HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: The future of general practice, HC 113

Tuesday 12 July 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Rosie Cooper; Dr Luke Evans; Mrs Paulette Hamilton; Marco Longhi; Rachael Maskell.

Questions 227 - 283

Witnesses

I: James Morris MP, Parliamentary Under-Secretary and Minister for Patient Safety and Primary Care, Department of Health and Social Care; Matthew Style, Director General for NHS Policy and Performance, Department of Health and Social Care; Dr Nikki Kanani, Medical Director of Primary Care, NHS England; and Dr Amanda Doyle, Director of Primary Care, NHS England.

Examination of witnesses

Witnesses: James Morris MP, Matthew Style, Dr Kanani and Dr Doyle.

Q227 **Chair:** Welcome to the Health and Social Care Select Committee in the Palace of Westminster, on the Committee corridor where one or two other things will be decided later today.

We are focusing on a very important issue, the future of general practice, which we have been thinking about very hard over the last few months. This is our final panel to discuss it. We have some very important bigwigs here: top people from NHS England, a top official from the Department of Health and Social Care, and the Minister responsible for general practice from the Department of Health and Social Care. He was newly appointed last week, so he is very new to the brief. We understand that. We are very grateful to him for joining us at such short notice and we have lots of very important things to discuss.

I will crack straight on, if I may, and start with a question to you, Minister, for a general view. You are very welcome to pass on to your colleagues so that they can follow up with more details. One of the themes we have been looking at is the fact that after contract changes in 2004 GPs stopped having individual lists of patients and moved to being attached to surgeries. We have been very struck by evidence from Norway. In fact, we heard from someone from Norway, who told us that people are 30% less likely to go to hospital and 25% less likely to die if they see the same GP over a long period of time. We have also heard from GPs that 9% of surgeries have kept the individual list system and that it is infinitely less stressful for GPs if the two thirds of the patients they see are people they know. We have been pursuing that. We asked the former Secretary of State, Sajid Javid, and Amanda Pritchard of NHS England about it, too.

From what you have been briefed in your short time in the job, are you concerned about the decline in continuity of care?

James Morris: It is fair to say that we take continuity of care very seriously. The evidence that you cite is important evidence in relation to improved outcomes. Continuity of care is obviously critical to the delivery of those, so we would broadly agree with that.

As you will be aware, it is the case at the moment that all patients must be assigned a GP who must lead on overseeing their care. That is something that is already in place. There is a legitimate debate about continuity of care for different cohorts of the population—people who have different conditions or requirements. How we define continuity of care might be different for different people.

By the way, I want to say that GPs have been doing an incredible job over the last few years, particularly with the challenges of the pandemic. I want to put that on record. I think that that is important. As you will be

aware, the stocktake done by Dr Fuller touched on continuity of care, and that piece of work was very important.

Q228 **Chair:** Thank you. Let me bring in your two colleagues from NHS England. Everyone agrees with the theory of it, but I want to get some details. One of the views that we have heard expressed is that we would love to go back to everyone having their own doctor, but we cannot do it at the moment because we do not have the capacity in the system. Another is that it is very important for complex patients with long-term conditions, but not for occasional patients who are broadly healthy.

We have heard evidence that both of those two views are wrong. We have heard very strong evidence that, for example, if you have a patient who smokes, they may be broadly healthy, apart from the smoking, but the long-term relationship with that patient means that you are more likely to be able to persuade them to think about quitting smoking. In other words, you can stop someone turning into a chronic patient: prevention rather than cure. We have heard from other GPs that, within the resource constraints that we currently have, if you try to develop such systems, it is immensely better for patients and GPs. In Bristol, we heard that 60% of patients see their regular GP. They get it to that level with the resources that they currently have.

Where does NHS England stand on that issue? I will start with Nikki and then come to Amanda.

Dr Kanani: As the medical director for primary care at NHS England, but also as a practising GP, I recognise many of the issues that you have described. Our workforce is certainly struggling. We have some serious workforce issues, which I am sure we will come on to later. I add to the Minister's thanks. General practice has done a phenomenal job, both before the pandemic and, in particular, through the pandemic, rapidly innovating and then delivering the lion's share of our vaccination programme, as well as providing care.

As that workforce pressure continues, and we have more challenges around retention, patient need has changed and, within that, patient expectations. For example, my children access general practice very differently from my grandparents, who speak only Gujarati and do not leave the house very often. What we need to be able to do with that real capacity challenge is to make sure that we support general practice to evolve into a model that works not just for the workforce but, most importantly, for our patients.

By developing the additional roles that sit around the GP, we are diversifying the workforce so that the GP becomes—

Q229 **Chair:** Sorry, Nikki, I want to talk about continuity of care. Where do you stand? Do you think that everyone should have continuity of care, or just a few? Do you think it is something that we can progress now? That is the thing. I am sorry to focus you there.

Dr Kanani: That's all right. I think that people who need continuity of care can be identified. We have seen lots of research evidence, from Philip Evans and others, that says that there are continuity flags and that for those people continuity matters particularly.

Q230 **Chair:** Are you going to change the GP contract to make sure that that group gets it?

Dr Kanani: Do you want to talk more about the contract, Amanda?

Q231 **Chair:** I have the sense of a hospital pass.

Dr Doyle: From the point of view of continuity, you are absolutely right. There is evidence that long-term outcomes are better for people where there is a continuous responsible GP. We need to be clear that there is a slight difference between having a GP who is responsible for your overall care and whose name is at the top of your record and that being the person you see every single time you need an intervention.

Q232 **Chair:** No one is arguing for the latter. We all understand the importance of teams. We know that, technically, people have a named accountable GP. In practice, it does not mean very much at the moment because what happens is that people see a different GP every time and there is not a great effort to make sure that people see a GP regularly, where they are able to. Let me cut to the chase, Amanda, because you are responsible for the contract.

Dr Doyle: I am.

Q233 **Chair:** Are you going to negotiate changes to the GP contract that make it more of a priority for GPs to keep tabs on a single group of patients, to go back to the individual list system, albeit exercising that care through a team?

Dr Doyle: We will always be exercising care through a team, but that does not mean that we do not need to put things in place. The blocker is not that we do not have contractual ability to tell practices that they have to do this. As you said yourself, GPs themselves want a relationship with patients that has continuity. It is easier to do your job with a person you know, where you have long experience of their care. It is not that GPs and practices do not want to deliver that. In the current situation, where we are struggling to retain GPs in the workforce in the numbers we need, it is very difficult to deliver it through a contractual route. All the things that we are doing to recruit and retain GPs, to expand our workforce and to support practices to work in ways that mean that patients can be identified, dependent on specific needs, are what is going to help.

Q234 **Chair:** The vast majority of GPs—certainly the ones we have heard from—say that they would like to look after the same patients regularly, but we do not have individual lists at the moment. That was the system that made that happen. What they really dislike is the system called QOF and the investment and impact fund—the IIF—because they say that that

micromanages what they do. Is that an appropriate system? Under the QOF system, you get money as a surgery if 90% of your diabetes patients have had seven tests. What about the patients in the final 10%?

Dr Doyle: The reason we have thresholds in QOF is that it is not always either possible or appropriate to deliver those interventions for every single patient on the list. There may be some patients it is really difficult to engage. You keep contacting them.

Q235 **Chair:** What if you are one of the patients who should be engaged but you are 91st per cent., not in the 90%? What doctors say to us is that, basically, the system tells you to stop trying when you have hit 90%, because you get your money. You have a pretty crazy system that turns patients into numbers because, come January—the year ends at the end of March—GP surgeries pick up the phones and try to get in enough diabetes patients to get over the 90% level. We are wondering whether that is proper care. Basically, what the surgery is incentivised to do is to hit a target, but then stop trying once it has got to 90%. Aren't we turning patients into numbers?

Dr Doyle: It is really important that we recognise that GPs running their practices are professionals who want to do the best for their patients. What you are describing happens because there are processes in place for calling and recalling patients for checks and reviews throughout the year. Practices will chase up patients who have them at the end of the year.

Chair: We understand that GPs are professionals. What they say is that they are pushed not to treat patients as individuals because they have to spend so much time hitting all of these targets. If they do not do that, they will not get money for the practice. The unintended and very depressing side effect is that, if you are in the 10% who do not need to be contacted to get the money, you tend to get forgotten. Let me bring in my colleague Paulette on that point.

Q236 **Mrs Hamilton:** Thank you, Chair. I want to bring it a step forward. You have ICSs. You have primary care networks. I absolutely agree with the Chair about these targets. Now that we have primary care networks and ICSs in place, what do you have planned? While I worked as a councillor and what have you, I was in the fortunate position of sitting on an ICS. The statement that was continually made to us was that we had to ask for forgiveness. We had to start to think differently and look at things differently and, if we had not quite got it right, to ask for forgiveness.

Going forward, what are you hoping to see so that we can look at people when we get past the 90%? The Chair is absolutely right. Let's be honest. Doctors are so overstretched at the moment. Once they get past the 90%, they are not continuing to look at the people who fall outside that figure. How are you hoping that, going forward, we will shore that up so that some of the mistakes that have been made in the past will not continue to be made?

Dr Doyle: QOF has been in place since 2004. There is no disputing the fact that it made a substantial difference to the inputs—the processes that need to be carried out to produce the outcome improvement that we want to see. We are now in a position where we have greater analytics available to us, which enable us to think prospectively about how we are going to give people the best care. I would like to see us move to not just performance-managing primary care by measuring what it did last year, but giving primary care the ability to identify the patients who are most at risk and most need interventions, and to do that prospectively. We need to look at whether the contractual drivers and levers that are currently in place will best enable primary care to do that, because what matters most is the people who are most at risk of deteriorating health, hospital admission or a worsening condition and those with whom GPs and their teams are unable to intervene and take action. That is what I hope we will be able to move to.

Q237 **Dr Evans:** I would like to talk a little about the workforce. We know that there are gaps in the workforce. I do not want to pick that bit up, because that is a future side. We are all in agreement here. Even the Government say that we do not have enough staff. There is a problem. For the next several years, the issue is how we get the best out of the staff we have. That is about retention, recruitment and remodelling. Those three things are really important. I want to try to break them down a bit.

Dr Kanani, can I start with you? As a GP, I could write a list of some of the fundamental things in a day-to-day GP's life that could and should change and would make a difference. The question that I find difficult is, who is making that decision? Clearly, it cannot come from a Government Minister, because they will not have the insight into what it should look like. Who will do it, and at what level? Will it be you making the decisions that could alleviate the situation for patients? I am happy to give some examples of things that could make a difference, but can you talk me through the decision structure? As yet, we have not heard that there is a plan for making life better day to day for a GP or someone working in primary care.

Dr Kanani: I would probably start with the review of bureaucracy that is under way at the moment, which is a concordat review between ourselves, the Department of Health and other Government bodies. It is looking at a range of things that would improve our working lives, our day-to-day lives, in the way that you describe. They include things like fit notes and DVLA checks—things that we have to sign off—which do not necessarily sit within an NHS England or even a Department of Health infrastructure. Some things sit within our own space—for example, the primary-secondary care interface. Some of the things that we find most challenging day to day sit at some of those boundaries.

Q238 **Dr Evans:** Let's pick that one up. It is a great one, because it is a prime example of hospitals potentially dumping work on to primary care. That would be the primary care argument. Equally, inappropriate referrals may

be going back up and the use of pro formas that are not pragmatic. There are different ones. I have worked in a multitude of settings across the country, and they are all different. That cannot be sorted out by Government, but it can be sorted out by the NHS and the trusts. For these simple things, who is the decision maker, and why isn't that being decided? Do you want to come in, Amanda?

Dr Doyle: Yes, because we have just been picking up that very thing. The Academy of Medical Royal Colleges is going to carry out for us a piece of work that says, "In a new world of integrated care systems, where a lot of the older perverse incentives around the behaviours and hand-offs of patients between primary and secondary care should, in theory, go away, what is the reset for the relationship between primary and secondary care and how patients flow through pathways, rather than being handed off?" You know exactly the things I mean.

Q239 **Dr Evans:** Let's pick that up. During Covid, we saw the pathways change overnight—just like that. It was absolutely fantastic. Everyone said, "Gosh, why the hell can't we do this?" I am now putting that back to you, because already we are falling back into the old style of bureaucracy and decisions. Patient safety is absolutely paramount, but we need to be creative in the way in which we deliver. For example, is there a space in the contract to say that we should be paying for thinking time? Every clinician who has come in has talked about having headspace to reinvent. That would be revolutionary for the coalface, because they are the ones who are going to solve the problems. Is there a way that we can think about putting that in place?

Dr Doyle: You are absolutely right. We cannot expect general practice to transform the way it works or to remodel its workforce with absolutely no headspace to step back to look at it and to put those changes in place. All of that takes time and work. I would like us to step away from an approach where we pay for specific interventions and look at an approach where we say, "What do we want general practice to look like? How do we want it to be able to deliver the best care for patients?" As you know yourself, each practice has a different sort of patient—a different demographic and a different priority—so I think that is really important.

We have Claire Fuller's stocktake. We are working now to look at how we implement that. It is not a very quick fix. There are big asks around integrated teams and estates. Nevertheless, it gives us a picture of what this might look like. We have to recognise that we have to give them that.

Q240 **Dr Evans:** Amanda, I am going to pick you up on that, because it is really important. This Committee likes to ask the question, should we look for revolution or evolution? From what you are saying, your approach now, especially with everything that is going on outside this room, might be that it is time to be saying that we should rethink the way in which we do the contracting around GPs in primary care and the way the system looks, given that we now have the integrated care

system as a bloc to try to undo that; that is, to give responsibility back down to the ground, to let clinicians be clinicians, let leaders be leaders and let the politicians take the flak when it goes well or badly. Is that a fair assumption?

Dr Doyle: I think we need a mixture of evolution and revolution. I do not think we can have a big bang where we rip it up and start again. As you know, there are opportunities each year, as we discuss any changes to the contract, to look at things we might want to put in place. The current five-year period of the contract finishes at the end of March 2024, so there is an opportunity to say, "How do we fit integrated neighbourhood teams, primary care networks and a much larger skill mix in primary care into what we want? How do we contract for what we want to see?"

Q241 **Dr Evans:** Is "we" you? We hear this a lot from people here. Do you feel that you have the power in your position, or is that more for the ministerial team? This is the question in the NHS: who is the carrier of the risk and responsibility at this point?

Dr Doyle: NHS England is the contractor at the moment, but we work in partnership with the Department of Health and Social Care. It is not a single Go map.

Matthew Style: Dr Evans, you made the point yourself that the creation of integrated care boards and their being on a statutory footing from 1 July is a huge opportunity in this space. Integrated care boards now have the flexibility to deploy their resources in the way that makes most sense for their local population. There are additional flexibilities in how the financial framework works that integrated care boards can exploit, partly to tackle some of the bureaucracy you referred to earlier, but also to engage in the delivery of the Fuller stocktake, in order to be sure that, as you say, clinicians can make the decisions to design services that best meet the needs of their patients.

Q242 **Chair:** Can I come in on that point? You say you are going to give them powers. How many national targets are you going to scrap in order to give them autonomy to do stuff on the ground?

Matthew Style: It is very well established that at the very heart of the new legislative framework that is now in place for integrated care boards is greater autonomy.

Q243 **Chair:** Yes, but there are no plans to scrap any of these national targets. I am just worried that you are paying lip service to autonomy, but, actually, they are going to be run on a very short leash, as you, NHS England and your former place, the Treasury, used to really enjoy doing. Basically, they are not going to have the freedoms, are they? They are not going to have any more freedoms than CCGs had.

Matthew Style: I think it is entirely appropriate that we set some very clear national expectations for what we expect our colleagues in frontline health and care to deliver for patients. That is particularly important in

the current climate. At the same time, more flexibility within those targets for local leaders to set their priorities according to the needs of their local population is absolutely at the heart of our vision for how the health and care system will work over the coming years.

Q244 **Dr Evans:** That is really helpful. My final set of questions is about retention. I am going to raise this point again. Every senior doctor we come into contact with raises pensions as an issue. I have raised this with the Secretary of State. I understand the trade-off over very well-paid people getting paid extra to carry out work. I get that, but, fundamentally, we have the biggest backlog that we have ever seen in the NHS, with the most experienced people saying that they are disincentivised to take on extra work. That is not them making a moral judgment. They are just saying that the practicalities are that they are already burnt out, so why would they go out and not get paid adequately for doing it? I think that is a reasonable position.

Matthew, do you still identify the pension issues as a problem? What workarounds have been put in place? A temporary measure was put in place for 2019. We have heard that some NHS trusts are putting in place the clawback, allowing people to write it off. Is that something that you would mandate to other trusts to get people to stay on and work? What other solutions has the Department been working on to try to resolve the issue?

Matthew Style: As the previous Secretary of State said when he appeared before the Committee, pensions and tax policy is a matter for the Chancellor, of course, not a matter for me. As you say, we have a role to play in supporting local employers to understand the full range of flexibilities that they can make available to support staff to stay in the active clinical workforce for as long as possible and, indeed, to increase their participation rate. We have already issued guidance jointly with NHS Employers on the range of flexibilities available.

At the same time, at the end of the day individual employers need the flexibility to make the decision about which flexibilities are appropriate in their workforce, balancing the range of factors they will need to take into account. Therefore, I do not think that at this stage we should be mandating particular flexibilities. As I say, our role is to support employers to understand the flexibilities fully. We will keep under review whether any further changes to national rules could be made to support employers to that end.

Q245 **Dr Evans:** That is a really useful answer. I appreciate that. There is a practical point. Every day that goes by, another GP is saying, "I am not going to take on more work," or is looking to take retirement. That is the reality of what we are living with. It is the same in secondary care. It has to be an active decision not to mandate, as opposed to a passive one to let it pass. Therefore, is there a timeline you are looking at to make a decision? I appreciate that there is a new change in the Department and that this has to be a political decision, but is that something that is being

actively discussed at this point to try to come to a resolution, given that we are in the summer and that the winter will be a very problematic time if this is not resolved?

Matthew Style: It is very actively under review. We are listening to proposals that both employers and workforce representatives make to us and are discussing those across Government. We have a track record of acting decisively on this. As you say, we took some very particular steps in 2019-20 to alleviate the issue. It is under active consideration.

Q246 **Chair:** I want quickly to finish off the discussion that we were having earlier. We have here four people from the centre: from NHS England, a Minister and someone from the Department of Health and Social Care. We have more national targets running our health system than any other health system anywhere in the world, which gives you great control over 1.4 million people. Very briefly, is this a good thing, or do you think that, just possibly, we might have too many targets, which make it more difficult for professionals to do their job? I will come to you first, Minister.

James Morris: As you know, targets play an important role in performance management. We would probably all agree with that. Given the challenge that we face in primary care and the discussion that we are having, and in the context of the reviews and stocktakes that have been done, I think that it is legitimate to say that we would evaluate anything and everything to improve the situation we have. As we have been discussing, we have major challenges in this area—on recruitment, on retention and in relation to the discussion that we were having about continuity of care and delivery. I think it would be legitimate to say that things are subject to review and subject to discussion.

Q247 **Chair:** That's great. Amanda, do you come to work every morning thinking, "It is great that we've got all these targets"?

Dr Doyle: I think that we should be setting expectations based on the evidence about what makes a difference to patients, their outcomes and their experience. For me, a lot of the targets are expectations about delivery, rather than—

Q248 **Chair:** They have money attached to them, so they are a bit more than expectations, aren't they?

Dr Doyle: Some do, particularly in general practice.

Q249 **Chair:** Nikki?

Dr Kanani: The movement towards more of an outcomes framework is important. Within that, we need to think about how we support the system to focus on our most deprived and under-served communities, because I think we have missed an opportunity and we have to do much more to make sure that we support the communities that are most at risk and do not get the care that they need.

Q250 **Chair:** I was asking about targets. You would like some more targets, but

focusing on deprived communities.

Dr Kanani: If we need targets in the system, they need to be about our most vulnerable and our most deprived.

Q251 **Chair:** But do you not see the issue? That is a very important issue, but if every time the answer is a target, you end up where we are, which is more targets.

Dr Kanani: This is why we want to focus on outcomes for people, as opposed to targets and input measures.

Q252 **Chair:** Let me ask you, Matthew Style, formerly of Her Majesty's Treasury, if you like targets.

Matthew Style: As Amanda said, I think targets should be informed by the evidence about what matters to patients and what will help change outcomes. I actually think it is important that there is clarity both for staff and local health leaders, and indeed for patients and taxpayers, about what they can expect from the service. That is the role of the framework we have in place.

Chair: Paulette wants briefly to follow up on that point, and then Rosie.

Q253 **Mrs Hamilton:** My issue with what you have all just said is that with primary care changing the way it is changing, and with ICS boards coming in, do you not feel that we are tipping GPs over the edge? We have all these targets. Nothing is being removed and no one has said here, except the Minister, that they feel they should be evaluated. We are adding more. We are not taking anything away to say, "Look, you've got the freedom to make a difference."

Do you not feel that, if we are to have a successful primary care system, we have to look at what we are giving them now compared to what we gave them eight or 10 years ago? We have to evaluate and remove some of what was given, so that they can successfully move forward in things like working around population health with ICSs.

Chair: Who is the lucky person you would like to answer that?

Mrs Hamilton: Can I be honest? I am going to be kind. Dr Amanda Doyle and Matthew Style.

Chair: Just one person, if that is all right.

Mrs Hamilton: They can choose which one answers. I will be kind.

Chair: It looks like it is Mr Treasury.

Matthew Style: I am happy to come in on that. The Fuller stocktake gives us a really important platform. There is strong consensus across the profession and across the NHS about the vision that Dr Fuller has set out for the future of primary care and how we expect clinicians in primary care to come together and build the services that are right for their populations going forward. Local leaders and integrated care board

leaders in particular have the flexibility to get behind that vision over the course of the coming years.

Chair: I am going to bring in Rosie Cooper and then Marco.

Q254 **Rosie Cooper:** I want to follow up on this bit. Later on, I was going to ask a question, which has sort of already been answered. I was going to ask whether ICSs were going to be given the freedom to make the decisions they need for their populations.

I want to reflect back to you what I am hearing today. Straight off, ICSs are here and they will have those freedoms. They will be able to make those decisions. We are not removing any targets. Amanda, the GP contract ends in 2024. That tells me you are already way into that negotiation. What are you really saying? You are not going to get to December and have a big surprise next year. What direction are you taking? How is that reflected in the freedoms that we are nebulously talking about with a very tight grip?

Matthew Style: Integrated care boards, as I say, have been given a significant amount of flexibility in how they deploy their resources. In particular, there is a significant commitment to increase the share of NHS spending on primary and community health over the long-term plan period. As to precisely how that is deployed and which services are prioritised, as I say, ICSs have the flexibility to make those decisions.

We will be working with the leaders of integrated care boards to consider what changes need to be made to the contract in order to support them to commission the services across primary care that they think are most important in their local area.

Q255 **Rosie Cooper:** Absolutely, but we are not removing any of the targets. We have perverse outcomes to some bits of the contract. ICSs are here and they are going to have to make decisions now. The new financial year is rolling right at us. What difference are you going to make, Amanda?

Dr Doyle: You are right that ICSs are here. We are currently working on how many of the functions that are currently held nationally in the central team should be devolved locally, so that ICBs can focus on the local population. ICBs will increasingly be responsible for commissioning primary care, but actually discretionary commissioning from primary care by ICBs locally, rather than everything held centrally, will be increased.

There is money in the national GMS contract that is bound up in the contract, and then there is a whole load of additional and enhanced services—for example, the primary care network enhanced services—which are all additional to the contract and which often change. They are often ways in which we flow extra money, some of the extra investment.

It is likely that some of that will be more appropriate for ICSs to commission locally for those services. In fact, if you look at Claire Fuller's

stocktake, that is what it describes. It describes local commissioning by ICSs of appropriate local services, but we are a national health service and there are some national contracts with a set of expectations about what the offer to patients is in any place that we need to keep.

The GP contract does not end in April 2024. What happens with the GP contract is that it rolls over unless we change it. The end of the current five-year agreement around the contract comes to an end then. We are not well into negotiations, but we need to be thinking very carefully about how the new landscape makes a difference to what that contract tells nationally.

Q256 **Rosie Cooper:** I appreciate that it is a rolling contract. If you are at the centre, are you looking at those perverse incentives or those changes? When would you plan to roll them in?

Dr Doyle: As you know, Rosie, I have the experience of having been a GP for 25 years. I also was the chief officer for an integrated care system in Lancashire and south Cumbria for four years. I have the perspective from each of those angles. I am now in the national team, seeing how that works. It is really important that we talk to people, not only GPs, both through their negotiators and widely across the country, but our 42 new integrated care board chief executives about what will enable them to make the most difference locally in their new roles. All of those 42 have signed up to Claire Fuller's stocktake and the vision that gives us of the medium-term approach. It is important that we listen to them about not only what we should be looking to deliver but how we do it most effectively.

Q257 **Chair:** It is nice to listen to them because they still have to do what you say, because you control them with very tight targets. It is a nice exercise. Could you explain a very simple thing to me?

On the logic that we pay GPs if they give 90% of their diabetes patients seven tests, should we not at the Department for Education have a pot of money where we only pay schools when they can prove that they have taught a Shakespeare play to every A-level student? It is the same logic, isn't it? "We're not trusting you to do what's right for patients, so we are holding back money until you can prove you've done it." Shouldn't we do the same for teachers and police officers?

Dr Doyle: I do not know anything about education policy, to be fair.

Q258 **Chair:** But it is the same principle.

Dr Doyle: The quality and outcomes framework around diabetes was brought in because the evidence showed that outcomes for patients, as regards complications of diabetes, were much better if those interventions happened—if you had blood pressure control and eye screening.

We need to think very seriously about what happens if we do not have those measures, and whether there is a better way of ensuring that we improve outcomes for patients. We need to do that piece of work and look at the evidence. We need to talk to people about how we do that.

Q259 **Marco Longhi:** I am afraid that I am going to labour the point around perverse incentives and targets. As someone who has worked in the NHS myself as a management consultant, I observe an organisation that, while of course well meaning, including GPs, is very much preoccupied with changing its structures all the time and, as a wonderful exercise of managing, its own reputation as well. It talks a great deal about being patient centred and patient focused, but all of the systems churn out frameworks that unfortunately do not reflect the patient being at the heart of everything. I am glad I am hearing about outcomes now, but we are in 2022 and we have been talking about outcomes for the last three decades. The systems have never changed to bring that about, so forgive the cynicism.

The system we have at the moment—I witnessed it only very recently—is that I could be a patient who turns up at a GP for an appointment that I have managed to get. I might want to see my GP about a couple of things. I have a problem. I do not realise, as a patient, that actually if I have three conditions, I need to book three appointments. I have known patients who turn up and are told to leave after they have talked about the first condition. They go to reception and say, "I need to make another appointment because my GP won't talk to me about my other condition," and the receptionist says, "Oh no, we can't book your appointment from here. You have to go home and call us to make another appointment."

This is what the system is delivering right now in 2022. It is appalling. We need to change the system. We need to see what you mean. By all means talk about targets. I will be one of the people who says that what is not measured is not actively changed, but I also completely support what all of my colleagues have said, from all sides, that targets then become outcomes rather than a delivery mechanism for delivering that outcome. We really need to see, at pace, what the system is going to do, led by politicians but also by you guys who need to make the changes.

Chair: Who would you like to go first?

Marco Longhi: All of them.

James Morris: Your description there of the patient experience might be an isolated example or it may not be, but it speaks to the broader challenge that the Government are seeking to address in primary care. We are recruiting 26,000 new practitioners into primary care in order to avoid precisely the situation that you have described. What we are looking at is a changing landscape from a policy perspective to try to address the problem that you are describing.

Marco Longhi: May I come in on that?

James Morris: Yes, of course.

Q260 **Marco Longhi:** On that very specific example, and I can give several other examples, that is a system which is creating additional burdens on the system so that a GP who might see the same patient may be stretching the 10-minute patient time to 15 and deal with all three comorbidities—if I can call them that—rather than telling the patient to leave and rebook another two appointments. That, surely, is not getting the maximum capacity out of the system. It is causing additional burden.

I hear a lot the response, "We don't have the capacity," but the perverse incentives that you have are an actual burden on existing capacity.

Dr Doyle: The experience you are describing is a poor experience for patients. There is no doubt about it. It is a symptom of GP practices feeling overwhelmed by demand and therefore taking steps to manage that demand. It makes absolute sense to deal with everybody's problems in the same consultation. If a consultation goes from 10 minutes to 15 minutes, that seems logical, but if that happens at 9 in the morning and it has happened for several patients, by the time practices get to 6.30 or 7 in the evening it is a big problem. I am not saying that is a good reason to take that approach, but it is a response of practices to manage the way they handle their appointments because they are overwhelmed by demand.

Q261 **Marco Longhi:** It is nothing to do with financial performance.

Dr Doyle: It does not make any difference to financial performance. If you look at the numbers around how often the average patient accesses their GP surgery, back when I qualified it was about three times a year on average. It is probably above 10 now, so we are seeing an older population living longer with more long-term conditions. We have an almost exponential increase in what we can do for people and the interventions we make. Twenty years ago, we were very much a reactive service. People came to us with symptoms, and we treated them. We are now a very proactive service as well.

None of that excuses a poor experience for patients, but what we need to do is ensure that we get enough capacity in primary care so that that does not need to happen and so that individual practices do not feel under so much pressure that that is the way they deal with it. You are right that if people have three conditions and three complaints, quite often they might be interrelated. We will not know that if we deal with each one separately.

Q262 **Dr Evans:** You are absolutely right. GPs are protecting themselves, becoming locums or dropping sessions, to give that list size. Therefore, the argument to deal with all this is to mandate fewer sizes. Drop it over a period of five years from 2,500 down to 1,800 so that you can manage that capacity. Every practice then has the continuity and ability to deal with that, with a workforce plan to match it. Is that something you would ascribe to?

Dr Doyle: The optimised list size for delivering the sorts of care we want to deliver is absolutely right. The issue we have at the moment is that we do not have the workforce to actually cut list sizes, and the workforce we have is not necessarily evenly spread across the country. There are places with significantly fewer doctors per patient than others. Often, those are the places with the greatest health needs, where it is more difficult to work—coastal, rural and deprived areas.

Q263 **Dr Evans:** If you do not do it, you lose more doctors.

Dr Doyle: Absolutely, and that is the problem we have. The increasing workload is making the job much more difficult to do. When you marry that with the earlier pensions issue, we lose experienced GPs, which is the biggest problem we have at the moment.

Q264 **Marco Longhi:** Matthew Style, do you want to come in?

Matthew Style: On that specific point, many of the witnesses you had before the Committee earlier in the inquiry spoke to the changes they have been able to make. I do not think it is for national action to set mandatory list sizes and so on. I think our role is to do everything we can to provide additional capacity to primary care, and support experienced GPs to make exactly the changes that many of the previous witnesses have talked about in order to ensure that they are able to deliver the care that they came into the profession to deliver. I think that is where we can make the biggest difference.

Q265 **Dr Evans:** A practice would struggle to close its list. If that was the case, all practices would just close their list because they are so oversubscribed, and say, "We're worked out." If that happened overnight, you are effectively saying that this is the problem. They have to keep their doors open because there is patient need.

Matthew Style: I think what I am saying is that the best support we can give to practices is the support we are giving in terms of expanding their capacity and expanding the number of professionals who are there to support GPs—

Chair: We are going to come on to the expansion of the GP workforce in a minute. Marco, do you have any further questions?

Q266 **Marco Longhi:** I sense that Matthew Style wanted to come back on a response from Amanda Doyle.

Matthew Style: I was going to follow up on your point about the experiences of your constituents and add to what colleagues have said. It is important that we have an appropriate emphasis on patient experience in how we look at the delivery of care going forward, and that we put much more emphasis on patient reported experience as one of the things we look at to assess the health of primary care going forward. I think that is a really important lens. The example you gave earlier is a very good demonstration of why it is important that we give due weight to that in future.

Dr Doyle: We have a new, better and more frequent survey—for want of a better term—of patient experience, which we hope will come online by April. That will let us get some meaningful information.

Chair: But let's be honest. What we are really hearing today is not any sense that micromanaging GPs through QOF and IIF might be part of the problem. You would like to change everything else, but you want to keep a really short leash on our GPs. That is the sense I am getting. I will give you a chance to come back if that is wrong.

Q267 **Rachael Maskell:** Thank you for your responses so far. What I have observed from listening and reflecting is that we are still very much focused on a demand-led service and, as a result, we are not addressing the issues of health inequality, which we know is certainly challenged at the moment. Therefore, this focus on outcomes will be absolutely essential, and will require a different, more holistic kind of input for a patient. Who is accessing services and who is not accessing services? We have heard about the inequality of who is able to even have sufficiency in their local health community of general practice. We recognise where the differentiations will grow.

As some of the witnesses said in earlier sessions, how do we create the headroom to bring about change into driving health equality and ensuring that we have a more public health approach rather than just a demand-led, ill-health approach, so that it is a health service and not a sickness service?

Dr Kanani: That is a really important question and part of the reason that primary care networks were set up in 2019. At the core of the services that were offered alongside the primary care network contract was a focus on tackling neighbourhood inequalities, which created space for primary care teams to look at what was actually going on in their own community—population health management, which Paulette has already mentioned, and the ability to deliver anticipatory care. For example, we are using our social prescribing team to think carefully about the personalised care offer that a patient should need.

We then entered the pandemic and the vaccination programme, so primary care networks were very rightly focused on and distracted by doing what they needed to do to care for their communities and to protect them from Covid, in which they did an incredible job. What we have now put back online are the service specifications that help to focus primary care networks on the key things that you have described.

I think we will start to see much more progress now in working with local communities, as primary care networks have been doing through the vaccination programme with targeted interventions, and using that learning as a sort of legacy so that they can work with their communities and direct people to the right sort of care. As you say, it is often much wider than health. I see many more patients now, and I have done since pre-pandemic, who talk to me about the noise issues in their housing

block or the mould continually growing on their housing estate house than I see people who are coming in for purely medical needs.

I enjoy seeing them, but I am not the best person to see them. That is why these additional roles are key through social prescribing. There is space through the primary care network contract to think about the community as a wider set of both individuals and services that wrap around those individuals.

Dr Doyle: My clinical general practice career has all been in central Blackpool, in an extremely deprived ward with extremely poor health outcomes. What is clear is that just trying to focus on very medical things for a deprived population does not work. What is important, and it is focused on somewhat in the Fuller stocktake, are the responsibilities of general practice around prevention. That is not just smoking, alcohol and exercise. It is about identifying disease and supporting people to manage their long-term conditions. That often takes more time and input in a very deprived population, a population that does not speak English as a first language, or a population that accesses care erratically rather than following our nicely set-out routine.

We need to recognise that GPs with some of those populations need more capacity. It might be a slightly different capacity. There is often a big mental health component for people who are struggling which interplays with their physical long-term conditions. If you do not support and approach that, you are never going to get anywhere with helping them manage their diabetes, for example.

It is not only important that we recognise that some communities are less well served and have less good outcomes, but that we recognise the things we need to do differently and the differences in approach and capacity we need in those communities. What we often see is that it is more difficult to work with those populations, so they are less well served. Some of the things that we are doing around enhanced recruitment and bursaries for people to come and train in less well doctored areas are helping us to recruit people to tackle that.

Q268 **Mrs Hamilton:** I want to talk a little bit about recruitment. My background is health. I am a nurse. I worked in the district as a nurse. Many years ago we had shortages of GPs. We then went on to have salaried GPs. When you look at the workload that our salaried GPs are carrying and the time they are given to do paperwork, how can you have individualised care in that respect? They are absolutely burnt out quite quickly, as are the partners, but I am going to focus on those GPs.

My concern is the number, highlighted in some notes I have, of people who are being recruited from abroad. It is over 50%, and in some areas it is up to 70% of GPs. Minister, what are your views on that?

Secondly, if we really want a quality service, when are we going to start looking at the salaried GPs versus the partners? It is a bit like an enrolled

nurse and a registered nurse. You have a two-tier system and they are feeling totally overwhelmed and burnt out at the moment.

Chair: Who would you like to go first?

Mrs Hamilton: I would like the Minister to start, and I am going to go for Nikki. She may not want to answer but I am going to go for Nikki.

James Morris: We have major challenges on recruitment and retention in this area. That is an incontrovertible fact. The Government remain committed to trying to improve that situation by improving the number of training places for GPs in the long term. That is not a quick win. It is a very long-term solution to the problem.

As we have discussed, we will look at innovative ways to recruit more people to do jobs in the primary care networks and so on in order to move towards the new landscape that we have been describing, which will reshape the nature of primary care. The Government remain committed to recruiting and retaining as many GPs as possible in the context of a very challenging environment with rising demand, as we have been describing, and continue to be committed to improving the service and the numbers of GPs coming into the service.

Q269 **Mrs Hamilton:** Through the Chair—sorry, I am butting in—why is the drop-out rate so very high if the Government are continuing to try to improve things? In the past, they have always been very keen to try to get women in, married women and people who are able to work quite flexible hours. You have salaried GPs paid for three days' work working five or six days a week. They are being given half a day a month to do paperwork. How is that encouraging retention?

James Morris: As a Government I think we are looking, as was discussed earlier, to reduce the bureaucratic burden on GPs, so that they do not have to do things like routine paperwork and so on that might not be an appropriate thing for them to be doing. There are lots of things that can be done to think about reshaping the way that the workflow happens for GPs. They are small changes, but I think they could have a big impact on the nature of what a GP does on a day-to-day basis. It is not a silver bullet. There isn't a silver bullet in this area, but there are lots of small things that can be done to relieve the bureaucratic burden on the primary care workforce more generally.

Dr Kanani: I am a salaried GP. I think our salaried GPs are phenomenal. As you say, they have done an incredible job, taking on a huge amount of work and working hand in hand with partners who hold the responsibility for the practice. It is a powerful combination.

We need to do a series of things, some of which are already in place, to make sure that our salaried GPs are supported. In the 2019 contract we described a series of retention schemes that would support salaried GPs and partners to work and to stay in general practice. That has to be coupled with the bureaucracy review that we have described, and with

growing the workforce. We can do that more quickly through the additional roles scheme, which brings people other than GPs into the team, but in the longer term it is through additional trainees.

You will know that we have seen more trainees than ever join general practice this year. There are 4,000 trainees. Once they come through their training, that will really grow the general practice workforce. I think that will have a very powerful effect on the amount of work that an individual salaried GP does.

The other side of it is our locum workforce; 70% of our locum workforce are female. They are mainly ethnically diverse and mainly working in carer-responsible roles. We need to bring them back into the workforce as well. We need a workforce model that works flexibly for people who cannot quite work in the way that traditional general practice describes. Part of what Claire described is how we support our workforce to work in a way that makes sense to them and the patients.

Q270 **Chair:** Could I follow that up with a very specific question? The previous Secretary of State talked about ending the partnership model by 2030, phasing it out and moving entirely to salaried GPs. That caused a lot of concern in the profession. People in the partnership model said that there is a lot of work they do for good will, which would not happen if you moved to salaried GPs. Can we clear this up? Is it Government policy to scrap the partnership model?

Matthew Style: If I may, Minister, as other witnesses before the Committee have said previously, to take an example, whether you are a salaried GP or a partner is not the decisive or determining factor in the ability to deliver, for example, continuity of care.

Q271 **Chair:** It is if you are a partner and you have been told that partners are going to be scrapped. The question is very straightforward. I am sure you know the answer, Matthew. The Minister has just arrived, so I will give him a little bit of leeway on this. Yes or no, is it Government policy to scrap the partnership model?

Matthew Style: It is not our policy to scrap the partnership model. Our policy is to work with the profession to develop the vision set out in Claire Fuller's stocktake. A range of different models will be—

Q272 **Chair:** That sounds to me like a no, because Claire Fuller's stocktake does not say that we are going to scrap the partnership model, so it is not the policy to scrap the partnership model. It is a very important thing for a lot of partners. Let me check with the NHS team and NHS England. Do you agree that it is not the policy to scrap the partnership model?

Dr Doyle: We have no policy to scrap the partnership model. It is really important, on the salaried doctor issue, that the things you are describing affect both partners and salaried doctors. We are actually seeing a relative increase in salaried doctors compared to partners at the moment. That is because less GPs want necessarily to take the risk and

responsibility of holding the contract and all the other responsibilities that brings with it. It is important that we retain all our GPs. We do not want to do anything that is going to cause a greater loss of GPs to the workforce.

Q273 **Mrs Hamilton:** Might it not be easier to move to a model which brings more equality? At the moment, permanent doctors, partner doctors, have their issues. Salaried doctors have their issues. Locum doctors are predominantly women and ethnic minorities. They have major issues. Is it not possible for the future, if this area is to grow and develop, that we look at perhaps another model? The problem is that 4,000 may start training, but how many of them will finish? How many of them will actually go into general practice, and how many will be there after a year? I think you will be down to 1,500, if not less.

Dr Doyle: What you are talking about is retention. We need to do everything we can to help GPs to do the job they trained to do, and to manage their patients in the way that they feel they need to manage their patients, so that we retain doctors. Our biggest single challenge at the moment is retention of GPs. Having two or three different options for being part of the GP workforce gives us the flexibility to keep more people, and we should keep more people.

Matthew Style: What we have already seen is that different models will be appropriate in different communities across the country. Again, it will be for integrated care boards to work with the GP profession locally to invest in and sustain the models that are most effective for delivering the vision set out in Claire's stocktake.

Q274 **Chair:** As long as they are all subject to all these targets, it does not really matter. That is the main point, isn't it?

Matthew Style: As long as they deliver what patients, taxpayers and their communities rightfully expect their local NHS to deliver.

Chair: A thousand flowers bloom under 1,000 targets seems to be the approach.

Q275 **Rachael Maskell:** The reality is that it is more than retention, isn't it? What we are looking at is a service of assessment and treatment. However, we all know that treatment moves into all sorts of different spheres. The nub of the challenge is the absence of a workforce plan for the future, of addressing population health, of addressing specific demand on people's health and of best utilising the multidisciplinary team, who triage the patient and then provide the wider services.

Minister, why are the Government so reluctant to embed the comprehensive future workforce plan to ensure that in primary care we have the right balances between GPs and other health professionals? Could you comment on whether or not the training model itself needs to come under review? We are stuck in a training model that goes back decades, yet healthcare and understanding have moved forward

considerably. Is it really in the right place today?

James Morris: You are right to identify that we have a significant workforce challenge in this area. We remain committed to growing the number of doctors in general practice, as I have already said. In 2021-22, we saw the highest ever number of doctors accepting a place on GP training, for example. There were a record 4,000 trainees, up from 2,671 in 2014, so there is progress being made. As we were just discussing, we are committed to growing and diversifying the workforce. We will do this through schemes to boost GP recruitment and retention, as we have already discussed.

We have also committed, as I was discussing earlier, to an additional 26,000 primary care staff, embedding the multidisciplinary teams that we have been describing. We have recruited since 2019 over 18,000 additional staff into general practice, covering a range of roles—for example, clinical pharmacists.

There is a lot of work going on to address the workforce issue. The issue about embedding the workforce plan, as you described it, was discussed exhaustively during the passage of the Health and Social Care Bill. We did not go down that route, but that does not mean that the Government are not committed to a serious workforce plan in the NHS.

On the training point, I might need to defer to my colleagues on the panel.

Matthew Style: Of course, the curricula for general practice training are set by the royal college in line with standards set by the GMC rather than by Government. On the issue of the workforce strategy, the Government have of course commissioned NHS England to develop a comprehensive long-term workforce strategy. It is important that that does not just look at the acute workforce, as it were, and that it takes in the primary care workforce as well as the broader health and care workforce in the community.

That exercise is not only looking at the workforce one would need to deliver the models of care of the past. It is also very importantly looking at the kind of changes in the needs of patients, and changes in medical practice and technology, to ensure that we are actually training, developing, recruiting and retaining the workforce that we need for the future. That work is ongoing. It has been commissioned jointly from NHS England and Health Education England.

Rosie Cooper: Why is it secret? The bottom line is that, yes, we are going to have a workforce plan. We are told we are going to have 4,000 new doctors. We are going to have this, and we are going to have that. As you have just said, Matthew, models of care change and all the rest of it. That is all being planned now, so you will know what numbers of NHS professionals you need for each speciality, however you describe it, but you will not tell us. We have had in front of us the people who were

producing the workforce strategy, and even the Secretary of State. Nobody will actually say, "We will publish it. This is roughly the modelling we have done and these are the people we need in each category."

I have been in the NHS for a long time. One year we have too many consultants; then we do not have enough nurses. We do this all the time, yet we cannot see it. If everyone is so confident, why is it a secret? Why can't you share it with us? We are paying for it.

Matthew Style: I do not think that the workforce strategy is secret. That work is ongoing by NHS England and Health Education England. It is right that that workforce strategy is developed alongside the work that is being done, for example—

Q276 **Rosie Cooper:** Will you publish what you have got now?

Matthew Style: —on the development of the—

Q277 **Rosie Cooper:** Can you tell me, if it is not a secret, that you will publish wherever you are up to, whatever it is, right now?

Matthew Style: It is very important that the work on that workforce strategy is done at the same time as the very important work on the development of the long-term plan.

Q278 **Chair:** The previous Secretary of State was very clear. We wanted to know whether the Government will publish the gaps that there are for different specialties, nursing, AHPs and so on. The previous Secretary of State said that he was in favour of doing this in the strategy published before the end of the year, but it would be subject to cross-government clearance. In other words, he could not guarantee it.

I think that is what concerns us as a Committee. The Government, when the Minister was a Whip, voted down three times publishing independent projections as to how many additional doctors, nurses, AHPs and so on we need. Three times they voted down the idea that there should be any independent projections. I think we were a bit surprised that the Secretary of State could not even commit that the Government would publish their own estimates. No to independence, and possibly burying their own estimates. I wonder whether you can give us any reassurance, because it feels like the Government are trying to cover up the problem.

Matthew Style: Chair, I am going to continue my previous answer, and this is relevant to your point about independence. It is absolutely critical that the work on that workforce strategy is done absolutely in tandem with the work that is also going on in NHS England about the future of the long-term plan, the clinical strategies and the models of care that will best allow the workforce to deliver the care that our patients need and deserve. I think those two things absolutely have to go hand in hand.

The Government's policy was very clear that offshoring the idea of a long-term workforce strategy into an independent body would not lead to the most robust strategy for future sustainability of our workforce and

our services. Those two things had to go together. I think the Secretary of State—

Q279 **Chair:** What you call offshoring was simply us wanting to know what numbers we were going to be told about, not the numbers the Treasury decides we can afford. They are the numbers we actually need. Unless you have some element of independence in it, that is our concern.

We have had this discussion many times.

Matthew Style: We have. If I may just finish, though, to say that the workforce strategy has been commissioned from, and will be completed by, NHS England at arm's length from Government and from the Department. I believe the former Secretary of State has also given a commitment both in this Committee and at the Dispatch Box that the conclusions of that work will be made available.

Q280 **Chair:** Yes, but he also promised us that it would be made available in the spring. Then we were told it was just going to be a framework, and that would be available in the summer. Then we were told that if there were any numbers, they would not come until the end of the year and that was not guaranteed until we got the so-called cross-government clearance.

Do my colleagues have any further questions, because I think we are coming to an end? I have a final question for all of the panel. I want to think about what Amanda told us about its being important to have evolution as well as revolution. Normally, the argument for revolution is that when there is a crisis or an emergency it has to be dealt with, and you have to do something very big and very decisive like getting rid of QOF, IIF and going back to what general practice is meant to be about, which is continuity of care. It is those kinds of things, which is why we have been exploring it. I wondered whether you think general practice is in crisis. Yes or no?

Dr Doyle: I think general practice is struggling to manage the demand that it is seeing at the moment. The things we need to do are things that help both manage the demand and increase the capacity. The trouble with revolution is that it paralyses activity while it is going on. That is why we need to do both. We have to keep general practice working and serving patients.

Q281 **Chair:** Would you use the word "crisis"?

Dr Doyle: It is very difficult. Language becomes very emotive. I accept that there is an absolute challenge and it is really difficult for both GPs trying to manage demand and people trying to access general practitioners in some parts of the country at the moment.

Q282 **Chair:** Minister, would you use the word "crisis"?

James Morris: No, I do not think I would, Chair. As we have discussed today, clearly it would not be correct to assert that we have anything

other than a major challenge in this area. The pandemic, rising demand and issues to do with the workforce are all big issues that need to be addressed over the long term. I think we have the tools and the means to be able to address those issues. There are no quick fixes, but, as we have discussed today, there are lots of elements in a changing landscape in primary care, and the approach the Government are taking is designed to address that. I would not use the word "crisis", but we have a serious challenge.

Q283 **Rosie Cooper:** Minister, all of that is really good but the word that is hanging in the air here is "trust". It is trust that you have the numbers right and trust that what you are thinking is right. Performance to this point does not make me feel that. You are hiding the figures, not telling us where the gap is and not being transparent. If you shared a bit more, people would be a lot more sympathetic and would try to help. The fact that it is kept quiet and has been voted down makes people feel that either the problem is too big and that you cannot get recruitment anywhere near, or that the reality is that it is going to cost too much and nobody wants to tell the truth. Minister, that is the bit that—

Chair: Rosie, we have a new Minister so this is a chance to rebuild that trust. He said an amazing thing, which we have not heard before, which is that he will look at all these targets, which are the lifeblood of the central bureaucracy of the NHS and which the system has been thriving on and loving for years and years. If you are actually going to look at them, I think GPs up and down the country will be cheering.

James Morris: Just to say—

Chair: Hold on, that was too far, wasn't it?

James Morris: No. As I think I said in my response, and as you will know as a former Secretary of State, performance management in the NHS is pretty critical. Targets have played a role over time, probably in the last 25 to 30 years, in improving performance in the NHS. I think that is a fundamental statement, but as we have been discussing on the panel today, as we look at the changing nature of primary care, we are focusing on a system that needs to be more focused on outcomes. It needs to be focused on more local autonomy and people making decisions about what communities need. The implications of that from a policy perspective are quite complicated. That is my response to that.

To the other point, in terms of the issue of trust, it is the case that we will share this workforce strategy. I cannot give a timescale for when it will be published, but we are committed to sharing it as it gets formulated. The point that was made about the need for the strategic alignment between what we are trying to achieve in primary care, because there are a lot of moving parts, with new institutional bodies being created, and the workforce implications of that is, I still think, from a policy perspective, having been a Minister for 48 hours, a moot point.

Rosie Cooper: I genuinely appreciate what you have just said. The

problem is that sentence about the moving parts, how difficult it is and, yes, you will share it. We have already waited a year-plus. I would not like to be the person who puts money on when we will actually see it.

Chair: Let's give the Minister a chance because he is new and thank our panel. We have had a very wide-ranging discussion and we are very grateful to all of you for your time. We wish the Minister good luck in his new brief. Thank you all very much for joining us today.