HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: The future of General Practice, HC 113

Tuesday 14 June 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Rosie Cooper; Taiwo Owatemi; Sarah Owen.

Questions 137 - 181

Witnesses

I: Beccy Baird, Senior Policy Fellow, The King's Fund; Sir Robert Francis QC, Chair, Healthwatch England; and Heather Randle, Professional Lead for Education and Primary Care, Royal College of Nursing.

II: Dr Margaret Ikpoh, Vice Chair (Professional Development), Royal College of General Practitioners; Professor Mike Holmes, GP Partner, Haxby Group, York; and Dr Peter Holden, GP Partner, Imperial Road Surgery, Matlock.

Examination of witnesses

Witnesses: Beccy Baird, Sir Robert Francis QC and Heather Randle.

Q137 **Chair:** Good morning and welcome to the House of Commons Health and Social Care Select Committee. Today's evidence is part of our inquiry into the future of general practice. We are looking at a number of things this morning: how traditional models of care could change; the role of non-GPs in the provision of primary care; and the partnership model for GPs. There are a number of different areas, which are all very important for general practice.

Later, we will hear from the Royal College of GPs, some GP partners and an expert on GP property issues. First, we focus on the role that can be played by people who are not doctors. I particularly welcome Beccy Baird, senior fellow at the King's Fund; Sir Robert Francis, the outgoing chair of Healthwatch England, who is joining us remotely because of his Covid, but seems to be in reasonable form—thank you very much for dragging yourself to the Zoom call; and Heather Randle, who is also recovering from Covid but has very gamely turned up this morning. She is the professional lead for education and primary care at the Royal College of Nursing. Thank you all very much for joining us.

Let me start with you, Beccy. Just talk us through how important the role of non-GP staff is going to be in the provision of services at our local surgeries, going forward.

Beccy Baird: This is not just a UK trend. It is an international trend as well. There are a couple of reasons for expanding the primary care team. One is to provide a fuller range of services to patients, particularly as people live longer with more complex conditions. Having staff like physiotherapists, pharmacists, health coaches and social prescribers adds to the totality of the care that people are getting in primary care. As the demand is growing, it is more and more important to expand those teams, particularly when we have a shortage of GPs, although these are not replacements for GPs. They can offer different things and allow GPs to work to the top of their licence—the phrase "top of their licence" is somewhat controversial occasionally—because they can deal with many things that GPs do not necessarily want to be using their time to do, so that the GPs can focus on the more complex patients.

Q138 **Chair:** Give a few examples of what those things might be.

Beccy Baird: For example, you might have a specialist pharmacist doing medication reviews with patients. They understand the drugs much better. That is their expertise. They can really look at people who are on multiple medications and think about the right interactions between them. They can work with them to make sure they are on the right amount and the right type of medication.

You might have a first-contact physiotherapist who is an absolute specialist in all things musculoskeletal, for example, and so can take all of

that work away from the GP. You might have paramedics doing acute on-the-day care—for example, with children with minor infections who want to come in. They might do home visiting to people. Paramedics are excellent at risk assessment. It is what they are trained to do. Going out and doing home visits, assessing whether somebody needs to be admitted to hospital, are the types of things they can do. We can expand that through to community link work, with social prescribers who can help people find connection in their own community and find ways of living in their community.

Q139 **Chair:** Do you think that is a good thing?

Beccy Baird: I absolutely do. All of the evidence suggests that where it works well—I will caveat that to where it has been implemented properly—teamworking in general practice provides much better care for patients. Research from the States has found that GPs working alone can get quite isolated. They do not necessarily have people to bounce ideas off. Working as part of a team, with really good administrative support, nursing support and case management support, can provide a much fuller service for patients.

Q140 **Chair:** Thank you. Heather, we hear a lot about the pressures that GPs are under and the shortage of GPs. There are GPs leaving the profession. Are the same issues affecting the non-GP members of the primary care workforce?

Heather Randle: Absolutely. We have evidence that shows that people are leaving the profession. One of the biggest problems is people not coming into the profession, so there is no incentive for them to be part of the team in general practice. One of the things that our nurses say quite strongly is that they have felt invisible, and that they are stressed and anxious about what is going on in general practice and the care that needs to be done that is being left undone as part of that. They are struggling, the same as our general practice colleagues.

Q141 **Chair:** Are they struggling more, from the feedback you are getting at the RCN, than their colleagues working in hospitals, or is this something that is a feature everywhere?

Heather Randle: Generally, healthcare professionals are struggling with the amount of work. I can specifically talk about general practice. In general practice, we see nurses working a lot more hours than they are commissioned for because they want to make sure that they finish their episodes of care. They are going home stressed. We are getting reports through our services that nurses come in and say, "I don't feel that I am safe in my practice because I need to finish the episodes of care and I just don't have time." Patients present with multiple issues nowadays, with things that they have saved up.

I think Covid exaggerated that a little bit. There are things that patients have held on to because they think, "I don't want to bother you during this busy time and you've got other things to do," but now patients are

presenting with late disease and patients have a lot more demands. They come in with lists of things to do. Nurses are very good at prioritising the work and figuring out how to meet patients' needs, but when you have five patients waiting at the door because you are running so far behind, it creates pressure and concern that things will get missed.

Q142 **Chair:** What is the solution? The Government would say, "Well, we are recruiting 50,000 nurses and we are more than on track to deliver that." Is that sufficient? What other things would you like the Government to be doing?

Heather Randle: We need to incentivise nurses into the profession. We still do not see any career pathways into general practice in a lot of areas. Nurses feel that they need to go into hospital work before they come into general practice. General practice is a completely different world. You have the additional roles reimbursement scheme, but that excludes nurses who have been in practice for a while. If they have worked in a hospital and then come into general practice, as far we are concerned they are new to general practice and it is a completely different world. We should be making sure that funding, for example on fellowships, is for nurses who are new to general practice and not just new to nursing.

Q143 **Chair:** Let me ask you a slightly strange question. It will come up later in the session, so I just want your view. There is a debate about whether the partnership model in general practice has a future. There has been some suggestion that the Government want to scrap it. What is the nursing perspective on working somewhere there is a partnership versus working somewhere that has a different model?

Heather Randle: In a partnership there tends to be more hierarchy. The senior partner is the person that people go to. I have worked in models where we have completely salaried staff. I was the clinical lead in a service, so I was the senior nurse in that clinic, and I oversaw the services. We do not see that model in partnerships.

To turn that on its head, some nurse partnerships work really well, where nurses are part of the partnership, but we are not seeing very many of them. For me, we do not see that because it is not something that is expected. It is not part of the model. Moving forward, nurses do not feel that they can become partners in a surgery because they do not have the skills.

I was speaking to a colleague yesterday who is a nurse partner. She needed to get an accountant; she needed some legal advice, and she needed some support in order to sign up to a partnership. We know that they are not skills that nurses are taught.

Q144 **Chair:** Thank you. Let me bring in Sir Robert. With your Healthwatch experience, what are patients telling you about their experience of general practice at the moment, and what are the particular areas of

concern?

Sir Robert Francis: Basically, there has been a decline in the satisfaction rate, which we get told about. During the pandemic it was particularly bad, but in fairness feedback has been over 50% negative for quite a long time. During the pandemic, the dissatisfaction rose to 75% of the feedback we had. Obviously, it would be fair to say that people tend to approach us when something has gone wrong rather than when it has gone right. It has improved since the pandemic, but it is still over 50%.

The issues that concern people, and that they tell us about, have been about access. They find it is difficult to book appointments. They certainly find it difficult to have a face-to-face meeting with a GP when they, the patient, feel that that is what they need. There have been issues about prescriptions and getting referrals to hospital. Among a group of people there are difficulties in registration. It is mainly about access. The feedback we are getting, and we have looked into this, suggests that some of the things that Beccy and Heather have been saying resonate with the public.

What they want is continuity of care. They want whoever they go to see at a surgery to know about them. They appreciate that the doctor is not always necessarily the right person to see them, and they are prepared to accept that, but they feel they need to have someone they can identify as the person who is co-ordinating their care. As I say, they are very happy to see a nurse, a physiotherapist or whoever else it might be appropriate for them to see, but they resent the information about them not being known to the people they see.

I think those are the principal things that we hear about. There is dissatisfaction about the difficulty of getting to see anybody and the long time you have to wait. There is dissatisfaction about the information available to people about how to access particular services, and there is inconsistency about that. Some places are very good at it and other places are not. That is one of the issues. Heather talked about staffing. That is a major factor, no doubt, in these problems.

Q145 **Chair:** Let me ask you one follow-up question, and then I will bring in my colleagues. In the last session we had on general practice, we had some very powerful evidence from a GP in Bristol, from one of the few places where they have kept GPs having their own individual lists of patients. That is not to say that the patient would always see that GP. They might see someone in a team, but there is a GP who is responsible for that patient's care. We also heard evidence from Norway, from a big study of 4.5 million people, that people are 30% less likely to go to hospital if they see the same doctor over a long period of time. Does that chime with the kind of service that you think patients who contact Healthwatch would like to see general practice move towards?

Sir Robert Francis: Very much so. They want to be able to identify the person who is responsible for their care, even if that is not the person they are seeing. I suspect what that really means is that they are confident that the people they meet know about them and their problems and will understand what their needs are, and that they are not continually having to repeat things. Of course, there is an argument that that is all a bit old-fashioned and comes out of "Dr Finlay's Casebook", but there is a sense behind it about the knowledge of people as a whole rather than looking at a person as a problem.

There are two types of case, and the Fuller report, which of course you will be familiar with, has identified this. There are those who are basically, and typically, the young and well, who have a particular problem and just want a quick in and out. There are those with more complex needs who need confidence that all their needs are going to be taken into account. They feel that that is only going to happen if they have "their" GP, to put it that way, who is in charge of their care and is the gateway, in effect, to the other services that they will obviously need.

Q146 **Chair:** We heard some counter-arguments to the idea that younger, healthier people do not need to have someone responsible for their care. The argument was that you want to stop someone becoming a chronic patient who has a long-term condition by nipping a problem in the bud, and you can only do that if there are doctors who clearly feel that they are responsible for every single person on the list, even if they do not necessarily see that person every single time.

Sir Robert Francis: I don't think the two things are inconsistent. A young and pretty well person should be entitled to have a named GP, but their needs most of the time may well be met by seeing somebody else. As I said, this is a concept that does not necessarily mean that the responsible GP is always the GP who sees the patient, even if a GP appointment is needed. It is a matter of organisation and responsibility. Underlying that, of course, is the vital need to have systems of information about patients that are readily shared by all the healthcare professionals who are involved in providing a service to an individual patient.

Q147 **Rosie Cooper:** I have some general questions to all members of the panel, starting off with Beccy and Sir Robert. I want to address the theory as opposed to the practice. I love the idea that we can all help each other, it is a great multidisciplinary team, we are going to deal with patients and everything is going to be okay. The reality is very different, isn't it? There are not enough of any speciality. Each speciality I talk to is always very short of staff, and each of them is handing off some of their responsibility to another part of the system.

Beccy talked about paramedics. Crumbs, I have had residents and constituents in a road waiting for an ambulance five or six hours later—this is a real story—and I managed to get a GP to go out and look at this 80-year-old man and get him sat up. It was in November and was getting

dark, so it was about 4.30 or 5 o'clock. They got him into a car and drove him to hospital.

It is all right saying that we can all work together, but if we continually take some of your role and pass it on to another speciality or another professional person, none of those areas is able to deal with it. I have just talked to you about paramedics; for example, if you have a fall now it could be 12 or 15 hours—that's roughly the timescale—before anyone can get to you. What they are doing now, which is great and very innovative, is asking district nurses, community nurses or whatever to go out to those people and get them up. That is fantastic, but they are not then doing the job that they are supposed to do. The theory is fantastic but how, in practice, are we really ensuring the safety of patients by continually handing it off? Where does that end?

Beccy Baird: It is really interesting and there is a lot to unpick in that. I guess the first thing I would say is that workforce shortages are clearly a real issue. I have not seen the workforce modelling for the additional roles in general practice. We have asked for it, but it is not available. I do not really know what the basis was for the decisions about which roles were going to be funded and how many.

I absolutely agree with you that implementation is key. I have just completed a piece of research for the King's Fund. We found some brilliant examples of teams working really well, but it requires general practitioners to change the way in which they work, as well as the team members. I absolutely agree with others here who have said that it is very important that people know who is in charge and that they can talk to each other.

When we have looked at teams abroad, for example, instead of all the individual professions sitting in their own rooms, sending tasks to each other and handing patients off, the professionals sit together and talk about the cases. Then they will go and see the patients in the consulting room and come back and share ownership of those cases. We call them micro teams, and they work really well. There are great examples from the States, from New Zealand and other places.

It is all about the implementation. When people are stressed and do not have the headspace to really think about the change management, the redesign of processes and how it is actually going to work, that is when it falls down. Our findings in the report are that if we do not invest in that kind of stuff—the leadership, the change management, the HR and the organisational development—the money is in danger of being wasted because they are not satisfying jobs. People get thrown into the deep end, it is fragmented, it does not work well and people get frustrated.

You are raising two issues there. On one, I absolutely agree that the implementation needs to be done very well and there are clear ways that we could improve on that. The second is workforce planning, which is clearly a big issue right the way across the health service. There is not

enough of anybody, so making what we have work well seems absolutely critical.

Q148 **Rosie Cooper:** Robert, do you have a comment?

Sir Robert Francis: Yes. The points you make are very valid. There are not enough people to go round to do anything in the health service, it seems to me.

There are two things. First, long-term, there is a need for an overall workforce strategy. We talk about more nurses and doctors, but I am not sure that I have seen anything that looks like a plan of how you produce balanced staffing of a service. That seems to be absent. Even if you did that, it would take some time for it to happen. In the meantime, you have to take mitigating action.

One thing that is already in place and is pretty successful, as far as it goes, is making the offer of remote consultations on the telephone or online. As we know, that is not a panacea for everyone. Certainly, the feedback we get—you have read the report on it—is that while it is great for some people, particularly those who are adept and are used to remote meetings, it is not satisfactory for some forms of case, when face-to-face meetings are necessary for diagnosis, or when particularly delicate subjects are being talked about. Therefore, there needs to be a really sensitive triage system available, with information about the choices available to people around that. I believe that is a way of saving some time.

The important point about passing people from pillar to post is that referral is necessary and is great, but actually that is why you need the GP or whoever it is who is responsible for the overall care. Just because they have referred the patient somewhere, they do not relinquish responsibility. They should be keeping track of what is going on. That is where the information systems come in. They should be chasing delays in a referral being taken up. They should have a system that informs the patient as to what is going on, so that the patient is not just left in a void waiting for something to happen and not knowing who to contact because nothing effective has happened.

I would say it is those two things, but you are absolutely right that until we have sorted out the staffing issue most of this will be very challenging.

Q149 **Rosie Cooper:** Heather, do you want to add anything?

Heather Randle: Yes, I want to pick up on something. The key to this is teamwork. One of the skills of the nurse is being able to work in a team, and to lead teams. It is not always appropriate for the GP to be the person in charge of the care of a patient. If they have chronic diseases, or if it is something related to their personal health, a nurse could be the person in charge of their care and could be the person who looks at it holistically. We are autonomous practitioners. We can manage the care of

patients and escalate as we need to, or refer on. We need to think about the leadership skills of the nurses working in general practice, as well as the leadership skills of their medical colleagues. That is often forgotten.

Q150 **Rosie Cooper:** Isn't the core of what we are saying confidence in the medical profession or the clinicians dealing with us? For example, you have difficulty getting an appointment with the doctor so you go and see the nurse, but you have a chronic condition which means that every time you see the nurse—I have a prime example of this—you have to go and see the doctor. There is no joined-up thinking so that they know the patient.

In order to get take-up, you need confidence in the professionals. Last night, for example, the "Panorama" programme talked about physician associates and the absolute outrage that they were people who were not medically qualified and were not supervised properly. Things like that will destroy any idea that you can move forwards with a teamworking model.

Chair: Let me bring in Heather on that one.

Heather Randle: At the minute, physician associates are unregistered healthcare professionals. Nurses are registered healthcare professionals with skills. When you look at the skills of the people they are working with, they have the autonomous practice to be able to do that. They also recognise their limitations.

You say that a lot of nurses go to the doctor. If you think about the media, throughout the pandemic, GPs and medical people did everything. When you looked at the vaccination clinics, who ran them? The nurses ran the vaccination clinics because that is our skill. We have the skill to run clinics and large-scale vaccination programmes. I developed a programme where ANPs saw patients within general practice. That is copied across services nowadays.

Q151 **Rosie Cooper:** Absolutely. The appropriate people doing the appropriate care is not a problem. The point I am trying to make is that unless you have a relationship between the patient and whichever professional they go to see that is really good, you are going to have problems. There are people who are not supervised properly and who regulators have not dealt with. I am looking at you and Sir Robert: that programme yesterday, and the activities of Operose, really will set you back so many years. Frankly, why would you go to see a physician associate if you are not sure that they are properly trained and supervised to do all of those things?

Heather Randle: We also need to change the attitude. Why should seeing the nurse be a poor alternative to seeing the GP? The nurse might be the right person at the right time to provide the right care.

Chair: I am going to stop the debate there. I need to bring in Sarah Owen.

Q152 **Sarah Owen:** Heather, I have a few questions for you and then some for

Sir Robert and Beccy. Yes, we know that sometimes the nurse is the best person to see. My mum is a nurse. I am absolutely terrified to say that her experience would not be the same as a doctor's in many circumstances. The Government talk about having 50,000 nurses. We have heard from previous evidence that that is not a magic solution. In your view, are we hiring and retaining nurses with the right experience?

Heather Randle: In general practice, we need to make it a more attractive position to go to. You lose so much going into general practice. You lose maternity pay; you lose sick pay; you lose your education and your release to study because you are not a part of the NHS any more. In some practices they provide it, but in a lot of services you do not get that. I did not realise until I went on maternity leave with my first child that I did not get maternity pay. Imagine that financial situation.

How do we entice the right people into this environment? We need to think about that. We need to make sure that there are standards for the pay and terms and conditions for all people working in general practice.

Q153 **Sarah Owen:** Absolutely. Following on from that, is one of the barriers to attracting people career progression within general practice?

Heather Randle: Absolutely. We do not think about the leadership. Very often, a nurse goes into a surgery and works behind a closed door for eight hours and then goes home. Nobody asks that nurse, "How can we improve this service? How can we make this work better? What leadership skills do you have?" We need to start looking and listening to their experience because they know their patients. When I worked as a practice nurse in general practice, I knew the patients. I had a radar: "Oh, I haven't seen this patient for a little while. Let me just give them a call and see how they feel." Those are the skills that nurses have and we need to make sure that we use them to the best of their ability.

Q154 **Sarah Owen:** You have already mentioned that the terms and conditions for nurses working in general practice are different from those working in the NHS. How does pay compare? Are you hearing that the cost-of-living crisis is impacting nurses in GP surgeries as much as it is in NHS trusts? We have already seen six trusts set up food banks for their staff. Are we seeing similar impacts elsewhere?

Heather Randle: Absolutely. Nurses have not seen a real pay rise in 10 years. I have an example of a nurse, where they offered a pay rise in the surgery and the GPs got 3% but the nurses got 1.5%. Why is there a variation in that if it is standardised? If it was through the NHS, you would never get away with offering that. Nurses have to leave the profession, do additional jobs or work extra hours in things like mass vaccination clinics because they cannot make ends meet.

Q155 **Sarah Owen:** Beccy and Sir Robert, you talked about access, and I think Rosie touched on that point. Do you think that patients are currently on board with seeing somebody other than their GP when they phone up their GP surgery?

Beccy Baird: Our experience is that often, the first time, no. Once they have seen them, yes. It is about the experience. Again, for me, it is about practices really knowing each other, so that the doctor says, "Actually, next time you come you're going to see Hannah, who is the occupational therapist"—or whoever Hannah might be—"and I trust in her." The more that the GP or whoever is in charge of that care and who sees the patient can name the person the patient is going to see and can clearly demonstrate trust, the more we start to build trust with patients.

You are right that the programme last night does not help. Those are not under-qualified physician associates. They are qualified to be physician associates; they are just not qualified to be GPs. They have a hugely important role to play. My Twitter thread was flooded this morning with people praising physician associates, but they need supervision and they need to be embedded in a team. They should not be working in isolation from each other, and nor should the GPs. They should be working as a team. That would include the administrative staff—

Q156 **Chair:** Is the supervision of those non-GP staff satisfactory, or do you think that we need to improve it?

Beccy Baird: No. It is very variable and it is not funded. The additional roles in general practice fund the staffing costs—the national insurance and the salaries of the staff—but it does not pay for supervision. It requires either a GP's time or, in some instances, they use professionals from other places. There are loads of different models—it could be physiotherapists from the trust who supervise physios—but the GPs need the time and the headspace to do that supervision and to have the time to answer the queries. It will change the role of the general practitioner. That is something that I know the college has been looking at as well.

How does this new way of working work, where we all have to work together and provide time for a senior GP to be the one giving supervision? GPs do not get great supervision. They get brilliant supervision when they are training, but it absolutely disappears the minute they qualify. How do we provide rounded support? It is important for all professionals. I know that my colleagues would agree that supervision is a lifelong thing and not just for junior or less qualified staff.

Q157 **Sarah Owen:** Can I follow on from that answer? Sir Robert talked about continuity of care and triage, and you have talked about having that relationship. Currently, 111 is being used almost as a triage service. How does 111 fit with the multidisciplinary general practice? Does it work currently, or is it not working?

Beccy Baird: It is not an area I have looked at in depth, so I will not comment in detail. The important thing for me is that people are using 111, for example, for out-of-hours care, not because they just cannot get through to their general practice. That seems to be happening at the moment. People are using it as a back-up. Again, with a service in crisis, there is lots of demand failure. We are creating lots of extra problems

because it is not working particularly well at the moment. It is hard to separate the workforce crisis—the incredible demand that services are facing at the moment—and teamworking. Things are all converging at the moment. There is a lot to do to unpick it, to make it optimum.

Q158 **Sarah Owen:** Sir Robert, do you want to add to any of the questions that I asked?

Sir Robert Francis: Thank you. On the physician associate point, supervision is obviously really important. When a patient is given or offered an appointment with someone other than the doctor, there needs to be an explanation of why that is happening. There also needs to be a decision behind that taken by someone who is qualified to make that decision. I am not sure that it is always obvious to the patient why that has happened.

The ideal scenario is probably a phone consultation with the GP, who says, "Well, actually with your problem you would be better off seeing the nurse, the physiotherapist," or whoever else it is. There needs to be a sense of organisation behind that. Critically, the patient should not have the feeling that they are being fobbed off because there isn't anyone better to see them for their particular problem. Other speakers are absolutely right: confidence is the key.

I had not come prepared, as it were, to deal with the 111 situation. My suspicion is that the co-ordination between 111 and what is going on in local GP surgeries is probably not great and needs to be greater.

Q159 **Sarah Owen:** My last question is about the 1.8 million people with long Covid. How are we and general practice geared up for that? Is it prepared for how to deal with and treat those patients?

Chair: Sarah, can you choose just one person to answer that? Who is the lucky person?

Sarah Owen: Heather.

Heather Randle: I think long Covid is an evolving thing. We need to be working together to figure out how to support people with long Covid. There is some good work. We have been part, with the RCN, of some Covid programmes to support nurses and other clinicians in supporting people with that. There is work to do on bringing a team together to work with people with Covid. It is an evolving thing, so we do not know everything.

Q160 **Taiwo Owatemi:** My question is to Beccy and it is on the additional roles reimbursement scheme. How effective is the regional variation in that? Do you think the funding mechanism is up to date, and what changes would you like to see?

Beccy Baird: My colleague Becks Fisher from the Health Foundation has done lots of work on the funding mechanisms. One of the issues around the additional roles reimbursement scheme is that it is not weighted for

deprivation. Where you might see more need in places, not only are they not necessarily funded as much but it is harder to attract the roles in those places. I think that is something to pay attention to. We see regional variation. That might be because a certain area does not have a pharmacy school in their university; therefore they struggle to get pharmacists.

The other important thing is that now, I am pleased to see, PCNs are allowed to recruit to a range of roles. There are some areas of the country where they do not want pharmacists. They already have lots of pharmacists in their practice. What they really want are mental health workers or substance misuse workers. Using the flex in the scheme to do that feels incredibly important. Regional variation is important, but it is harder to attract people to work in more deprived areas. The funding does not match. As Heather alluded to, the additional roles are not subject to "Agenda for Change" mechanisms. They are funded that way. Sometimes they are employed through trusts and therefore subject to "Agenda for Change", but if they are employed through the practice they are not. You see PCNs competing with each other for those roles. We have a lot to do more generally to unpick GP financing, particularly so that it reflects deprivation. It does not do it well at the moment.

Taiwo Owatemi: Thank you, Beccy.

Q161 **Chair:** I have a final question to Sir Robert to follow up on the 111 issue, although I know that you have not come prepared to talk about it. Isn't the landscape, from a patient's point of view, incredibly confusing? I think most people understand that if it is a real emergency you dial 999, but if it isn't, do you dial 111? Do you dial the out-of-hours service, or do you contact your GP surgery? Have you had feedback at Healthwatch from patients who say that they find that landscape extremely confusing?

Sir Robert Francis: The simple answer to that is, yes, they find it confusing. Then they find that, when they try one or other of those potential solutions, they are kept on the phone forever or they cannot get through. Then they really do not know what to do. It is undoubtedly one of the factors that leads to people going to A&E, which we all know is the wrong place for almost all such people, but it is absolutely the case.

Because of the way 111 works, it takes a long time to describe your problem because of the algorithms that are used. I have seen that happen myself. There is then confusion about what happens next. You are told that someone will ring back in two hours, and you are still waiting some time later. It is not a service that people have as much confidence in as they need to have. There needs to be better clarity and accessible information for all the community about where to go for whatever service. Also, if people contact the "wrong place", which is not where they are meant to go, there should be a simple explanation given to them about where to go or, ideally, whoever receives the call does the referral themselves straightaway.

Chair: Thank you. That brings our first panel to a conclusion. It is a good moment for me, on behalf of the Committee, to thank you, Sir Robert, for your work at Healthwatch before you stand down, and indeed for your work helping people affected by the contaminated blood scandal. I know that you have been putting together a compensation scheme for the Government. Thank you very much for that, and a speedy recovery from your Covid.

A speedy recovery from your cough, Heather Randle. Thank you for joining us. Thank you, too, Beccy Baird, for your insights. Thank you all very much indeed. We will move straight on to our second panel.

Examination of witnesses

Witnesses: Dr Ikpoh, Professor Holmes and Dr Holden.

Q162 **Chair:** I welcome our second panel: Dr Margaret Ikpoh, who is the vice-chair for professional development at the Royal College of General Practitioners; Professor Mike Holmes, who is a GP partner at the Haxby Group in York; and Dr Peter Holden, who is a GP partner at Imperial Road Surgery in Matlock. Thank you very much for joining us.

Let us crack into something that is a new topic for this morning but is very much on people's minds. I would like to start with you, Professor Holmes. What are the strengths and weaknesses of the GP partner model?

Professor Holmes: Good morning. I will start off by saying that I have been very lucky. I have been in a well-supported partnership for 20 years now. From my perspective, the strengths are that I am in a very supportive environment. There has been career progression. I have learned from colleagues. I have been able to commit to a registered list of patients. We have been able to innovate. You mentioned that I practise in York. We have moved from York towards health inequalities on the north-east coast, opening surgeries in Hull and, more latterly, in Scarborough. That ability to innovate has been really positive.

You asked about weaknesses. We have heard from Nigel Watson's report and other sources that the partnership model is viable, when resourced properly. What we are finding more recently is that that resource is difficult. Workforce is a problem for general practice. You have talked about that in this Committee previously. Over the last five years, we have gone from 52 whole-time equivalent GPs per 100,000 patients down to 45. In some of the more deprived areas, such as Hull, it is down to around 42, so it is really difficult.

We have seen workload go up. The number of consultations now is much greater than it was even two years ago, pre-pandemic. We are seeing reduced financial resources. That is magnified in some of our more deprived areas. I know you have heard from Becks Fisher on that very topic. It is really difficult. The key point for me is that the model works. It

is just the inputs into that model that are making it difficult for it to continue and to thrive.

Q163 **Chair:** Have the recommendations of the Watson report been implemented?

Professor Holmes: They have in some places. Reducing the risk for GPs of taking up partnerships is difficult. Clearly, the partnership model has unlimited liabilities, but there are models around, including our own, where we have created other vehicles to take on riskier projects and have been able to limit the liability, while still using the partnership model to drive care, to commit to registered lists of patients and to improve quality.

Q164 **Chair:** Is it your understanding that the Health Secretary wants to abolish the partnership model by 2030?

Professor Holmes: That is not clear yet. We are concerned that that may be the way forward. My response to that is that it is not the model that is the issue. We need to increase the number of GPs, improve the resources and manage the workload. At the same time as we are struggling with workforce and workload, the population is increasing. RCGP Research and Surveillance Centre data from this year shows that there are almost 5 million more patients than there were five years ago, which makes it really difficult. What we need to look at is not scrapping the model, but how we can resource it better.

I agree with the Secretary of State that there needs to be much more seamless interaction between sectors. I am not sure that vertical integration is the answer to that. I would like to see supra-PCN GP collaboration that can sit alongside the acute sector and, because we deal in the biopsychosocial model, other sectors: local authorities, mental health trusts and the community and voluntary sector. We need to interact at the same level, seamlessly, in order to provide better care—patient-centred care for systems.

Q165 **Chair:** Dr Ikpoh, what is your feeling about the partnership model?

Dr Ikpoh: Thank you for having us here today. My sentiment mirrors Mike's as regards how we can provide better care for our patients.

To take my own experience, I work in the far east of Kingston upon Hull, which, as you are aware, is quite deprived. Apparently, we have only one GP for 2,500 patients, which is stressful. I started as a salaried GP 20 years ago. I have been a partner for 10 years now. I have found that I am able to really impact on my community because I can shape the services that I feel that we need. We are on the coast and we have a lot of deprivation. We are able to address those inequalities.

Q166 **Chair:** For people who are watching this for the first time, just so that we can all understand it, what can you do as a partner, with a partnership model, that would not be possible if you had the salaried GP model?

Dr Ikpoh: The difference that I have felt personally, moving from being salaried to being a partner, is that I am more accountable to my population. I am not—forgive the term—clocking off when it is time to go, because I am committed to the people I care for. For me, that has been the profound difference as a partner.

Because I am in a position of leadership, I have also been able to influence the next generation of trainees who want to be partners. They feel, perhaps at the end of a very short training scheme, that they may not be well equipped with the clinical and business acumen that they need to provide the partnership model for their patients. That is really important.

With the partnership model, it is sometimes quite difficult to implement what we want to do. One thing that has been quite phenomenal for me is being part of a primary care workforce strategy board. Outside my college role, I co-chair a workforce strategy board, which is a subgroup of the regional people board for the north-east and Yorkshire. We have been able to bring together all elements of the community, including pharmacists. I have asked for dentists to come along next week because we know the impact that not having dental care is having on the community. As a partner in primary care, I am able to give a viewpoint and to say how I think that we could work better at a systems level with members of our community to improve, and to put patients at the heart of what we do.

Q167 **Chair:** Do you think that GP education gives people the non-clinical skills necessary to be an effective partner?

Dr Ikpoh: I think it does. The GMC sets our curriculum. We work within the guidance to try to shape that, and our statutory education bodies, such as Health Education England, deliver it. However, what we are witnessing at the moment is what I call the inverse education law. We have areas of high deprivation that are seeing lots of international medical graduates, which is a good thing, because we need the workforce; 47% of our trainees are from the international community, and in places such as Hull and Grimsby in the north, up to 70% are from the international community.

While that is a good thing, ultimately what we are doing is putting trainees who are not particularly familiar with the nuances of the NHS into a system that is already under-doctored and stressed and which perhaps does not have the capacity or the premises to provide the training that they need to become partners. It is almost a double challenge, as it were. We need some understanding that perhaps we need to move forward to a longer training programme, for four years, that makes sure that trainees have at least two of those years in general practice so they can understand what it means to become a partner, should they wish to choose that route.

We would also ask that we have more training places. I know that Health Education England is trying to increase its number of training places to 5,000. While that is admirable, in Hull—I default to that because it is where I work—the number of our medical school places has increased, which is great, but, as a former director of the medical school, I know that we simply have nowhere to put everybody. That has become a big challenge.

Q168 **Chair:** Before I bring in my colleagues, I have one question for Dr Holden. In 2018 there was a survey that said that only 50% of GPs thought that their premises were fit for purpose. We have just been talking about the partnership model. Your two colleagues said how important it is to the future. To what extent do problems with premises threaten the future of the partnership model?

Dr Holden: Hugely. I would not dissent from a word that either Mike or Margaret has said. I completely agree with them. Premises are a threat because, although in general practice we are largely all independent contractors and are required to run as a business, we cannot make whatever you would think of as a sensible business decision. That is because it is a cost-plus contract, just paid in a different way. There are therefore huge constraints on our innovating anything. I cannot put my prices up to produce a bigger profit to fund better premises. I rely on a handout from Government. That is not the way that I would like it, but it's the way it is.

What does it mean for premises? You heard this morning in the first session about all the extra people. I have nowhere to put them. I am having to work from home on a Thursday, whether I like it or not. Last week, we looked again at whether we would extend our practice—we are a teaching and training practice—to take on more trainees. I was told, "Yes, Dr Holden, you can have the money if you don't mind giving us £150,000, because we would have to destroy equity in the premises to make the extension." When we get the extension, we have to pay for a third of it, and there is no more borrowing cost reimbursement. Why am I paying to fund the NHS and its training? Premises are a problem when it comes to training.

At the other end, the problem is the question of last man standing. Partnerships are unlimited liability partnerships, for reasons we looked at in 2004. I am the last one standing who negotiated the '04 contract. Premises and finance were my responsibility. Unfortunately, the money that I negotiated went into the correction factor at the last minute. The problem is that, if you get a practice that starts to fall over, you get a domino effect. The last person standing is left holding the debt for the business. Only last night I sent Matt Case an essay I found that I wrote 10 years ago, because it encapsulates that. It describes exactly what happens when things fall over. Let's say that you have premises worth £1 million. You could have a four-partner practice where two of them retire. That leaves the other two having to find £500,000. Then the third one

goes off with stress because of that. That leaves the last guy having to find £750,000. No bank is going to lend him that.

It is worse when you look at the Government's review of premises ownership, when it is published. I have not seen it in detail, but the thrust is that there will be three categories of premises: core, flex and tail. If you were a tail practice and I were a banker, I would be calling in your loan. There is no guarantee that it will go on. It is about confidence, in the same way as on the pound note it said, "I promise to pay the bearer." We know there isn't the gold there, but it was the promise. It is about confidence. Premises are a long-term bet, but property is no longer the one-way bet that it was. Premises are a healthcare cost. You cannot practise out of a cardboard box. There are problems. It is risk, it is confidence and it is getting the youngsters to understand the business.

Q169 **Chair:** It puts youngsters off wanting to become partners. That is very true.

Dr Holden: To some extent. Once they are educated, they want to be partners. Yesterday, I appointed the third of three partners in the last year.

Q170 **Sarah Owen:** Dr Ikpoh, I want to pick up on some of the stats that you gave about the international community and how many of your recruits, and your new recruits, are from the international community. You talked about training as an issue. Are you seeing any other barriers to international recruitment and retention, particularly around visa fees and the immigration health surcharge?

Dr Ikpoh: Yes, in a nutshell. One of the major barriers that trainees have from day one are the financial pressures that they have to maintain their visa status. They also need a certain threshold in their bank accounts to make sure that they can stay. That looms over them for the duration of their training, whether it is for three years or more.

I am contacted on a regular basis by trainees who, at the end of their training, are literally going from celebrating the fact that they have become a GP to receiving letters threatening them with deportation, despite the fact that we have spent 50 grand a year training them up and, in areas of deprivation, they may also have been given funding through the targeted enhanced recruitment scheme. That cannot be right. It has to change. We have to value them better. If we do not, we will lose them. Some are already going to places where they feel that they are more valued. Canada is at the top of their list. It is an easy win for all of us to try to sort that out. I heavily appeal to the Committee today to try to look at it.

Q171 **Sarah Owen:** In other hearings, we have heard evidence about medical student burnout. Is that a reality in general practice as well?

Dr Ikpoh: It is a reality. Throughout the last two years, medical students have had to work remotely, especially in the early phases of their medical

studentship, and that has been quite challenging for them. I have a thing in practice where I say to everyone, "Put your smiley face on, because this is our next generation. If they see that we are burnt out, it is only going to filter through." It is happening. We are seeing a higher number of referrals to the mental health support for students in our regions. We need to do our best to make sure that we support them through their journey.

The other thing I need to mention is that there is strong evidence at the moment that medical students are not picking general practice as their first-choice career because of the issues they see in general practice.

Sarah Owen: That is a really big statement, so I would like to come back on that.

Chair: Please do.

Q172 **Sarah Owen:** What do you think would encourage them to be able to choose it as their first choice?

Dr Ikpoh: It all comes down to headspace, which has been mentioned several times in this place—to have time for individuals. You need to value them and to have time to guide them through the process, and they need to see that we are here because we love general practice. I love being a GP. Despite all the negativity around it, we wake up and do it all again tomorrow. Whether that means that we are just martyrs or something else, I don't know. They see that enthusiasm, because we are literally the carers of our population from cradle to grave. That is why I became a general practitioner. I love that continuity of care.

Q173 **Sarah Owen:** Peter and Mike want to come in on that.

Professor Holmes: One of the things I would like to raise is that we clearly have a shortage of doctors and a shortage of GPs, yet we have 28,000 young people applying to medical school each year for 7,500 places. That is 20,000 people who are disappointed. I wonder whether we can do more in that regard, because when we get to the other end, when we are recruiting to GP training, only about 53% of the applicants are UK graduates. What is going wrong in between?

I would also like to pick up on the inequalities piece, and that it is more difficult to recruit in areas of deprivation where I work, in Hull and in Scarborough. What can we do to incentivise that? Do we need to encourage more people who grew up in those areas to come into UK medical schools? I know that we have widening participation, which is laudable, but I wonder whether we need to do more of that. There is long-term evidence that 30% of doctors will go back to where they grew up to practise medicine.

Dr Ikpoh: Can I stress one thing? I was told this by Health Education last week. We have a significant proportion of medical students who are British and who study in Europe. I was told that the figure is up to

thousands. I am not quite sure what the strategy is to try to get them back into practice in the UK, because they are struggling to get clinical placements and are competing with other colleagues for foundation placements. That is something else that really concerns me.

Chair: We have to wrap up at 11. Do you want to ask a last brief question, Sarah?

Q174 **Sarah Owen:** It is about premises. The Sundon Medical Centre in Sundon Park in my constituency is a typical surgery, probably like hundreds across the country. It is a converted old house and has just one parking space for patients. How can we get over that hurdle so that they have the facilities at the premises that they actually need? How do we take away all the barriers that you have mentioned and enable that practice to work in the way they want to?

Dr Holden: In a word, cash. In a word, we have to start investing in premises. You do not necessarily want to invest in those premises. Equally, if you build shiny new premises down the road and ask the GP who is in the other premises, and for years has supported and subsidised the health services by those premises, to move there, why should he or she give up an income stream and be left with a load of premises for which he or she has the conversion costs? Bluntly, there are costs in decommissioning a surgery, and there is no way of properly meeting them. In theory, there is, according to the rules, but the practicalities of getting it are very small. When you are dealing with a multi-partner practice, each partner has different needs and aspirations. If you are young, you will want to move. If you are close to retirement, you will not.

To go back to your last point, on recruitment, the reason is that we have a task-delineated contract; we have to work for as long as it takes to do it. Others, in other parts of the health service, have a time-delineated contract. They can say, "I'm sorry, but I am out of contracted time now." That is not to say that you walk away from the patient in front of you, but it means that you have a workload that is doable. We have a workload that is not doable.

Sarah Owen: Thank you.

Q175 **Taiwo Owatemi:** Dr Holden, earlier you spoke about how you had to contribute towards the training of new GP trainees. Can you explain to all those listening how that actually works and the impact it has?

Dr Holden: The experts on training are to my left. The bottom line is that we get a training grant, but that is just to do the educational bit. It is recognition of, not compensation for, time for supervision. You can read that to every other topic we have talked about this morning.

The point is that a trainee must have somewhere to work from. They must have a consulting room. We must have computer terminals. We must have support staff. If I have to build a new consulting room to house the trainee, how is that funded? At the moment, the nation is

asking me to fund that, one way or the other. There is a wide range of models for doing it, but the bottom line is that the capital repayment is coming from my take-home pay. Why should I? There are better homes for my money.

In the old days, from 1966 to 2000, it was a hedge against inflation. We were all used to living—

Chair: I am sorry, but I am going to ask you to move on. We have heard that point. Taiwo, do you want to ask your next question?

Q176 **Taiwo Owatemi:** You wrote to us about the Scottish model of premises. I would like you to explain the advantages and disadvantages of that.

Dr Holden: The principle was that in Scotland they realised that they had a major recruitment and retention problem, all tied up with last person standing and things like the problem, particularly in rural and remote areas, of cost never coming up towards market value. It has to be said that they are more wedded to the NHS north of the border than they are south of the border. That is the first issue.

Secondly, they saw that premises were the rate-limiting factor in getting recruitment going. Premises were the problem causing instability.

Q177 **Chair:** What did they do?

Dr Holden: I devised, and they took on, a managed equity transfer scheme. I supplied you with a paper on it last night. I'm sorry it was late. Essentially, the Scottish Government said, "Over 25 years, we are going to buy those that want it out of their premises." That is exactly what they are doing. I can send you details later, if you wish. Effectively, at no cost to the GPs—without detriment—they are required to keep the premises up to standard and, in 2038 to 2043, the Scottish Government hold the deeds to the premises. It costs £25 million a year.

Q178 **Taiwo Owatemi:** Thank you. Dr Ikpoh, you talked about how in the north you have one GP to about 2,000 patients.

Dr Ikpoh: It is 2,500.

Q179 **Taiwo Owatemi:** That is a lot. How do you think GP workload can be managed in a way that does not impact patient care but safeguards GPs from experiencing burnout?

Dr Ikpoh: One thing that was discussed earlier was the evolution of the multidisciplinary team. Particularly over the last five to six years, not just in the north but in the west midlands as well, I have seen heavy reliance on the additional roles that we have in practice. I note that physician associates were referred to as not medically qualified by Rosie earlier, but I would argue that the majority of our physician associates have a background—a degree—in the biomedical field. They are among the most committed trainees that we have on the programme, when we have them alongside our medical students.

We have paramedics, podiatrists and social prescribers. We use the social prescribers now to support our international trainees. For me, having so many roles in practice is all well and good, but the public need to be able to understand what each of those roles means. I remember that when we first had a paramedic, patients would be very angry. They would say, "Why have you sent me a paramedic? I didn't ask to go to hospital." There is something around our having a public-facing campaign, so that people can know who the right person is to see at the right time and in the right place. While we are still struggling to fill up doctored areas, we are fortunate, and grateful, that we have those additional roles to support us.

Chair: I bring in Rosie at the very end.

Q180 **Rosie Cooper:** There are so many questions, and we do not have time now. I was going to explore the benefits of and downsides to phasing out independent contractors and whether you think that general practice, as an integrated part of the NHS, would be affordable.

Dr Ikpoh: Affordable as a salaried model in its entirety? No. You would lose good will from a lot of GPs. It would just become a job. For me, this is more than just a job. There is a lot of work that we do that is unremunerated, effectively. I work seven sessions in practice, which equates to about a 50-hour week. I often work weekends as well. It is not that I am complaining, because I love to do it, but it is not sustainable for a lot of people, particularly our newer generation coming through. I think we need to look at a mixed economy. There are mutterings that having a wholly salaried workforce is perhaps the bigger picture of what people want, which is inducing a lot of anxiety in a lot of people.

Professor Holmes: I support that stance. I think it would be unaffordable. The added value that you get from the partnership model is well documented and was one of the key findings of Nigel Watson's report.

The other key factor is that delivering general practice takes a primary care mindset—putting disease in the heart and the context of patients' lives—and the continuity we heard about earlier. We strive for that. The partnership model has delivered that in the past. If you ask other sectors to run general practice, we are missing something. That is why we are specialists in general practice. In the same way, we would not be asked to run a hospital. We must work together and learn from one another.

Perhaps we need to move away from the siloed working that we have seen over the last decade or so. The concept of integrated care systems is a really good one. We have to grasp that. One of the things Nigel Watson asked for was a voice at system level for general practice. We really must have that. Whether it comes from PCNs or whether it comes from larger GP providers working at the level of place is yet to be seen, but I have seen examples where it works really well.

Q181 **Rosie Cooper:** I have a final question. You mentioned PCNs. How are they enabling you to work differently? Are they making a difference? How will you defend the partnership model to Government and help MPs who might want to help you to do that?

Professor Holmes: We have to think of the system in layers. The bottom layer is the practice, where we give relational continuity to patients. The partnership model is well suited to that, as we have already talked about.

The next layer up is the PCN layer; collaboration at 30,000 to 50,000. One of the challenges with PCNs is that it is a subcontract. It is quite prescribed. There is very little room for innovation within it. You have heard about some of the challenges that we are facing with the ARRS. I wonder about the future. I wonder whether that is the model moving forward. We have to explore it further.

Above that, we have the GP provider, at place, where you can deploy scale and perhaps shift some transactional work out of general practice, allowing practices and partnerships to focus on the relational continuity that we know is important to healthcare outcomes.

Chair: Thank you. This has been a short but incredibly important session. Thank you very much for the insights on premises, the partnership model, training aspects and supervision. We have covered a lot of ground, but it has been very important. A very big thank you, Dr Ikpoh, Professor Holmes and Dr Holden for joining us this morning. That concludes the session.