Medicine and Veterinary Medicine	57.0%	20.8%
Glasgow (University of), Faculty of Medicine	67.6%	18.6%
Hull York Medical School	72.4%	31.4%
Imperial College School of Medicine, London	67.7%	16.0%
Keele University, School of Medicine	85.9%	38.5%
King's College London School of Medicine (at Guy's, King's College and St Thomas' Hospital)	70.8%	25.7%
Leeds (University of), School of Medicine	72.5%	29.8%
Leicester (University of), Leicester Medical School	78.8%	28.3%
Liverpool (University of), Faculty of Health and Life Sciences	69.0%	25.9%
Manchester (University of), Faculty of Medical and Human Sciences	64.8%	25.1%
Newcastle (University of), Newcastle Biomedicine, The Medical School	66.9%	23.8%
Norwich Medical School, University of East Anglia	74.5%	36.8%
Nottingham (The University of), Faculty of Medicine and Health Sciences	67.7%	24.6%
Oxford (University of), Medical Sciences Division	83.7%	12.8%
Peninsula College of Medicine and Dentistry	57.1%	26.1%
Queen's University Belfast, Faculty of Medicine and Health Sciences	64.6%	16.9%
Sheffield (The University of), School of Medicine	68.3%	33.5%
Southampton (University of), School of Medicine	55.0%	23.9%
St George's, University of London	69.6%	27.0%
Swansea University, School of Medicine	64.0%	20.0%
University College London, University College Medical School	68.5%	17.9%
Warwick (University of), Warwick Medical School	77.1%	27.5%
Other UK medical school	75.0%	25.0%
UK Total	67.8%	24.4%
Other EEA (non UK) country	57.6%	19.8%
Other non-EEA/non-UK country	57.1%	23.2%
Non-UK Total	57.2%	22.1%

¹¹⁸ National F2 Career Destination Survey (2012)

<http://www.foundationprogramme.nhs.uk/index.asp?page=home/keydocs#fpar>