



NAPC | National Association
of Primary Care

Independent Review of Under Doctoring in Kent and Medway – March 2026

Commissioned by Kent and Medway ICB

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Executive Summary

Kent and Medway Integrated Care Board commissioned this independent review to develop a shared, evidence-based understanding of under-doctoring across the system and to identify practical actions to stabilise and strengthen general practice. The review was undertaken over six weeks and combined structured qualitative interviews, a cross-system workforce survey, and detailed quantitative analysis of workforce, activity, demographic and performance data.

The findings demonstrate that under-doctoring in Kent and Medway is not simply a numerical shortfall of GPs. Rather, it is a structural, geographically concentrated and system-amplified condition shaped by rising clinical complexity, demographic pressure, supervisory burden, workforce configuration, cultural expectations and interface inefficiencies. Across interviews and survey responses, under-doctoring was consistently described as not just headcount alone, rather: increasing patient need, particularly in deprived and coastal communities, is intersecting with declining partnership capacity, FTE drift, and supervisory expansion through ARRS and training roles.

Emotional fatigue and moral distress are strongly linked to retention risk. Attrition appears to be driven less by isolated stress events and more by sustained cognitive load, loss of relational continuity, perceived system unfairness and erosion of professional agency. Deprivation and ageing populations amplify these pressures in specific localities, creating self-reinforcing recruitment spirals.

The evidence shows that under-doctoring is not uniformly distributed across Kent and Medway; rather, it clusters in neighbourhoods where demographics, lower GP WTE per 10,000 patients and workforce fragility combine. Historical commissioning and contracting across the patch has not been consistent, and a number of the issues highlighted in this report are longstanding and the time and capacity needed to address this should not be underestimated. Although the medical school is now in place, there has not yet been enough time for locally fully trained GPs to enter the workforce. Nationally the system is the 5th lowest for under-doctoring, with a general concentration in the South East, and some suggestion that this may be impacted with the proximity to London.

Survey findings reinforce this picture. Recruitment is perceived as slow and constrained within a competitive labour market. Retention pressures are systemic. Supervision capacity is stretched. ARRS and skill-mix expansion are seen as helpful but not transformative where clinical complexity exceeds substitution capacity. Cultural norms of “absorptive buffering” mean doctors are compensating for structural gaps, masking risk while increasing burnout. Funding, incentives and local support mechanisms are perceived as misaligned with workload reality.

Quantitative analysis corroborates these perceptions. Workforce growth is largely driven by salaried and trainee GPs while partner numbers decline. GP workforce scaling flattens in larger practices, indicating diminishing proportional coverage. Lower substantive GP density is associated with higher locum utilisation and operational volatility. A non-linear demand relationship demonstrates a strain zone where high appointment volume and sub-benchmark GP capacity coincide. Demographic modelling identifies high-risk ageing hotspots where workload exceeds workforce scaling. An imbalance index further highlights practices with critical under-supply relative to need.

Taken together, the evidence indicates that under-doctoring in Kent and Medway is a compound structural condition requiring targeted, locality-sensitive intervention rather than uniform system-wide expansion alone.



Whilst the aim of the review was to consider under-doctoring, care should be taken to avoid this as being a proxy for under-caring. The language used when moving to delivery needs to be considered. For some practices 'under-doctoring' may result from active decisions based on multiple factors including workforce cost and availability (real and perceived), future funding uncertainty, size of practice, operating models, and estate constraints. These causes for under-doctoring should be considered separately to a number of factors such as inability to recruit and lower retention rates which are not direct decisions of practices. The need to understand the balance between these necessitates a requirement for a nuanced, tailored approach to any solution.

The review recommends an overlapping, relational and developmental approach focused on:

- Creating a shared and more sophisticated understanding of workforce capacity using a weighted under-doctoring index that incorporates complexity, supervision and interface burden.
- Targeting investment to high-risk localities through stabilisation support.
- Engagement using a peer to peer, tailored curiosity-based approach, recognising that for individual practices, the causes that underpin under-doctoring, are complex and perceptions as to the cause may be misaligned.
- Addressing supervision capacity as a binding constraint to enable safe workforce expansion.
- Repairing primary–secondary care interface friction to reduce inefficiency and moral injury.
- Modernising employment models and establishing credible post registration career pathways to strengthen retention.
- Embedding flexibility and portfolio career opportunities aligned to changing professional norms.
- Consider a commissioning approach initially, rather than a contracting approach to reflect the need to address the need for understanding. Contractual changes could follow later once enough alignment has been reached.

Sustainable improvement will depend as much on how change is approached as on the interventions themselves. Trust, continuity of relationship, and alignment between system support and frontline reality will be critical.

Short-term actions include: stabilise pressure and rebuild trust. In the medium-term: correct structural misalignment and embed recruitment & retention infrastructure. Long-term actions include: redesign workforce architecture and commissioning logic to reflect complexity and demographic reality

This report provides a clear diagnostic foundation and a structured direction of travel. Implementation will require phased, adaptive action supported by continuous monitoring and partnership working.



Introduction

General Practice sits at the heart of the NHS, providing the first point of contact for the majority of patients and coordinating care across an increasingly complex health and social care system. The availability, stability, and sustainability of the general practice workforce is therefore fundamental to population health, system performance, and public confidence in healthcare services. Persistent shortages of General Practitioners place significant strain on practices, staff, and patients, and risks undermining efforts to improve access, continuity, quality, and integration of care.

Kent and Medway have experienced sustained challenges in relation to GP workforce capacity over many years. Relative to population need, levels of GP provision have remained below national average. This has contributed to higher workloads, recruitment and retention difficulties, and pressure on service delivery. These constraints have been compounded by rising demand, demographic change, increasing clinical complexity, and a changing policy landscape. As a result, under-doctoring has become a structural issue rather than a short-term fluctuation, with implications for both current performance and future resilience.

In response to these long-standing concerns, Kent and Medway Integrated Care Board commissioned the National Association of Primary Care (NAPC) to undertake an independent review of under-doctoring across the system. The purpose of this review was to develop an evidence-based understanding of the factors contributing to workforce shortages, to assess how these challenges are experienced at practice and system level, and to identify practical opportunities for improvement. Importantly, the review was designed to be independent, reflective, and grounded in the lived realities of general practice.

The review was conducted over an intensive six-week period, reflecting the ICB's commitment to addressing this issue with urgency. This compressed timescale demonstrates a strong intent to move rapidly from diagnosis to action. Within this period, the review team at NAPC undertook a structured programme of engagement and data collection, including in-depth interviews with key system stakeholders and practice leaders, alongside a comprehensive survey distributed to all general practices in Kent and Medway. The review team also reviewed existing data from the ICB and publicly available data in relation to general practice.

The qualitative interviews provided insight into strategic, operational, and workforce perspectives across the system. Participants included senior leaders, commissioners, clinical leaders, and representatives from partner organisations, as well as GPs and practice managers. These interviews explored recruitment and retention challenges, workload pressures, organisational sustainability, support arrangements, and the wider context shaping workforce decisions. They also examined the success of previous and existing initiatives that have been implemented to address this issue.

The survey complemented this qualitative work by capturing the experiences and views of practices at scale. This mixed-methods approach ensured that the review was informed both by depth of understanding and breadth of participation, strengthening the robustness of the findings.

Throughout the review, emphasis was placed on understanding under-doctoring as a multifaceted challenge rather than a single cause problem. Workforce shortages are shaped by national policy, funding mechanisms, training pathways, contractual arrangements, local labour markets, estate capacity, population health needs, and organisational culture. At practice level, these factors intersect with leadership capacity, partnership models, financial viability, and community context.



The review therefore sought to move beyond surface-level explanations to examine how structural, system, and practice-level dynamics interact.

The review was also informed by wider national evidence on primary care workforce trends, recruitment patterns, and service redesign. Kent and Medway's experience reflect many of the pressures facing general practice nationally but also exhibits distinctive local characteristics. Understanding both the shared and unique elements of these challenges is essential in developing responses that are realistic, proportionate, and locally appropriate.

This report presents the findings of the review and sets out a series of conclusions and recommendations for the ICB and system partners. It aims to provide a balanced, evidence-based assessment of current conditions, identify areas of risk and opportunity, and recommend informed decision making.

The pace of this review means that it should be seen as a foundation for ongoing work rather than a definitive endpoint. Some issues identified will require further detailed analysis, co-design with practices, and sustained investment over time. However, the findings provide a clear starting point for strengthening workforce planning, improving system support, and enhancing the long-term sustainability of general practice in Kent and Medway.

Ultimately, addressing under-doctoring is critical to ensuring that residents have timely access to high-quality, continuous, and coordinated care. It is also central to maintaining a motivated, supported, and resilient primary care workforce. This report is offered as a contribution to that shared objective, and as a basis for collective action across the system.

Methodology

This review integrated a rigorous mixed-methods approach, combining qualitative inquiry, quantitative analysis, and structured data interrogation to generate a multidimensional and comprehensive understanding of under-doctoring in Kent and Medway. The methodological architecture was intentionally constructed to capture both analytical depth and lived experience as well as contextual nuance, at system-level breadth, strategic relevance and population coverage.

Qualitative Interviews

A programme of Structured interviews was conducted across two analytically distinct cohort: system-level stakeholders and general practices leaders. Discreet interview frameworks were designed for each group to reflect their differing statutory functions, accountability and vantage points within the concentrated on macro-level determinants including strategic intent, commissioning architecture and policy, commissioning, workforce planning, and support mechanisms.

In contrast the Practice-level interviews examined frontline operational conditions, recruitment and retention dynamics, workload pressures, organisational sustainability, and the lived experience of under-doctoring within the day-to-day service delivery.

All interviews were delivered using a standardised core structure to enable cross case comparability, while preserving sufficient flexibility for contextual elaboration and emergent insights.



A structured thematic analysis was applied to the qualitative interview dataset. Transcripts were systematically reviewed, coded, and iteratively synthesised to identify recurring patterns, areas of convergence, and material points of divergence across participant groups. The resulting thematic architecture constituted the principal qualitative evidence base for the review and directly informed the formulation of the report's strategic recommendations.

Practice Survey

A structured survey was developed and disseminated through multiple means to all practices across Kent and Medway to obtain practice-level insight at scale and to triangulate the qualitative findings.

The survey framework was organised around defined analytical domains, which aligned to the reviews conceptual model, including structural workforce determinants, demand and workload intensity, professional cultural norms, systems incentives and constraints, place-base variation and the perceived impact and effectiveness of prior interventions.

Survey Structure

Responses were recorded using a standardised Likert-scale format, to enable qualitative aggregation and comparative analysis. Targeted follow-up questions were incorporated to allow respondents to contextualise or qualify their ratings.

Contextual variables including respondent role, contractual type, organisational configuration and geography were collected, to facilitate a stratified analysis and to interrogate variation across professional groups, contractual models and localities within Kent and Medway.

Survey content was organised around a set of core analytical domains reflecting the principal drivers and consequences of under-doctoring. These domains examined structural workforce capacity, demand and workload pressures, professional and cultural norms, system-based incentives and constraints, place-based variation, and the perceived effectiveness and unintended consequences of interventions. Each domain was underpinned by a defined rationale and a set of aligned statements designed to test specific hypotheses about workforce sustainability and system functioning.

Where respondents indicated disagreement or concern, structured response options were used to identify underlying causes, including recruitment barriers, market constraints, premises limitations, and regulatory or visa-related issues. This approach supported more granular interpretation of headline scores and reduced reliance on open-ended responses alone.

The survey design was informed by existing workforce and system performance evidence and aligned with the broader analytical framework used in the review. This ensured coherence between survey findings, interview themes, and quantitative system data.

Survey responses were analysed at various levels, enabling identification of common pressures, differing experiences, and place-based variation. Findings were then triangulated with qualitative interview data and secondary datasets to strengthen validity and inform the development of recommendations.

Quantitative Data Review

The review incorporated analysis of existing workforce, performance, and access datasets provided by Kent and Medway ICB, alongside relevant National publicly available datasets that were localised, but was not limited to. These included workforce establishment and full-time equivalent metrics,

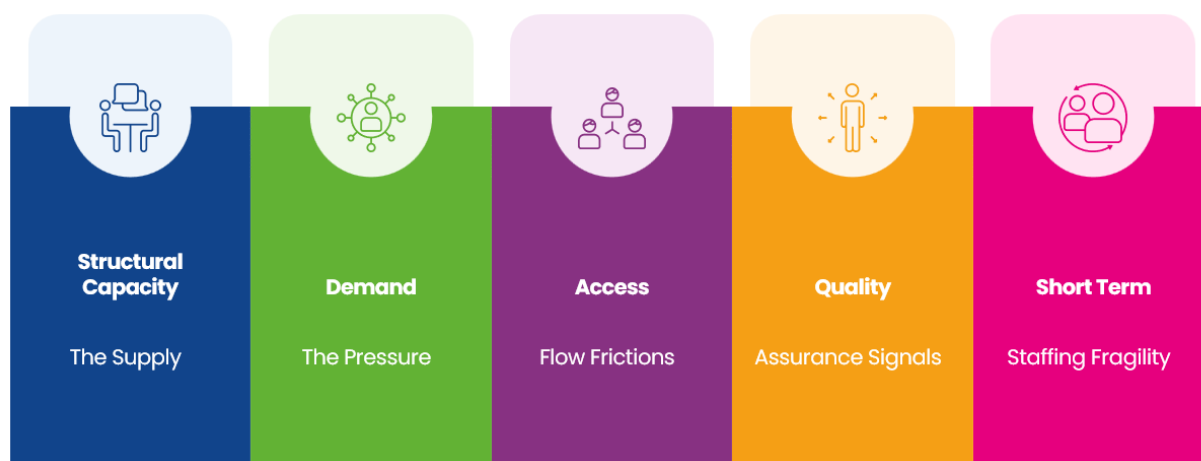


activity volumes and access indicators and findings from national patient experience and performance surveys, including the National GP Patient Survey.

These data sources were interrogated to contextualise locally derived insights, identify longitudinal trends and assess unwarranted variations across geographies. The qualitative review established an objective evident baseline against which qualitative interview and survey findings were triangulated and stress tested. This integration of system level data with stakeholder insight materially strengthened the analytical rigour and overall credibility of the conclusions.

In addition to primary data collection, a structured quantitative data review was undertaken using workforce and performance data provided by Kent and Medway ICB alongside publicly available datasets. The data review methodology followed a defined structure and variable set.

To support systematic interpretation of quantitative indicators, the data were organised within a five-domain framework. This was designed to capture the dimensions through which under-doctoring appears and impacts system performance, moving beyond single-metric workforce measures to reflect the interaction between domains.



Data Review Methodology

Key variables included:

- GP Whole Time Equivalent (WTE) per 10,000 patients
- Appointments per 1,000 patients
- Patient DNA (Did Not Attend) rates
- QOF weighted achievement percentage
- CQC ratings
- Locum utilisation and vacancy risk indicators (Considerations for fluctuations such as sickness absence and Parental leave)

These variables were selected to provide a composite view of workforce capacity, demand intensity, service resilience, and performance outcomes.



Risk Scoring and Weighting

A weighting framework was applied to reflect the relative impact, persistence, and system-level influence of each risk indicator. Rather than treating all indicators as equivalent, weightings were used to prioritise those risks that materially affect workforce sustainability and service continuity.

Risk contribution was assessed using a structured approach:

Expected Risk Contribution = Impact × Persistence × System Influence

Higher weighting was assigned to indicators that:

- Directly constrain GP availability, list coverage, or clinical resilience
- Represent structural or sustained pressures rather than short-term fluctuations
- Affect dependency ratios, substitution capacity, or downstream system demand

The application of weighting improves clarity and actionability by elevating high-impact structural risks, supporting defensible prioritisation and sequencing of interventions. The weighting reflects analytical judgement informed by workforce data and system knowledge and is intended to support focus rather than replace detailed local assessment. It reflects a view at the time of writing and if continued to be used should be reviewed as system conditions, data quality and the relative importance of the risks evolve.

Risk Stratification

Practices were stratified along a risk spectrum (e.g., lower to higher risk) based on composite indicators. Data were source-mapped and chronologically validated against ICB-provided datasets to ensure consistency and reliability. The outputs of this analysis informed the selection of practices for structured interviews, ensuring representation across varying risk profiles.

Secondary Benchmarking

The review also incorporated analysis of relevant national datasets, including the GP Patient Survey and other publicly available performance indicators. These were used to contextualise local findings and support benchmarking against regional and national comparators.

Integration and Analysis

Finding derived from the qualitative interviews, structured surveys and secondary data analysis were examined concurrently and subsequently integrated through formal process of methodical triangulation. Emergent qualitative themes were systematically compared against quantitative survey outputs and system-level performance data to assess convergence, interrogate discrepancies and refine interpretive judgements.

This integrative analysis approach enabled the review to differentiate between structural, system-level drivers, place-based variation, and practice-specific operational factors. The consolidated evidence bases directly informed the formulation of report's recommendations, ensuring that proposed interventions are empirically grounded, contextually calibrated and operationally credible within Kent and Medway.



Considerations

Given the compressed six-week timescale, the methodology prioritised rapid but rigorous evidence gathering, consistency of approach, and practical relevance. While the review provides a robust diagnostic assessment, some issues identified will benefit from further longitudinal analysis and ongoing monitoring.

Previous and current Interventions

These include a previous mid-career coaching offer that was funded through the training hub and the LMC in a collaborative piece of work and delivered by a coaching consultancy. Continuing funding could not be found, however the LMC felt it was important and now offer 1:1 sessions to any GP in Kent and Medway. Feedback has been positive with colleagues reporting increased enthusiasm and cases of individuals being able to return to work. There is a steady current uptake according to the LMC.

The LMC also run a mid-career peer group which meets four times a year. Uptake is not as high as GPs attend in their own time with no backfill. The LMC also fund and deliver the Next Generation GP programme – supported by NHSE’s Nish Manek in the background who helps to find speakers, with the LMC funding venue costs. There have been four cohorts, once every two years. Many have gone on to become system clinical leads, CDs of PCN and GP partners.

There has also been a GP attraction offer which was independently reviewed. The evaluation of the GP Attraction Offer and Coastal Fellowship programmes found that while the schemes were positively received in principle and contributed to increased confidence, mentoring support, and delivery of quality improvement projects, the impact was variable and constrained by a lack of clarity, structure, and consistent communication. As summarised in the report’s Kirkpatrick-based evaluation framework, the New to Practice Programme (NTPP) and protected learning time were highly valued and, in at least one case, prevented early attrition, while mentoring was widely appreciated despite limited formal structure. The Coastal Fellowship demonstrated clearer educational and career trajectory impact, particularly in relation to deprivation and population health insight. However, many participants reported uncertainty about the specific expectations and added value of the Attraction Offer beyond financial incentives, with delays in payments and limited governance clarity reducing perceived effectiveness.

Overall, the intervention showed evidence of individual-level benefit and potential retention impact, but required clearer design, defined pathways, structured mentoring, and stronger operational oversight to function as a reliable workforce stabilisation mechanism in under-doctored areas.

The visa application support offer from Training was mentioned several times in the interviews. Whilst this is run by one individual, several mentioned that it was low cost and helpful.

It should be noted that a common feature during conversations was a difference between what GPs mentioned that was or would be supportive and what was offered by others in support. There were also differences between practices about what had been helpful.



National policy

A new national contract appears with current timescales to be scheduled to commence in 28/29. Given any implementation and benefits will take time, it appears unlikely that national interventions will deliver what is needed for Kent.

The upcoming contract for 26/27 allows more flexibility to employ GPs within ARRS. This combined with some PCN funding moving to practices and being earmarked for GP recruitment, provides some potential freedom even if no new overall investment. However, given the possibility of a ballot for strike action, attention will need to be given to how any local schemes are presented and delivered alongside national changes.

Results

Qualitative interviews

18 interviews were conducted. 9 were from practices, with 6 being from lower risk and 3 from higher risk practices. Whilst the aim was to conduct an equal amount from each end of the risk spectrum, there was less uptake from the higher risk practices. This could indicate a level of operational pressure. The remaining 9 interviews were from other stakeholders and included members of the ICB, workforce, population health, medical directors, training hub and the LMC.

There were six consistent themes that emerged from the interviews. There were also some minority views and some views that came across more strongly or with more emphasis from a particular sector.

Common themes

Theme 1: Under-doctoring is experienced as complexity and capacity strain, not simply headcount

“It’s not as straightforward as GP patient population ratio.”

Across interviews, under-doctoring is rarely framed as “just not enough GPs.” It is described as:

- FTE drift (headcount up, FTE down)
- GP to patient ratios worsening in deprived areas
- Complexity: “we’re not seeing the sore throats”
- Supervisory burden of ARRS roles
- Reduced capacity due to cognitive load

Under-doctoring is experienced as compression of complexity per GP combined with supervisory expansion.

Theme 2: Moral distress, burnout and emotional fatigue

“Absolutely undoable.” “Hamster wheel.” “Fighting the fire all the time.”



- “Moral injury”
- “Burnt out”
- “Decision fatigue is high”
- “Thrown to the lions”
- “The buck stops with us”

The effect of the pressure is such that several describe early retirement intent or trainees intending to leave.

Attrition is strongly linked to sustained emotional load rather than isolated acute stress.

Theme 3: Deprivation and geography amplify attrition risk

“Inverse care law.” “Rusty coastal fringes.”

Areas that were repeatedly named included, Medway, Swale, East Kent and coastal communities. Practices in deprived areas were described as experiencing spirals and facing churn. The system metrics used did not reflect carrying safeguarding and complex unmet need.

Recruitment difficulty and workload complexity cluster geographically, reinforcing inequity.

Theme 4: Interface failure (primary-secondary care) drives inefficiency and frustration

“Trust has gone.” “We end up holding the hot potato.”

Interviewees spoke of referrals rejected or bounced, with secondary care managing its own capacity by deflecting work. Appointments being duplicated whilst patients were waiting.

Attrition risk is amplified by perceived system unfairness and loss of professional agency.

Theme 5: Loss of continuity and relational medicine

“No humanity in medicine.”

There was a feeling of loss to the extent of grieving precipitating a drop in work satisfaction. The focus on transactional care and digital front door is seen as diluting relational meaning.

Attrition is not purely workload-driven; it includes erosion of professional identity.

Theme 6: Leadership, supervision, and culture should act as the leverage points

“Leadership and culture are the highest leverage.”

General practice was described as “Quite lonely”. Suggestions to improve this were:

- Educational leadership
- Filling mentorship gaps
- Early-career supervision
- A focus on belonging and culture



Retention may be more sensitive to local leadership ecology than to numbers alone.

Minority perspectives

Beyond the 6 themes described above there are perspectives that although were in the minority are important to acknowledge. From a system perspective this may represent the loudest or unheard voices, and the practices that are perceived to be struggling, or with solutions that might not be applicable to others.

“We are not under-doctored locally” - “It kind of works well for us at the moment.”

A few practices report:

- Stable staffing
- Good retention
- Balanced workflow
- Apex data-driven management

This minority perspective highlights intra-Kent heterogeneity.

Alternative narrative: *“We don’t necessarily need more GPs”*

- Workforce mix may matter more than GP count
- MDT substitution is appropriate
- “I genuinely don’t care” if fewer GPs but the outcomes are good

This contrasts with strong GP-ratio emphasis elsewhere.

Data scepticism varies:

- A few describe metrics as “rubbish data” or “sketchy”

Role specific comments

As would be expected comments varied depending on the role and view with which general practice is seen. This is important when considering what levers exist in differing parts of the system and how they need to be used.

GP Partners more likely to emphasise:

- Burnout and retirement
- Financial risk and premises
- “Buck stops with us” accountability

Systems based / Strategic Roles more likely to emphasise:

- Data systems and variation
- Equity and commissioning narrative
- Association vs causation caution

Training / Workforce Leads more likely to emphasise:

- IMG sponsorship as leverage



- Supervision capability
- Early-career attrition signals

The overall interpretation of the interviews suggests that the core drivers of attrition are:

- Sustained cognitive and emotional overload
- Deprivation-linked workload asymmetry
- Supervisory expansion without time relief
- Interface inefficiency and rejection loops
- Loss of relational continuity
- Partnership fragility and premises risk
- Perception gap between system narrative and frontline reality

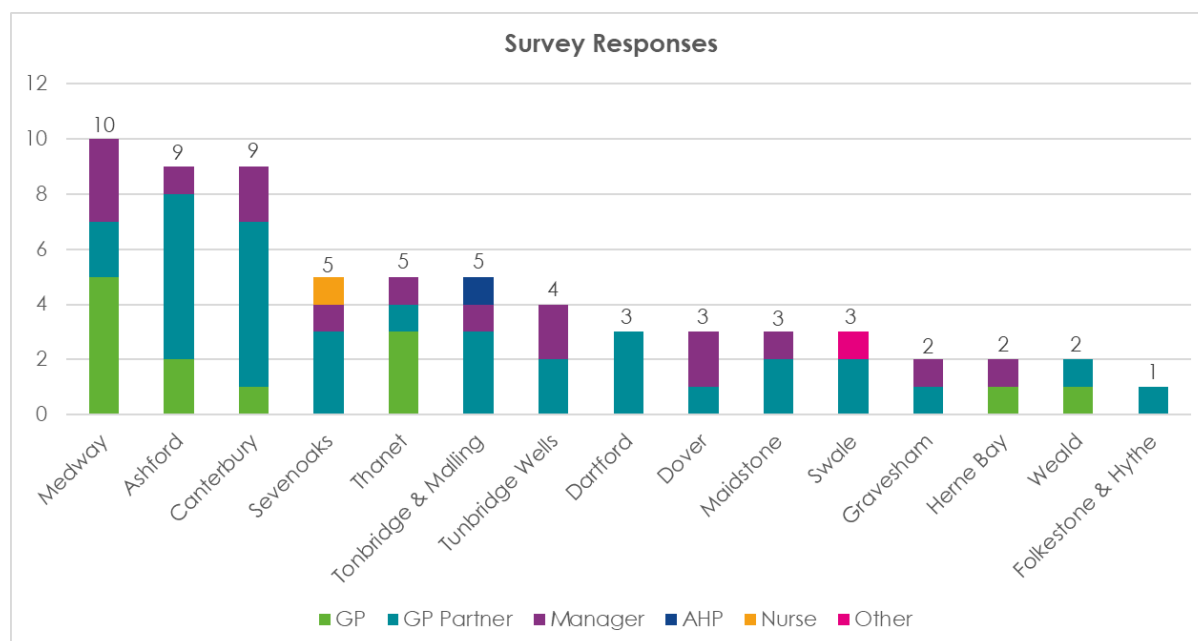
Although a few practices report stability, and a minority (2) rejected the GP centric framing, the problem facing Kent should be interpreted as not just a numerical shortage. Rather it is a compound effect of complexity, supervisory expansion, emotional fatigue, and geographic inequity, amplified by system interface friction and perceived loss of professional agency.

Practice Survey

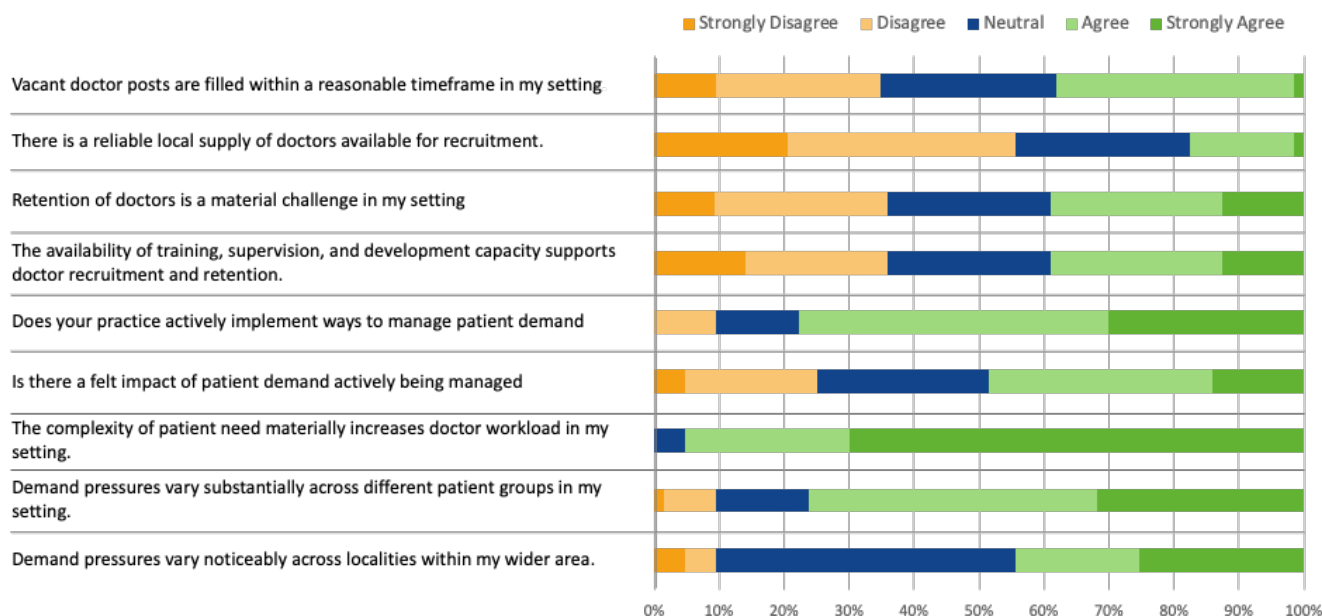
This cross-locality workforce perception survey covered recruitment, retention, demand pressure, skill mix and system support. It was distributed in two routes, via the ICB and the PMC. There were 66 responses covering the following roles: 35 GP Partner, 26 Salaried, 1 Locum, 4 Other/Management. This survey dataset appears structurally partner dominated. This matters because:

- Partners may perceive funding and premises constraints more acutely.
- Salaried doctors may weight workload boundaries differently.
- Minimal locum voice means locum-related perceptions are largely second-hand.

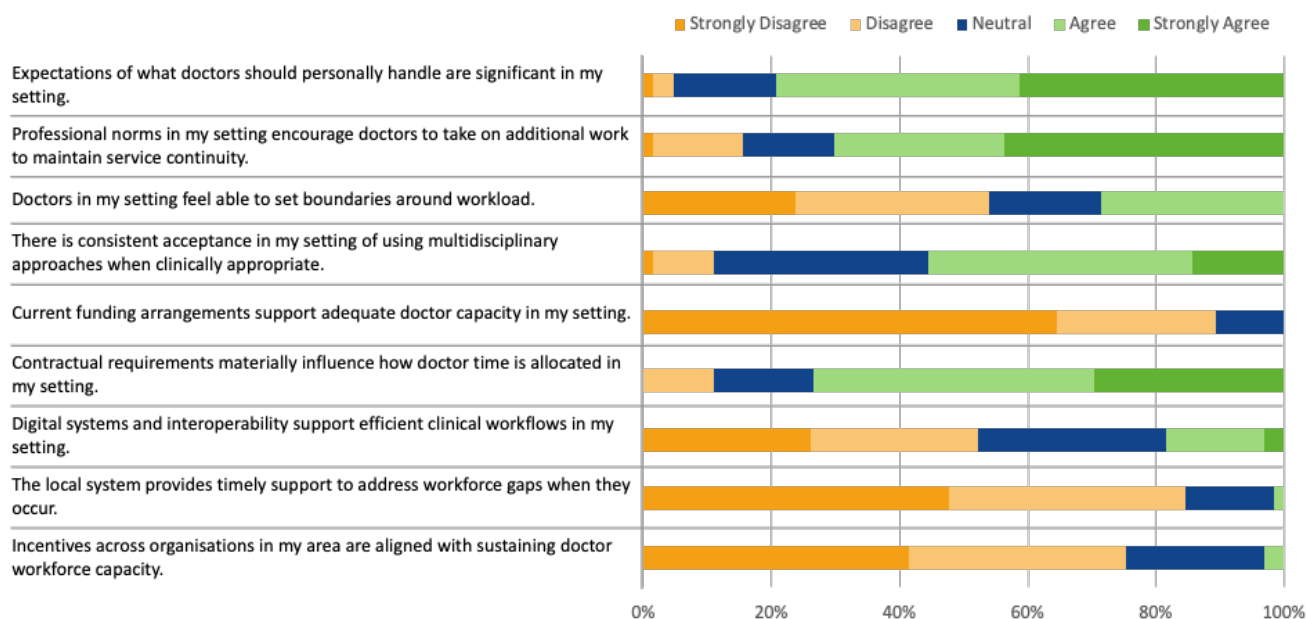
System implication: Findings may reflect ownership and governance pressures as much as frontline workload.



The response rate is interesting as areas with perceived under-doctoring such as Medway and Thanet had high response rates compared to Swale and Herne Bay with lower response rates. This variation in engagement should be considered during support interventions as the top three localities account for 42% for the responses. For the localities with fewer responses conclusions from the survey should be triangulated with the workforce data such as the WTE per 10,000 patients and the age profile.

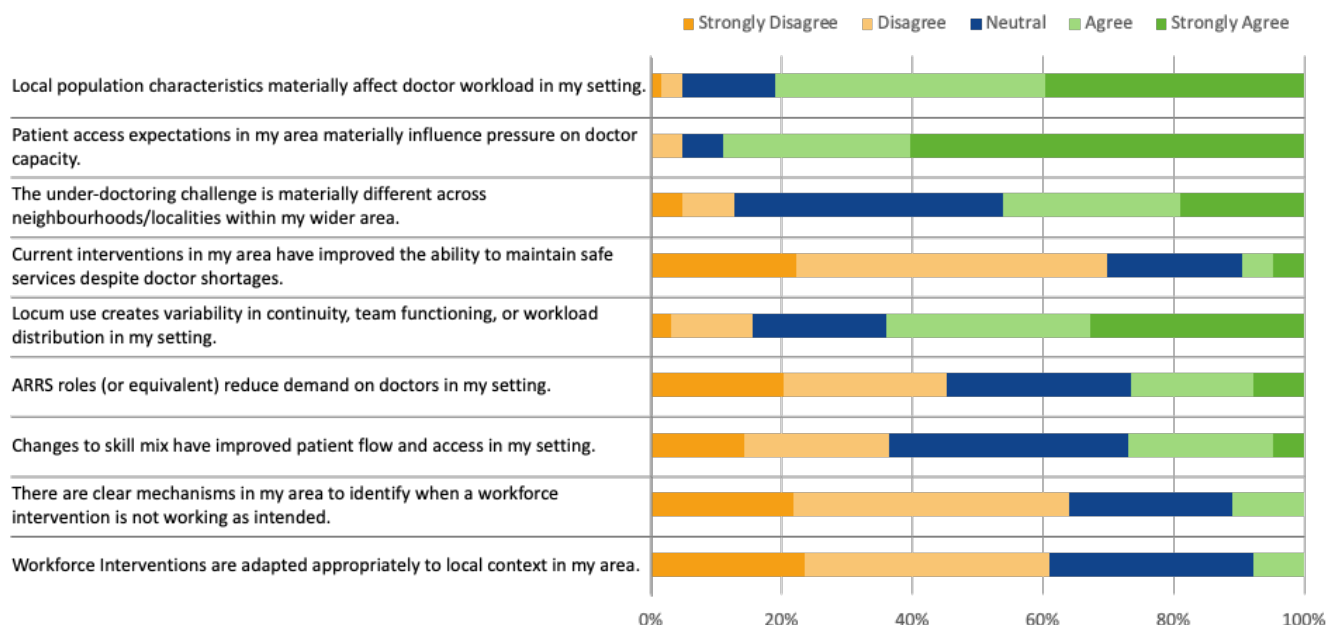


The responses on recruitment, retention and demand pressure collectively suggest a slow recruitment pipeline within a constrained labour market, with retention perceived as a systemic rather than episodic issue. Other issues include stretched supervision capacity, uneven intervention effectiveness case mix severity acting as a major workload driver, and workload pressures distributed non-uniformly across Kent and Medway.



The key interpretations on cultural, funding and system factors from the responses are indicative of a classic “absorptive buffering”: a cultural pattern of doctors compensating for structural gaps. There is

strong agreement in the expectations on doctors being significant, with professional norms encourage taking on additional work.



The responses indicate that perceptions of interventions, ARRS and system variation are characterised by views that impact has been partial rather than transformative. Local tailoring remains inconsistent and feedback mechanisms appear weak, set against strong agreement that population characteristics increase workload, and access expectations intensify pressure.

The level of under-doctoring varies across neighbourhoods, and locum use disrupts continuity and team functioning. There are mixed views about whether ARRS reduces demand, and skill-mix changes have improved flow. Finally, existing interventions have only limited endorsement for improving safety.

What are the reasons for lack of supply of doctors at the point of recruitment?





The survey suggests the following system view:

Workload & Working Conditions

- High workload intensity and complexity.
- Poor working conditions driven by excessive demand.
- ARRS and skill mix are helpful but not transformational.
- Complexity and population characteristics are dominant workload multipliers.

Retention & Workforce Stability

- Burnout and early retirement among existing GPs.
- Locum roles being more financially attractive.
- Retention seen as materially challenging.

Geography & Attractiveness

- Certain local areas viewed as unattractive to candidates.
- Funding and incentives are perceived as misaligned.
- Under-doctoring varies geographically.

Recruitment Processes & Market Dynamics

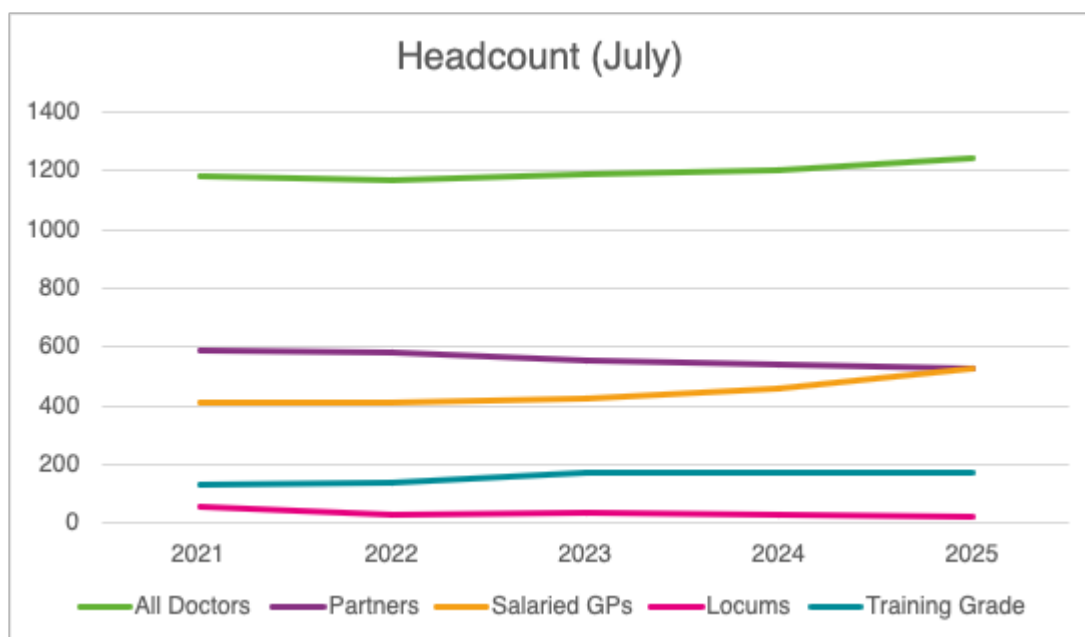
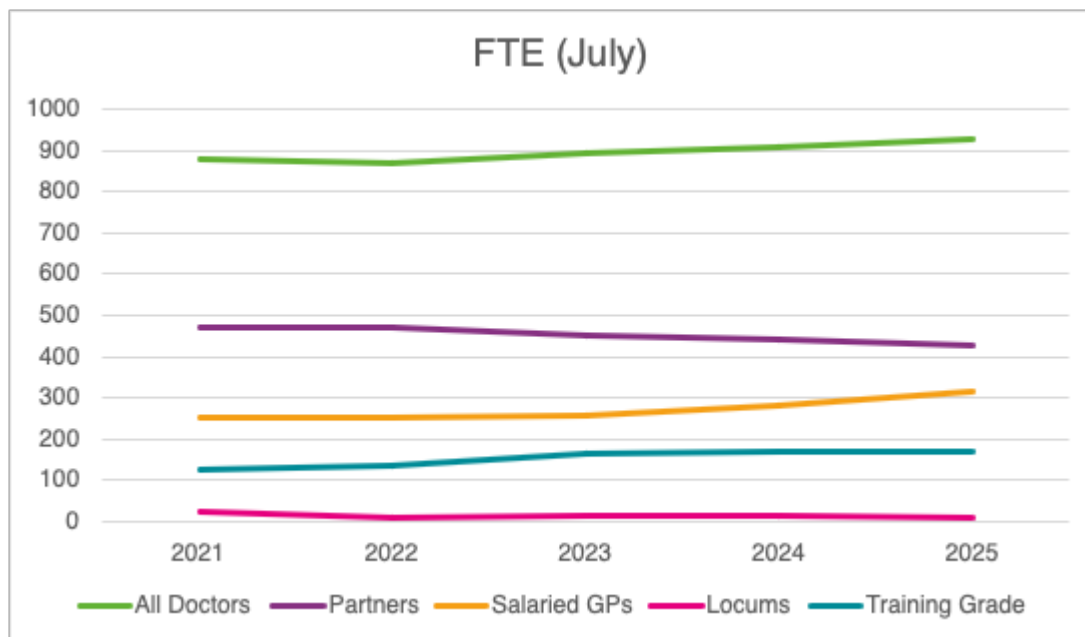
- Competitive job market favouring applicants.
- Recruitment pipeline seen as slow and constrained.
- Slow organisational recruitment processes.

The combination of rising demand, increasing clinical complexity, reduced recruitment supply, fragile retention and misaligned structural enablers such as premises, funding and incentives produce chronic under-doctoring concentrated in specific localities rather than a uniform workforce deficit across the entire ICB.

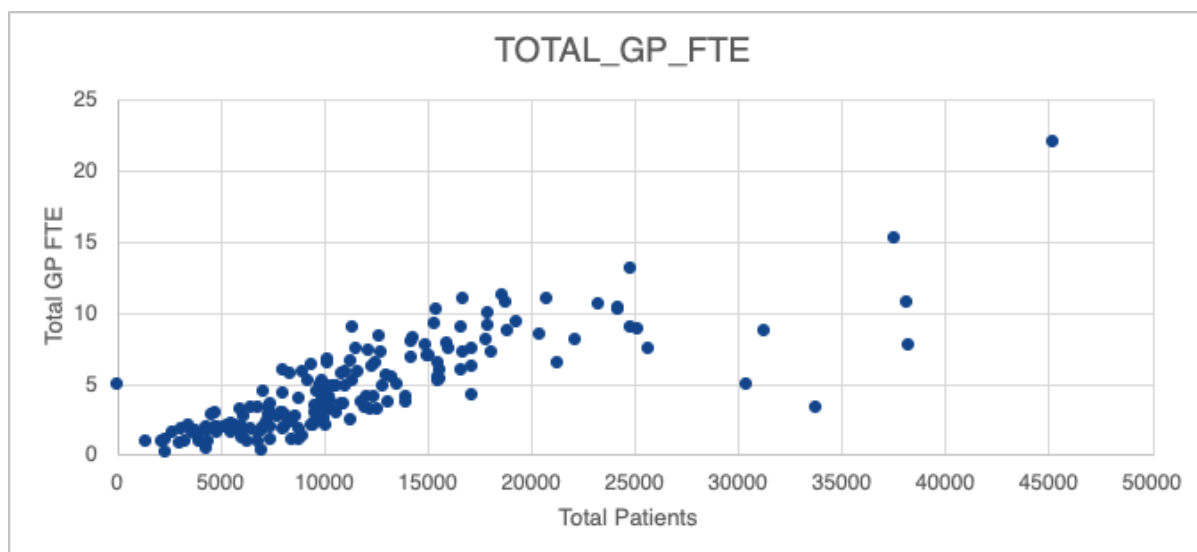


Quantitative data review

Workforce

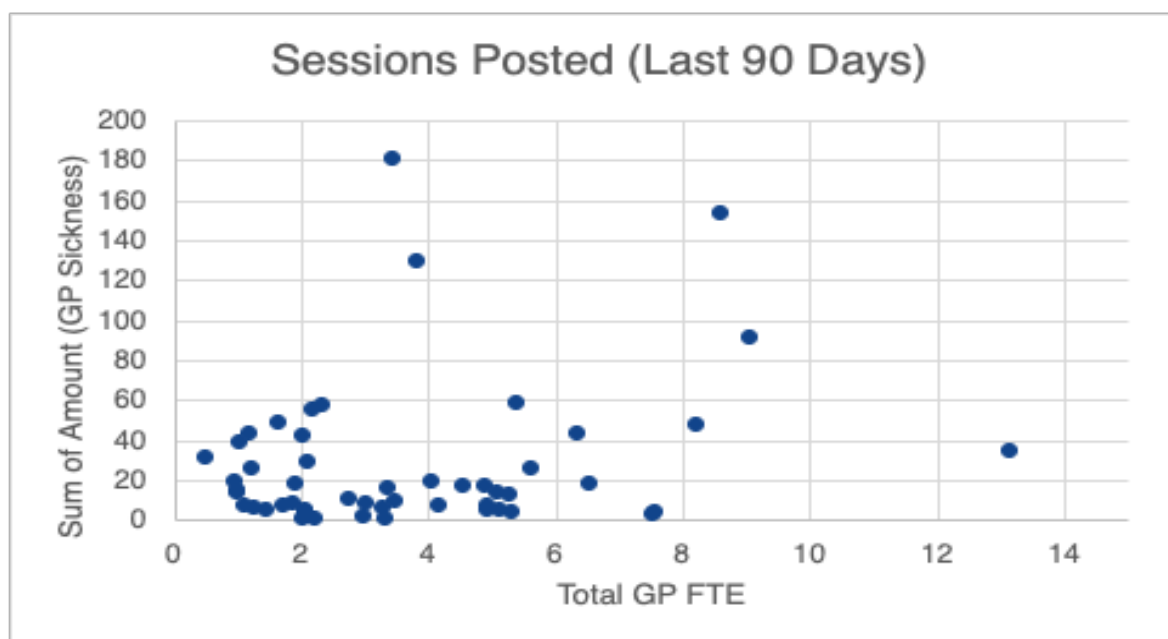


The increase in doctors is being driven by salaried and those in training grades. It will be important to retain those being trained in the area, both undergraduate and postgraduates. The reduction in partners reflects the national trend alongside headcount increasing more than fulltime equivalents.



The scatter plot demonstrates the expected positive association between registered list size and total GP FTE, with workforce capacity broadly increasing in line with patient volume up to approximately 25,000 patients. However, beyond this point the relationship visibly flattens and dispersion widens, indicating diminishing proportional scaling of GP resource at larger list sizes, substantial heterogeneity in staffing models among large practices. Evidence that list size alone becomes an unreliable predictor of GP workforce intensity, likely reflecting structural variation, workforce substitution effects, or differing levels of workload compression rather than simple linear growth.

Locum use



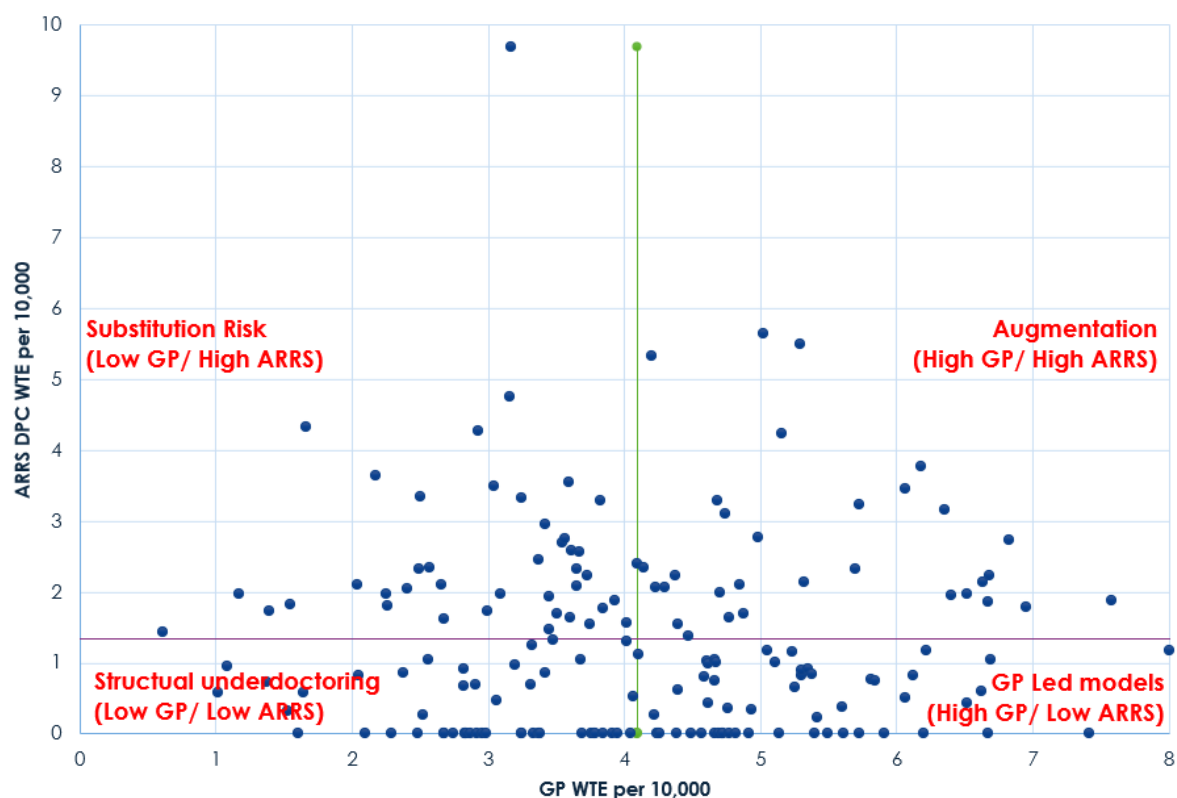
The scatter plot indicates an inverse relationship between substantive GP FTE and locum sessions posted for sickness cover over the last 90 days. Lower-FTE practices exhibit disproportionately higher locum utilisation and greater variability, suggesting increased workforce fragility and reduced

resilience at smaller scale; this pattern implies structural dependence on short-term cover where baseline capacity is thin, leading to reduced continuity, elevated marginal staffing costs, and potential diversion of funding from longer-term workforce stabilisation.

When considered alongside the previous chart (Total Patients vs Total GP FTE), a structural link becomes evident: practices that do not scale substantive GP FTE proportionally with list size, particularly where workforce density per 10,000 patients is lower, are more likely to rely on locum cover during sickness episodes. This is suggestive of under-scaling or baseline workforce compression and is associated with higher episodic locum substitution. In combination, the two charts suggest that inadequate substantive WTE density amplifies operational volatility and increases reactive locum expenditure, reinforcing the risk profile of practices operating below optimal GP-to-population ratios.

ARRS roles

ARRS Substitution vs GP Density



GP workforce density (GP WTE per 10,000 patients) against ARRS workforce density (ARRS WTE per 10,000 patients) illustrates overall clinical capacity and skill-mix configuration at practice level. It shows that low GP density reflects limited substantive medical cover relative to list size, whereas high GP density reflects stronger core GP provision. Low ARRS density indicates minimal multidisciplinary support requirement and high ARRS density indicates greater capacity for demand absorption through role substitution.

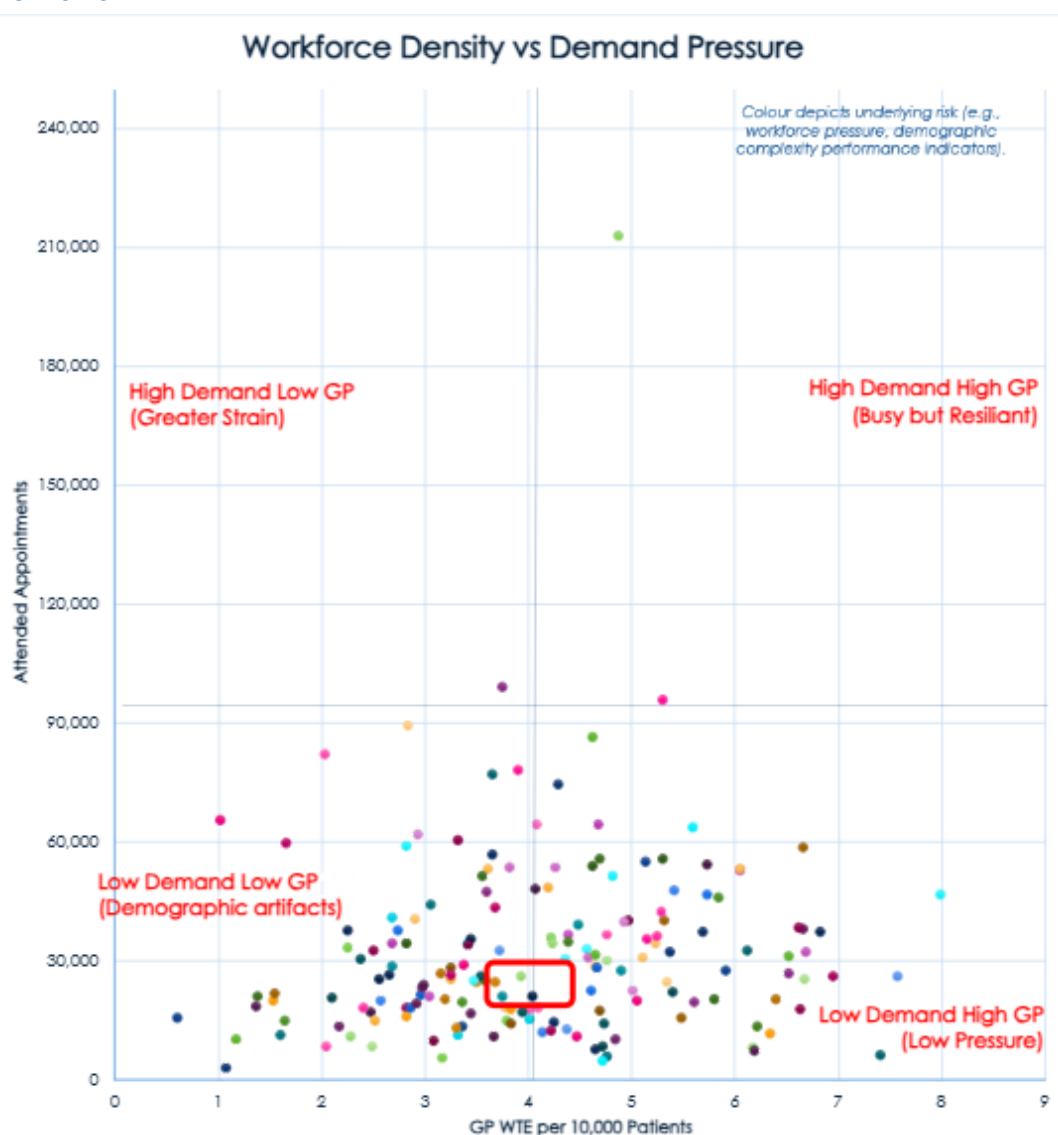
When viewed together, the quadrants reveal whether practices are structurally balanced, substituting GP gaps with ARRS roles, proportionately augmenting high GP supply, or operating in the most vulnerable position, the low GP / low ARRS quadrant, where both medical capacity and multidisciplinary support are constrained, indicating heightened risk of under-doctoring and workforce fragility.



It is important to note that with high ARRS substitution:

- Higher complexity means ARRS cannot fully absorb demand
- Mental health, LTC reviews, complex frailty, polypharmacy, multimorbidity require considerable GP judgement.
- Access metrics worsen quickly
- DNA, urgent-same-day requests, avoidable attendances, and email/phone backlog rise disproportionately.
- GP sickness and turnover increase
- Several practices in this quadrant already show elevated sickness costs (e.g., Summerhill, Sheerness, Martello, Old Parsonage).

Demand



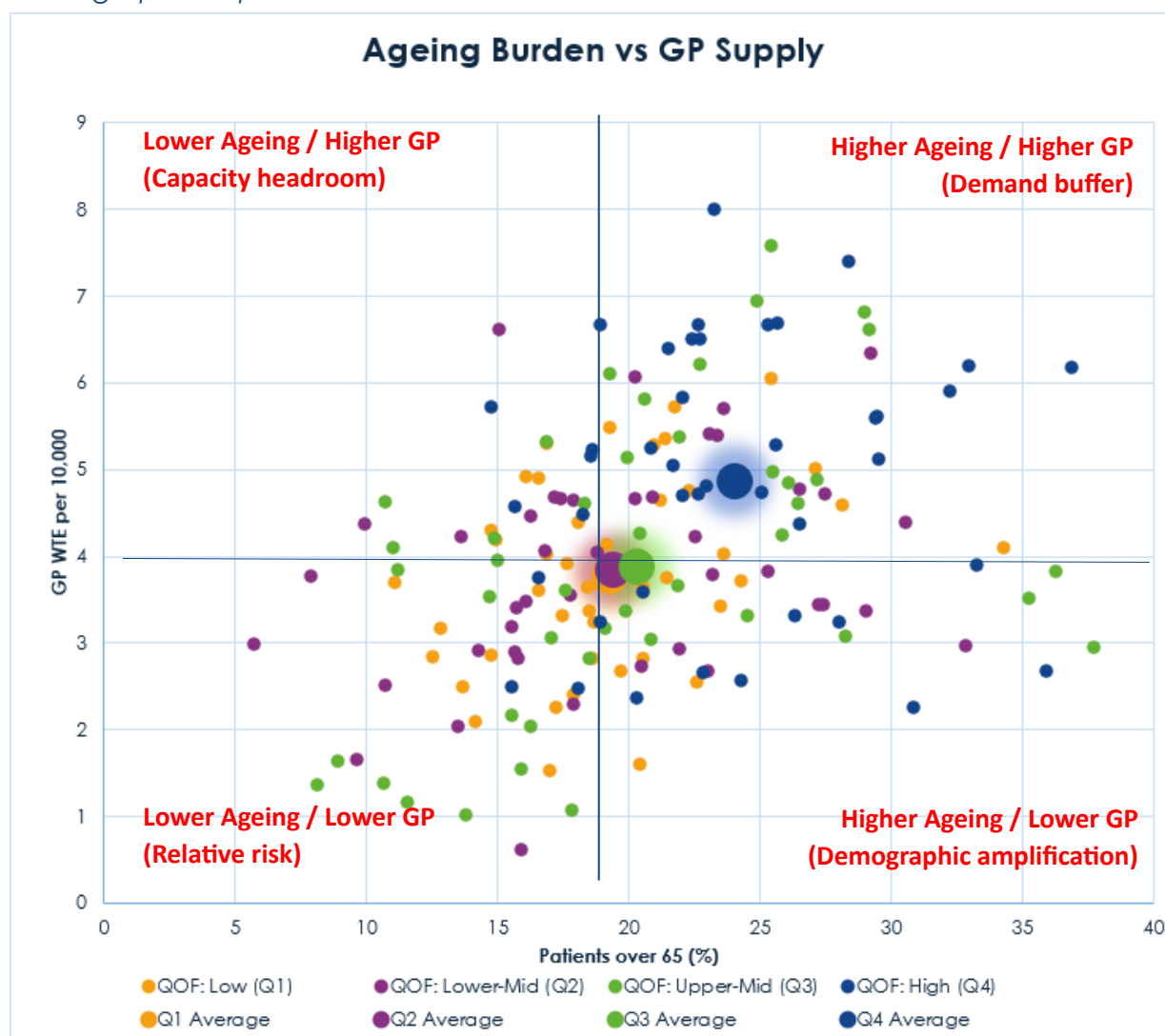
Most practices cluster between 2 and 6 WTE per 10,000 patients and 15,000 to 45,000 annual appointments, indicating moderate variation in workforce density but a wider spread in activity levels. The red box shows 3.5-4.5 WTE per 10,000 patients (note the BMA recommends 10 GPs per

10,000 patients). There is a non-linear relationship between WTE and output, evidenced by the absence of a clear linear productivity slope, the presence of high-WTE practices delivering relatively modest activity, and mid-WTE practices generating disproportionately high output.

This suggests that case mix, age structure and clinical complexity are mediating factors rather than workforce volume alone, with the strain zone emerging in the upper-left quadrant above 45,000 appointments and below 3.5 WTE per 10,000 where increases in workload are no longer absorbed proportionally.

Caution should also be taken in that appointment data does not reflect all practice or professional activity and practice efficiency and effectiveness will also impact on the requirement for appointments. When combined with the known differences in how practices complete workforce returns, trend data may give more insight.

Demographic impact



The analysis demonstrates a positive but non-linear relationship between the burden of an ageing population and GP workforce density, with most practices clustering between 15 to 25% aged 65+



and 3 to 5 WTE per 10,000 patients. However, supply scaling attenuates beyond approximately 25% elderly population. Dispersion remains substantial at comparable demographic levels, and a clearly identifiable high-risk cohort emerges where elevated ageing coincides with sub-benchmark GP capacity. This indicates that workforce distribution is only partially responsive to demographic demand and that, in the highest ageing quadrant, workload complexity is likely to amplify faster than clinical capacity growth.

Practices with high % aged 65+ and low GP WTE/10k face geometric workload pressure.

Multiple NHS and academic workload analyses (e.g. Hobbs et al., *Lancet*, 2016; NHS Digital workload datasets) show:

Patients aged 65+:

- Consult approximately 2-3 times more frequently than younger adults.
- Consult for longer duration
- Have higher prescribing volume
- Require more complex multimorbidity management
- Have higher administrative burden (referrals, results, care coordination)

Therefore, workload impact is not linear with age proportion, and if at the same time GP WTE/10k decreases, the denominator shrinks which creates multiplicative strain.

This is operationally important as it can manifest itself through GP burnout, access deterioration, increased urgent care cases, higher locum dependency and reductions in continuity of care.

For Kent, the following practices are highlighted:

High Risk ageing burden - These are the true under doctoring hotspots.

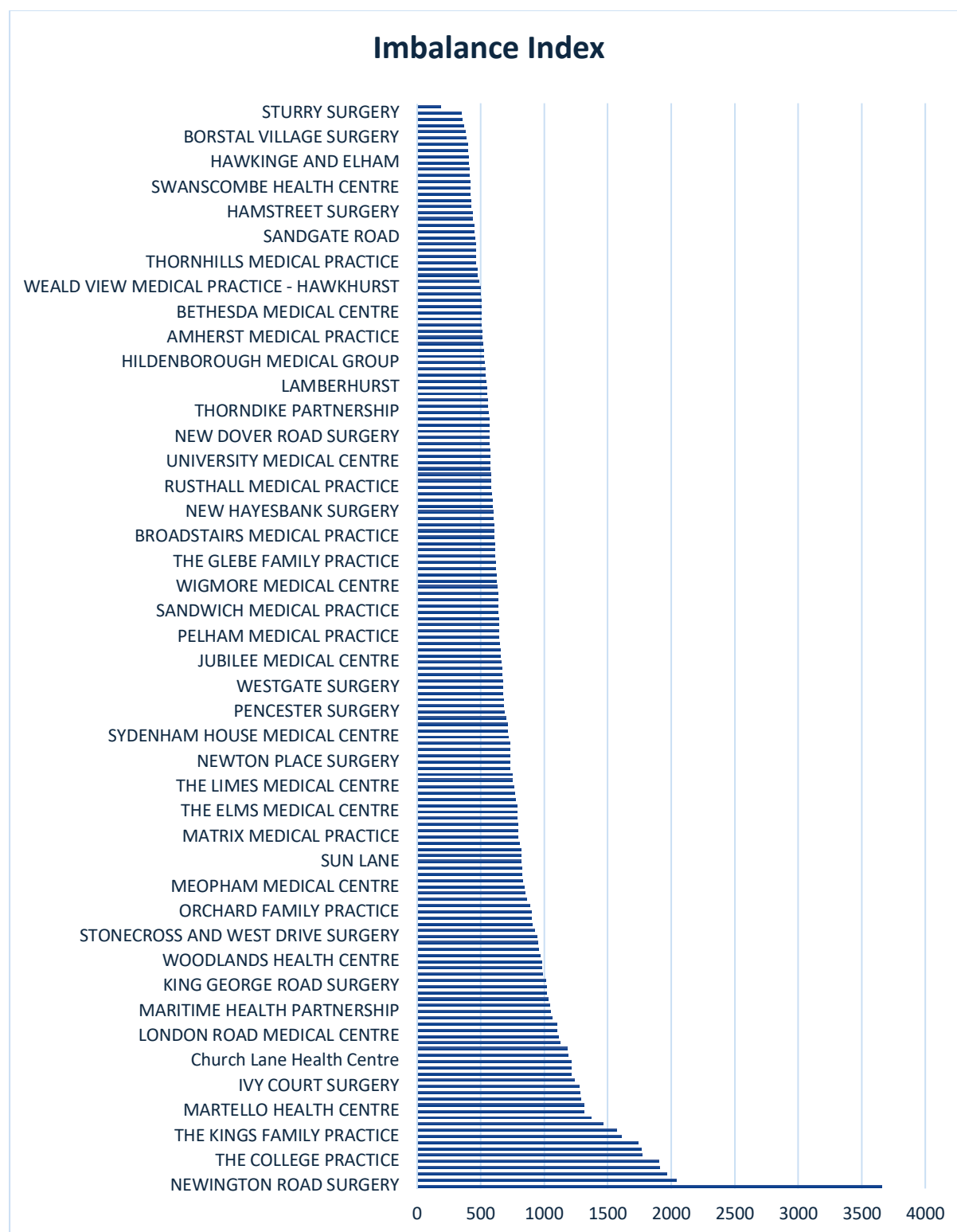
- Birchington Medical Centre Higher Aging / Lower GP
- Martello Health Centre Higher Aging / Lower GP
- Oaklands Health Centre Higher Aging / Lower GP
- Woodchurch Surgery Higher Aging/Lower GP
- Ivy Court Higher Aging/Lower GP

Moderate Risk ageing burden - under doctored heading into ageing growth.

- Old School Surgery Lower Aging/Lower GP
- Newington Road Surgery Lower Aging/Lower GP
- Pilgrims Way Surgery Lower Aging/Lower GP
- St Werburgh Lower Aging/Lower GP
- Marlowe Park Lower Aging/Lower GP



Imbalance Index



The imbalance index is a tool that could potentially be used to describe how unevenly resources are distributed to meet population need. The higher imbalance index, the greater the inequality, potential systemic or structural imbalance. The lower the value, the more likely the practice can meet patient needs. The table below gives more detail to the practices with the highest imbalance.



Top 10 Practices with an Imbalance	
Newington Road Surgery (Ramsgate PCN)	Very low GP supply (GP WTE/10k $\approx$ 0.61), small list ($\sim$ 6.9k), QOF $\sim$ 417—critical under-doctoring
Marlowe Park Medical Ctr. (Aspire Medical PCN)	GP WTE/10k $\approx$ 1.17; substitution risk already flagged in workforce sheet; Critical banding
Edenbridge Med Practice (Sevenoaks PCN)	GP WTE/10k $\approx$ 3.75 but extreme activity (appts/1k $\approx$ 7,360), indicating flow/triage issues more than headcount alone
Sheerness Health Centre (Sheppey PCN)	GP WTE/10k $\approx$ 1.53, CQC “No assessment”, high system-strain indicators
The College Practice (ABC PCN)	Huge list ($\sim$ 33.7k) with very low GP WTE/10k $\approx$ 1.02; substitution-risk pattern present
Summerhill Surgery (Ramsgate PCN)	GP WTE/10k $\approx$ 2.68, very high demand (appts/1k $\approx$ 4,752) and rising DNA/sickness costs in peer group
Mocketts Wood Surgery (Margate PCN)	GP WTE/10k $\approx$ 2.25, CQC “Requires improvement”, high demand (appts/1k $\approx$ 3,969)
Pilgrims Way Surgery (Garden City PCN)	GP WTE/10k $\approx$ 1.39, rising ARRS presence but still low GP core
The Kings Family Practice (Aspire Medical PCN)	GP WTE/10k $\approx$ 1.37, very high ARRS substitution vs GP (workforce sheet flags HIGH)—skill-mix imbalance
St. Werburgh Med. Practice (Aspire Medical PCN)	GP WTE/10k $\approx$ 1.55, HIGH substitution risk pattern like the Kings Family Practice

Taking into account all the metrics analysed over the previous pages, it should be noted that depending on which metrics are used there are some differences in which practices are highlighted. There is also variation in these multiple factors at individual practice level.

Summary of results

The findings present a consistent and multi-layered picture of under-doctoring in Kent and Medway as a structural, geographically uneven and system-amplified challenge rather than a simple numerical shortage of GPs.

Qualitative interviews (n=18) revealed six dominant themes. Under-doctoring is experienced primarily as complexity compression and supervisory expansion rather than headcount deficit, with FTE drift, worsening GP-to-population ratios in deprived areas, ARRS supervision burden, and rising cognitive load reducing effective capacity. Emotional fatigue and moral distress were strongly associated with attrition risk, with early retirement and trainee exit linked to sustained overload rather than episodic stress. Deprivation and coastal geography amplify risk, with Medway, Swale and East Kent described as facing self-reinforcing recruitment spirals.

Primary–secondary interface failure contributes to frustration, duplication and perceived system unfairness, further eroding professional agency. Loss of relational continuity was described as diminishing job satisfaction and professional identity. Leadership, supervision and culture were identified as key leverage points, with early-career support and belonging seen as central to



retention. Minority perspectives highlighted heterogeneity, with a small number of practices reporting stability, and some questioning GP-centric framing in favour of skill-mix optimisation.

Role-based differences were evident: partners emphasised burnout and financial fragility, system leaders focused on data and equity, and workforce leads highlighted supervision and IMG leverage. Overall, attrition drivers were interpreted as cognitive and emotional overload, deprivation-linked asymmetry, supervision expansion without relief, interface inefficiency, relational erosion, partnership fragility, and a perception gap between system narrative and frontline experience.

The Practice survey (n=66), with predominantly partner respondents, reinforced these findings. Recruitment was viewed as slow within a constrained labour market; retention pressures were systemic rather than episodic; supervision capacity was stretched; and workload intensity and case complexity were dominant multipliers. Cultural norms suggest “absorptive buffering,” whereby doctors compensate for structural gaps.

Funding, incentives and system support were perceived as misaligned, with interventions including ARRS viewed as partially helpful but not transformative. Under-doctoring varies geographically, with certain areas considered unattractive to candidates. Locum roles were seen as financially attractive and disruptive to continuity. Overall, rising demand, increasing complexity, fragile retention and structural enablers (premises, funding, incentives) combine to create chronic under-doctoring concentrated in specific neighbourhoods rather than uniform deficit across the ICB.

Quantitative analysis corroborates these perceptions. Growth in workforce numbers is driven by salaried and trainee GPs, while partner numbers decline and FTE growth lags headcount expansion. Workforce scaling flattens beyond larger list sizes, indicating diminishing proportional GP density and heterogeneity in staffing models. Lower substantive GP WTE is associated with higher locum utilisation, signalling fragility and reactive expenditure. ARRS substitution patterns show that practices in low-GP / high-ARRS configurations remain vulnerable where complexity exceeds substitution capacity. Demand analysis demonstrates non-linear strain, with a pressure zone emerging where high appointment volumes coincide with sub-benchmark GP density. Demographic modelling highlights multiplicative workload strain in practices with high proportions of patients aged 65+ and low GP WTE, identifying clear ageing-related hotspots. The imbalance index further demonstrates structural inequity, with a cohort of practices exhibiting critical under-supply relative to need.

Across methods, the evidence converges: under-doctoring in Kent and Medway is a compound structural condition shaped by demand intensity, demographic amplification, workforce configuration, supervisory burden, cultural buffering and geographic inequity. It is not a uniform numerical deficit but a clustered, complexity-driven and system-interactive phenomenon requiring targeted, locality-sensitive intervention.

Suggestions for change

To increase the possibility of success the following points are important to underpin any changes adopted:



- A need to acknowledge that the terminology of under-doctoring as a single input factor causing the problems in general practice, does not reflect the complex structural and cultural issues at its heart.
- There is risk when under-doctoring is used as a proxy for under-caring. Some clinicians are working under extreme pressure and long hours to meet demand.
- There is much heterogeneity across individual practices and therefore variability for which and to what extent each potential factor is a major driver.
- As independent business, practices aim to meet need in a variety of ways with a mixture of success
- There is misalignment between the views of what practices and professionals may need and what is being offered in support.
- Whilst the centrality of neighbourhood health in the current NHS reforms is important, it will not alone solve the problems facing general practice. General practice will not be fixed as a side effect of implementing the 10-year plan and the 3 shifts.
- As ICBs move towards a more strategic approach to commissioning and reduce headcount, the loss of local relationships and capacity will be felt keenly by general practice. Blunt contractual levers might not be sophisticated enough to drive the local flexibility required.
- Consider how the changing provider landscape could be developed and harnessed to encourage peer to peer challenge and support.

Principles of approach

To address the issues facing Kent, the approach to 'how' change is approached is just as, and potentially more important than 'what' the changes are.

- Use a relational and developmental approach to increase trust that will enable,
- A plan that is tailored to each practice, that is build up into
- A system plan that reflects population needs and ensures partner buy-in.

To achieve this:

- Collectively reframe the language used to describe the problems and find common ground
- Combine senior experienced management support with a peer-to-peer approach (consider whether local, elsewhere in Kent or outside Kent is appropriate)
- Ensure continuity of relationship with the practice
- Present data as data, recognising its limitations. Acknowledge that insight comes from a combination of data held by multiple parties, local knowledge and context.
- View support as an ongoing resource rather than a one-off change management process – it will need continuous development
- An overlapping phased approach should be adopted with flexibility in time and over geographies.
- Consider carefully how changes to business models are introduced into conversation, starting with function rather than form.



Recommendations to address under-doctoring

There are five recommendations that if enacted using the principles described above will help to address the issues facing Kent. These should be considered as overlapping phases noting that building trust and relationships is fundamental, difficult, takes time and underpins success. The recommendations are to create a common understanding, to consider where funding is invested, support workload both within practices and at a system level, and to help with both workforce recruitment and retention.

Create common understanding

- Co-design a weighted under-doctoring index that includes deprivation/complexity, safeguarding/transient workload, supervision load, and interface friction, that is recognised by practices
- Pair this with a narrative that distinguishes headcount vs FTE vs capacity vs quality/continuity (to reduce policy misfires driven by crude metrics).
- Encourage the collection of meaningful workforce data (some anecdotal evidence that national submission data is used to tell the story that is required, rather than the reality)
- *Several interviews explicitly state current metrics miss complexity and “you just can’t measure that” with list size alone.*
- *Others criticise “rubbish data” and misplaced conclusions.*

Funding

- Apply equity-weighted targeting to the most under-doctored, high-complexity places (explicitly referenced: Medway/Swale/coastal and deprived areas).
- Build “stabilisation bundles” (supervision, estates, interface relief and development and wellbeing) rather than isolated incentives.
- Tailor these to individual practices
- Equal distribution is argued to entrench inequality where baseline capacity differs, however recognition is needed that the whole of general practice needs to change and innovation needs to be supported across all of Kent.
- Incentives alone can be insufficient without affordability and workplace quality.
- *Interviews describe a self-reinforcing recruitment spiral known high pressure then fewer applicants and more pressure.*

Workload: Intra-practice

- Create a supervision capacity offer for under-doctored practices: funded, protected supervision time; backfill; and a clear supervision model for ARRS + trainees.
- Align PCN/ICB investment to supervision as infrastructure, not “optional goodwill”.
- *In multiple accounts, the system can “double, triple... trainees” but cannot absorb them without supervision/space.*
- *Early supervisory burden creates anxiety/attrition risk (new GPs asked to supervise without confidence).*
- *Skill-mix expansion increases GP oversight burden, reducing GP capacity (not laziness).*
- *“I can double, triple, quadruple the number of GP trainees... if you’ve got somewhere to put them.”*
- *“He was asked to supervise all these hours... and he was like; I don’t have that expertise.”*



Protect role satisfaction: reduce moral injury drivers (restore “doable” work)

- Help practices to redesign care processes and appointment systems
- Prioritise access to downstream services (community/secondary) that make GP work feel “completed” rather than endlessly recycled.
- Ensure system prevention programmes, are effective in reducing demand

Workload: Primary secondary care interface

- Ensure primary/secondary care interfaces are working effectively and involve 2-way genuine partnership working. The left shift should not be the left shunt.
- *“Referral rejections are increasing.”*
- *“Holding that hot potato.”*
- *Admin/interface work “starts to wear people down.”*

Workforce recruitment

- Create mechanisms to collect data on advertisements, and the ‘time to fill’ rates
- Collect and analyse retention and attrition rates across practices, to evidence where the incoming GPs are locating and the duration at which their tenure lasts in each location (within the ICB geographical footprint).

Workforce retention

A lack of GP career pathway arose in the structured interviews multiple times. Not just a plan of work in practice, but an acknowledgement that GPs want to expand on their skills and work on wider projects. There was also a clear reference that the next generation of GPs want to work differently and that average GP hours might be considered a better measure instead of assessments against the WTE marker. This reflects a more modern general practice.

Collecting data about age of GPs and retirement would be helpful for workforce planning.

Specific actions include:

Modernise employment models: flexibility as a retention lever

- Encourage flexible sessional models (6 sessions or fewer where desired), portfolio combinations, and employment options aligned to life stage.
- Where appropriate, commission roles that allow GPs to maintain interests locally (so portfolio work doesn’t require leaving the system).
- Flexibility is explicitly called out as a major problem and lever.
- Partners describe changed capacity norms (e.g., 6 vs 9 sessions historically) and sustainability constraints.

Create credible post-CCT pathways (progression, not just fellowships)

- Convert fellowships/ “New to Practice” offers into structured progression pathways with commissioned endpoints (e.g., extended roles with funded sessions, mentorship, and clear jobs to step into).
- Ensure development funding is stable, not one-off, so it can function as retention infrastructure.



- Retention programmes are described as effective but fragile and at risk when funding is removed or not ring-fenced.
- Funding perceived to be absorbed into deficits; programmes undermined.
- Potential to keep senior GPs by engaging them as mentors for younger GPs to aid with career progression and retention and variation to jobs

Short, medium and long-term plan

Given the complexity of the problem being faced by Kent, any programme of work needs to be flexible and ensure the principles outlined above are not lost. Assuming that these can be actively monitored a high-level action plan could have the following aims:

- **Short-term:** Stabilise pressure and rebuild trust
- **Medium-term:** Correct structural misalignment and embed recruitment & retention infrastructure
- **Long-term:** Redesign workforce architecture and commissioning logic to reflect complexity and demographic reality

This could be used as a framework for a more detailed plan:

Short-Term Actions (0–12 Months)

Stabilise, build trust, improve clarity, address immediate pressure points

1. Reframe and Align

- Agree and adopt shared language that reframes under-doctoring as a structural and complexity-driven issue rather than a proxy for under-caring.
- Communicate clearly that variation across practices is expected and legitimate.
- Present data transparently, acknowledging limitations and contextual nuance.
- Establish regular relational touchpoints between ICB, PCNs and practices to maintain continuity of relationship.

2. Create a Common Understanding

- Co-design a prototype **weighted under-doctoring index** incorporating complexity, deprivation, supervision load and interface burden.
- Share practice-level dashboards for discussion rather than performance judgement.
- Begin collecting improved workforce intelligence (advertisements, time-to-fill, attrition rates, retirement intentions).

3. Immediate Stabilisation in High-Risk Areas

- Identify highest-risk localities (e.g., high ageing + low GP density).
- Deploy targeted **stabilisation bundles** including:
 - Funded protected supervision time
 - Backfill support
 - Estates troubleshooting
 - Wellbeing and mentoring offers



- Ensure interventions are tailored rather than uniformly distributed.

4. Supervision as Infrastructure

- Introduce a funded supervision capacity offer for under-doctoring practices.
- Clarify expectations for ARRS and trainee supervision.
- Align PCN/ICB funding so supervision is treated as essential infrastructure.

5. Reduce Moral Injury Drivers

- Rapid review of primary–secondary referral rejection patterns.
- Establish joint interface escalation mechanisms.
- Support practices to redesign appointment systems and internal workflow.
- Prioritise access to downstream services where delays cause recycling.

Medium-Term Actions (1–3 Years)

Strengthen system design, embed recruitment & retention infrastructure, address structural misalignment

1. Embed Equity-Weighted Funding

- Formalise equity-based investment targeting.
- Transition from isolated incentives to structured stabilisation programmes.
- Review premises and infrastructure barriers in high-risk practices.

2. Workforce Data and Planning Infrastructure

- Implement routine reporting on:
 - Attrition and tenure length
 - Recruitment pipeline flow
 - Age and retirement projections
- Integrate workforce intelligence into commissioning planning.

3. Modernise Employment Models

- Promote flexible sessional models (e.g., 6-session norms where appropriate).
- Develop portfolio opportunities within Kent to retain local talent.
- Commission blended roles that allow clinical and system leadership activity.

4. Create Credible Post registration Pathways

- Convert fellowship and “New to Practice” schemes into structured career pathways.
- Commission funded extended roles with defined endpoints.
- Stabilise development funding so it is ring-fenced and predictable.
- Engage senior GPs formally as mentors and educators.

5. Improve Primary–Secondary Interface Design

- Develop jointly agreed referral standards.



- Co-design pathways to prevent workload “left-shunt”.
- Implement shared accountability measures for rejection loops.

6. Peer-to-Peer Support Architecture

- Build structured peer challenge and support models across practices.
- Consider cross-Kent or external peer reviews where helpful.
- Strengthen leadership networks.

Long-Term Actions (3–5+ Years)

Reshape structural drivers, align system reform, ensure sustainability

1. Institutionalise the Weighted Capacity Model

- Fully embed the under-doctoring index into commissioning decisions.
- Replace crude FTE: list-size metrics in planning conversations.
- Align system resource allocation to complexity-weighted need.

2. Align Commissioning to Practice Sustainability

- Develop commissioning frameworks that recognise practice heterogeneity.
- Move from blunt contractual levers to relational, development-based commissioning.
- Ensure strategic ICB restructuring does not erode local relationship capital.

3. Redesign Workforce Architecture

- Shift from WTE as dominant metric to sustainable sessional norms.
- Plan for generational workforce change and altered career expectations.
- Build a resilient supervision and leadership pipeline.

4. Address Demographic Amplification

- Incorporate ageing and deprivation projections into long-term workforce modelling.
- Anticipate and pre-empt geometric strain in high-ageing localities.
- Integrate prevention strategies that demonstrably reduce primary care demand.

5. Cultural and Professional Renewal

- Rebuild relational continuity as a system priority.
- Strengthen belonging, leadership culture and early-career support.
- Normalise mentorship as part of career structure.

Conclusion

This independent review concludes that under-doctoring in Kent and Medway is a structural and systemic challenge, not a transient workforce fluctuation. It is driven by the interaction of



demographic amplification, rising clinical complexity, supervisory expansion, recruitment constraints, retention fragility and system interface inefficiencies. It manifests unevenly across geographies, with identifiable hotspots where workforce density, deprivation and ageing converge to create multiplicative strain.

The evidence makes clear that increasing GP headcount alone will not resolve the issue. Without supervision capacity, interface reform, equitable funding alignment and meaningful retention infrastructure, additional workforce inputs risk being diluted or destabilised. Equally, blunt contractual or centrally designed levers are unlikely to succeed without relational trust and local tailoring.

Kent and Medway's general practice workforce continues to demonstrate resilience, professionalism and commitment under sustained pressure. However, the current trajectory carries risk: continued partnership decline, increasing locum dependency, widening inequity between neighbourhoods, erosion of continuity and escalating burnout. Without coordinated action, these pressures will further compromise access, safety and system performance.

The opportunity now is to move from debate about numbers to a shared understanding of function, capacity and sustainability. By reframing under-doctoring as a complex systems issue, targeting support to areas of greatest need, investing in supervision and career pathways, and repairing system friction points, Kent and Medway can stabilise general practice while laying the foundations for longer-term transformation.

The recommendations in this report are interdependent and should be implemented in overlapping phases, underpinned by relational leadership, transparent data use and sustained engagement with practices. Addressing under-doctoring will require persistence, flexibility and partnership across organisational boundaries.

General practice remains central to the success of neighbourhood health, prevention and wider NHS reform. Securing its sustainability is therefore not only a workforce priority but a strategic necessity for the whole system.