



Health Committee

Oral evidence: Primary care, HC 408

Tuesday 15 December 2015

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Written evidence from witnesses:

- [British Medical Association](#)
- [Care Quality Commission](#)
- [Royal College of General Practitioners](#)

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Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Dr James Davies; Andrea Jenkyns; Emma Reynolds; Helen Whately; Dr Philippa Whitford.

Questions 268-356

Witnesses: **Dr Maureen Baker CBE**, Chair of RCGP Council, Royal College of General Practitioners, **Professor Steve Field CBE**, Chief Inspector of General Practice, Care Quality Commission, and **Dr Chaand Nagpaul**, Chair of the BMA General Practitioner Committee, British Medical Association, gave evidence.

Q268 Chair: Good afternoon. Thank you for coming. As we get started, could I ask you to introduce yourselves to those who are following this debate from outside the room, perhaps starting with you, Professor Field?

Professor Field: I am Professor Steve Field. I am a GP and chief inspector of general practice at the Care Quality Commission. My responsibilities extend beyond general practice to dentistry, medicines optimisation, the new models of care integration and to remote doctors and 111, but this is focusing on general practice, I guess.

Dr Nagpaul: My name is Dr Chaand Nagpaul. I am a GP in London. I chair the British Medical Association's General Practitioners Committee. We represent over 40,000 GPs across the UK, of all denominations—GP trainees, partners, locums, salaried GPs and CCG board GPs. All GPs come under our umbrella whether or not they are BMA members. We are also supported, some of you will know, by local medical committees, which are bodies of statute that represent GPs in local areas often aligned to CCGs. We have a two-way relationship with local medical committees and are very well placed, therefore, to be a national body that has a very real connect with grass-roots GPs.

Dr Baker: Hello. *I am* Maureen Baker. I am a GP in Lincolnshire and chair of council at the Royal College of General Practitioners. We are the professional body for GPs in the UK and we have in excess of 51,000 members.

Chair: Thank you, and thank you all for your evidence and the supplementary evidence you have sent in. I am going to start with Ben Bradshaw.

Q269 Mr Bradshaw: Thank you, Chair. We are going to start with a few questions on quality. Professor Field, I came back to this policy area after a break and saw the table that the CQC published last summer on performance, which, on the face of, it looks pretty shocking. Compared with school performance, for example, it has far fewer GP practices as outstanding and, overall, paints a rather depressing picture. Why is it so bad?

Professor Field: I think it is a good picture that 85% of practices are good or outstanding. The vast bulk of practices are providing safe, effective care.

Q270 Mr Bradshaw: But only 4% are outstanding. That is very low.

Professor Field: Only 4% are outstanding—that is right—but, at the other end, 4% are inadequate. If you compare that with hospital and social care, it is a good news story for general practice, although the 4% that are inadequate are generally worse than I thought they would be before I started. Our estimates on the GP arena were that round about 5% would likely be inadequate, looking at what had happened in Tower Hamlets and other areas.

Q271 Mr Bradshaw: Are we measuring the health service providers more rigorously than we are schools then? Is that why the figures are more negative?

Professor Field: No. It is difficult to assess the comparability with Ofsted because the standards we are setting for clinical care are different from education. There are some similarities across all the sectors. The practices that are truly outstanding—and you have some in your constituency, as others down in the south-west—tend to be well led, have a vision for how they want to take the service forward, and, like the practices you have, they link in with the patients really well. They have active patient participation groups, are feeding back to the practice and are changing their services. Perhaps the best example is Cullompton, which I pronounced badly, on the way down to Exeter.

Mr Bradshaw: You pronounced it very well.

Professor Field: It is certainly one of the most innovative practices I have ever been to, with great leadership. They are really into prevention, trying to support the local population. The practices that are bad, which are the ones that I really worry about, have poor or absent leadership, no vision, poor systems, do not keep their medicines in date and the fridges do not work. It is very basic stuff. But, to be honest, Ben, I think the message is a good one—that the majority are good.

Q272 Mr Bradshaw: Are there any other common factors to poor performance to do with geography or practice size that you have found?

Professor Field: On performance, if you look at small practices, some are outstanding. Two that we visited in the last couple of months on Exmoor are tiny practices, but they work together and have set up charities to support the patients. Again, it is very focused on the patients. But we have a large number of smaller practices in inner cities that are failing and are inadequate. We think most of that is due to professional isolation—that they are not connecting with local practices. It is not really the size; it is the fact that they do not learn and share with others. Some of those are very poor. In a few of those, the single-handed doctors have already been suspended by the GMC, so that is a clue before we go in. I am not sure it is the size. Inevitably, practices are all working together now in large, loose groups and federations or are merging. In small practices, 10% of those in special measures do not have any nurses. There is a direct correlation between inadequate practices—on fewer nurses, fewer sessions—and outstanding practices, which have really good multiprofessional care, using nurses and therapists, and a few now are using physician associates and pharmacists. The bigger the practice, the more multiprofessional they are.

The next clue, which, again, is about professional isolation, would be that the better practices link in with other practices, share their data, their performance improvement and services, but also link into community services very well. If you look at some of the outstanding practices in Salford, they are linked integrally but not part of Salford—one of our two outstanding hospitals. It is about the networking versus the professional isolation.

Q273 Mr Bradshaw: You mentioned data. The King's Fund has raised question marks as to whether you have adequate data to do this job properly. What is your view on that and what more data would be helpful for you to do a more effective job?

Professor Field: If you look at the sectors we regulate in the Care Quality Commission, general practice sits in the middle of social care, where it is pretty data-free, and hospitals where we are very data-rich. There is a little usable data on the areas of safety and a little bit out of effectiveness, using QOF data, but we are very good on the patient survey, which is a particularly good thing for us. The area we are missing in general practice compared with hospitals is a staff survey. Mike Richards, my colleague, the chief inspector of hospitals, believes that is the best indicator of performance in a hospital setting and we are starting to do some piloting looking at what makes a learning culture in primary care, because the numbers in a small practice are too small to be valid and reliable. We could do with more data looking at safety effectiveness, and the well-led domain work we are leading off with Michael West from Lancaster University might give us some of those answers.

There is a supplementary answer to that, if I may. It is about how we use that data constructively with NHS England and the GMC, and we are starting to do some work with them to try and reduce the data load, the workload, for general practice so that we collect data once and it is used for many different reasons. There is some work starting on that now.

Q274 Mr Bradshaw: You also suggest in your evidence that, where there have been problems, these have largely been known about for quite a long time but nothing has been

done about them. That indicates a complete failure of performance management, does it not, by the former PCTs and now NHS England?

Professor Field: Yes, it does. It is much better now than it was before. If you talk to colleagues in NHS England, they will say—and we had a quote yesterday—that more work had been done in London on poor performance since we had been there, particularly over the last six months or so, than in the three years before.

Q275 Mr Bradshaw: Since you had been there or since—

Professor Field: Since the CQC had been there. In a way, you could say that we are putting some backbone into the system. We are an independent assessor of the quality. Many of these practices, as you say, have been known about for years. There is a failure of my colleagues and the systems that have been in place to identify and do things about it, unless you live in places like Tower Hamlets, where they have an inspirational chief executive and groups of doctors, who did not just sort out the bottom 5% of the practices but, what is equally important, they federated the GPs to work together and put money in to improve the system as a whole. I do not think we should be talking only about us being punitive. We are there to encourage improvement. Unless you invest in general practice and put money in to improve it, it is very difficult. You want to shift the whole curve to the right and you also want to make sure that poor practice is not tolerated. I do think we have failed over the years.

Q276 Mr Bradshaw: Do you think you should be given more power to deliver improvement in quality?

Professor Field: No. I have been asked that and offered the idea of whether we should be given the resource; £10 million has gone to NHS England, which is a start, to give out to practices that are struggling. There was a suggestion at one point that we should have that money and use it ourselves. I thought, personally, that our role is to encourage improvement and work with NHS England, but also the practices are contracted to the NHS and have a responsibility themselves.

Q277 Mr Bradshaw: Do you think NHS England is doing an effective performance management job as things stand?

Professor Field: That is different from the money to improve. The money on improvement has only just been announced and I am satisfied that the criteria they are using is right, but I believe that right at the top of the CCGs' agenda, now that they have more co-commissioning responsibility, must be supporting practices to improve. If you can improve the quality across the board, you can prevent people having to go to A&E, you can reduce the load on the acute hospitals and work with social care to keep people out of hospital, which is very important.

Q278 Mr Bradshaw: You do not think there is a danger with co-commissioning that that performance-management regime will be diluted because of local conflicts of interest.

Professor Field: The evidence so far, from working with the CCGs, is that those who have taken on the co-commissioning responsibility work much more effectively with us now on informing us where they need help. Ideally, through the contracting system, you would not

have had failing practices. The good thing about where we are at the moment is that it is the first time in England that general practice has been regulated; so I can understand the push back from the profession because they are not used to it. But by the time we have finished—this time next year—there will be a baseline and, hopefully, that 4% to 5% will have improved. The evidence is that they are improving; 93% of the 100-plus practices we have re-inspected have improved. So they are improving. If we can sort out the very poor practices, that means we can all focus on how we improve care and move to a much more efficient integrated health and social care system.

Q279 Mr Bradshaw: Does appointment length make any difference to the quality of service, and, if so, what can be done to extend it?

Professor Field: Maureen might be able to give you more of the academic evidence on that.

Dr Baker: Yes. At the moment most practices still operate a 10-minute consultation, which most colleagues think is insufficient—certainly, insufficient in many cases—to deliver the aims of the consultation from the point of view of the patient. However, with the current set-up, with the number of GPs we have, the demand for appointments and the lack of resources coming into general practice, it is very difficult to do anything about that. Increasingly, though, we are seeing practices look at different ways of operating with a view to trying to give people with multiple, complex or difficult or dangerous conditions longer periods of time. The difficulty with this, as in so much else at the moment, is all this planning, thinking, testing and making sure it is safe takes time and headspace, and most colleagues at the moment struggle to get through the day, never mind trying to plan to make things better.

Q280 Helen Whately: I have one follow-up question on the quality area. We know patients, when asked about how good their GP is, often talk about access—how easy it is for them to get appointments—and their experience of the care, but not so much about the clinical quality of the care. Do you think patients should be made more aware of the clinical quality of care that they are getting, and, if so, how might that be done?

Professor Field: I do. Part of the transparency agenda is about that. I know Anna Bradley gave evidence here last week talking about the satisfaction of patients and that, when you scratch the surface and have a deeper conversation, many patients are very grateful for having a service in areas but do not question that quality. Publishing data for those who are interested in outcomes, and particularly patient-reported outcomes, is important. The biggest step is having access to their own medical record as well so that they can get a better understanding and use it proactively going forward. It is a mixture of data and information for them in a usable form, access to patient records and, when we are looking at more joined-up systems, it is the access to the record and data that is key.

Dr Nagpaul: Can I come in and say I am not sure that the current CQC inspection process is measuring quality in the way that we are discussing it? Let us remember that it is a moment-in-time assessment, and many practices can change rapidly from the day of the inspection to a month later if a partner retires, a person goes off sick and they cannot recruit. Let us recognise that general practice as a whole, including all those good practices, are struggling; they are under immense pressure. I find it extraordinary how well

GPs are managing to continue to provide services in the face of what seems to be an impossible task, where we have seen the biggest resource reduction compared with any other sector in the NHS and the greatest expansion of volumes of care. We need to put that into perspective.

Secondly, the CQC process is not measuring like for like. Practices vary at the moment in funding per head by twofold. You cannot compare two and say one is great and one is not without understanding that. Practices that are being inspected may have, as I said earlier, recruitment problems; they may be trying to run a practice three partners down and no one is there to fill those spaces. Ranking them without understanding the context does not help.

As to some of the aggregate ratings, you mentioned the King's Fund, but it is not just them. The King's Fund and the Health Foundation were both very critical of the aggregate way in which these ratings occur. To say that a practice is outstanding or good masks poor performance within that organisation but also conceals good performance. Any patient will know that, where there is a group practice, they may like a particular doctor who they think is caring, who gives them all the time that they need, but that is not measured in these inspections for that particular doctor. The inspection process is measuring processes; it uses language like "safety", which is relating to recruitment processes, et cetera, and a patient sitting in the waiting room may think, "My care is unsafe." It is not quite like that.

If you look at care for older people, the parameters used are things like the number of dementia checks you do. That does not tell you whether the GP is spending time with an older person, whether they visit a patient or have a good bedside manner. There is a real vacuum of proper data, proper information, information that should not be just aggregated and lumped together in simplistic terms, which is what the Health Foundation has said. It needs to be real time. There is no point saying a practice is outstanding, three years on it is great and another one is not. This is a dynamic process, and quality needs to be something that is in real time but, crucially, should be something around supporting improvement. The system at the moment feels threatening to GPs. It feels like a judgment. We need practices that are going through difficult moments to be able to put their hands up and say, "I need some help. I want to improve."

When you look at some of the other parameters around measuring quality, many of the single-handed GPs in London, let us say, are working in premises not out of their own choosing; they would love to move to premises where they have adequate consulting rooms and they have the space to employ a nurse. They would like to employ more nurses but they are locked into a fossilised, historic funding system. We need, collectively, to be resourcing the system in the right way, improving and giving an opportunity to all GPs to do their best. That is not happening at the moment.

Dr Baker: I would agree with my colleague Chaand. In particular, the parameters that the CQC use in their inspection are challenged by many of my colleagues. For instance, in the safety domain, there is, "Have you attended a course and have you recorded that attendance of the course?" If you take something like regular attendance at CPR courses, okay, that sounds reasonable; on the other hand, if I have not been, does it mean my patients are any less safe? The last time I attended a cardiac arrest was in 1985. I may or may not be at a cardiac arrest in the next 10 years, and if I do attend one I can probably—almost certainly—perform effectively there. However, if you really look at the safety of

patients and what is important in practices, almost certainly the biggest factor in patient safety in general practice at the moment is doctor fatigue. Doctors who are stressed, overworked, exhausted or worried are much more liable to be doctors who make mistakes. It is a huge factor in safety in any domain we look at; in engineering, transport and construction you look at fatigue. The CQC does not look at fatigue. It is not a part of that domain and yet, when things go wrong in general practice, that can be a very important underlying cause.

We are saying that the CQC processes as they currently stand can contribute to fatigue and stress. I have been contacted by a colleague this morning to say that they have been told in the last two days that they are having a CQC inspection on 5 January, the first day back after the holiday season. I do not think that over Christmas and new year colleagues in that practice will rest, have time with their families and recharge their batteries. They will be stressed out of their minds trying to see how they can get everything put together for the 5th. I want to place on record that the issue of doctor fatigue and overwork is much more fundamental in terms of patient safety than whether you have attended a course or recorded that.

Q281 Chair: So, presumably—

Mr Bradshaw: Chair, I think Professor Field should be given an opportunity to defend the rigour and methodology of his inspection regime from those assaults.

Chair: Indeed; I would like to do that. The other thing I would like to reflect is that I think everyone recognises that the CQC has said that the poor practices are very poor indeed. Would you accept, though, Dr Baker, that this has been a mechanism to identify the very worst practices that are a risk to patients? If you look at some of the reports from the practices that are rated inadequate, some are quite disturbing.

Dr Baker: My members do not oppose regulation: they support regulation. They are not fighting back against regulation. Where there are poor practices, where there are disturbing tales, it is entirely right that those practices are identified and addressed.

Q282 Chair: But we were hearing that they had not been addressed.

Dr Baker: That should not mean that the bulk of the profession is burdened with a very heavy bureaucratic, onerous process with many areas that people do not feel are valid in terms of quality and safety. There should be a way to identify unacceptable poor practice that is much more focused and proportionate and does not produce a burden on the vast majority of practices that are good and outstanding. Mr Bradshaw made an unfavourable comparison with Ofsted. I have recently seen a press release from Ofsted saying how pleased they were that 82% of schools, after an inspection regime of many years, are now good or outstanding. General practice, despite 10 years of under-investment, despite huge recruitment pressures, is already at 86%. Most of my colleagues are doing a really good job. It is entirely right to focus on those who are doing a bad job but not at the expense of everyone else.

Q283 Chair: Your point would be that the CQC should only inspect practices that people have concerns about.

Dr Baker: My point is that the CQC should focus on minimum standards and have effective mechanisms to identify and deal with those practices without imposing a huge bureaucratic burden on the rest of the profession.

Q284 Chair: Thank you. I am going to give Steve an opportunity to respond to the points that were made about the methodology.

Professor Field: There is the methodology and also feedback from the practices. The problem we have, as Ben said earlier on, is that many of the practices we have known about for years and in fact with some of the practices we are going to inspect now we are not told there are problems, either by the CCG or NHS England, before we go in the following week. This is the first baseline that has happened of practices independently across the country. If you were lucky to live in Tower Hamlets, you had a PCT that cared so much that they invested in general practice; they ensured that the poorest GPs were referred to the GMC and their contracts were removed. In most of the country that did not happen. You have only to read our reports to realise what is happening. We thought that we would find, initially, the poor practice and that would taper off as we got through thousands of practices, but each week we find the same sort of numbers.

The idea of the inspection is that it is part of a broader system. We have registration of the provider and we then monitor. That is a good question about the data, on which we have been working with Chaand, Maureen and colleagues. I agree with Chaand that we need more real-time data, because the monitoring aspect is probably more important than the inspection. If you are monitoring well with data, you would not have to go back as frequently to inspect. The idea is that you look at the data—patient survey and QOF data. We have an increasing number of whistleblowing complaints, like in hospital, particularly from nurses from small practices, many of whom are working outside their scope of practice and under pressure. We have complaints and suggestions from the public. That is the monitoring.

We then inspect. At the moment, we are trying to get through the inspection process by next autumn, so we will know what the baseline is. We are already going back and inspecting on the inadequate practices. As I said before, of the “inadequate” and “requires improvement” practices, 93% have improved. The good news on the special measures practices is that nine have left special measures and improved dramatically over six months, about a third of those with the support of the Royal College of GPs, who are being paid to go in by NHS England and help them. Of the other nine, two have voluntarily cancelled their registration, four have closed, we have been to court and closed one practice down, and two have been taken over by hospitals and other providers.

We can get into the academic detail of the process, but if you want to look at safety, I agree with Helen that we are short on data on safety. So we look to see whether the practice is improving by looking at its significant events and learning from them. The poor practices do not. When we go in and ask them, the evidence is that most practices are starting to do this more now because we are there. If there is not a process to continually improve, you haven't got a hope, whatever the size of practice. We go and check the fridge. You would have thought, after having a pilot where I was in the national press saying that fridges are not being monitored for temperature, that people would have got new fridges and thermometers. We have been going into practices even in the last few

weeks where vaccines are not being stored in the fridge at the temperatures at which they are meant to be stored. If you do not store a vaccine at the right temperature, the children who have the vaccine are possibly—if the vaccine does not work—prone to getting infected with meningitis when the parents think that they are immune. What is worse is that, if you vaccinate your child for rubella, they later on get pregnant thinking they are immune from rubella and they have a baby who is a rubella baby, that baby is deaf and blind. In my first week at medical school, I was in tears because we were taken to a centre outside Birmingham that was full of babies who were deaf, blind and sensory-impaired, being cared for in what was a sort of community hospital. Frankly, that has had an impact on my emotions ever since. You go into a fridge and you see that the vaccine is not being stored properly.

I was at a surgery near Marble Arch one afternoon when there was a locum nurse in the practice giving immunisations. On the wall was a box with the emergency drugs. That is great; it had adrenalin in. If you collapsed and needed adrenalin there was adrenalin, but it was out of date. The nurse said, “Don’t worry—we have in-date adrenalin in the fridge.” I opened the fridge, and in red on the box it said, “Do not store in a refrigerator.”

Whatever the academic evidence is on how you are looking at safety, this is basic stuff and I am doing this job on behalf of patients and the public. I used to have Maureen’s job as chair of the Royal College of GPs and, frankly, I am ashamed that some of my colleagues are still providing inadequate care for the citizens of this country. We are going to sort it out.

Chair: Thank you. I know Emma has caught my eye and also Andrea, or has your point been answered, Emma?

Q285 Emma Reynolds: There seems to be criticism of the inspection regime. If that is the case, what is the alternative? Are Dr Nagpaul and Dr Baker saying there should not be an inspection regime or that it should be significantly different?

Mr Bradshaw: They want to suspend it.

Dr Nagpaul: Can I say this? There is so much false assurance on the idea that we have a system designed to assure safety based on an inspection that might occur every few years. That is not assuring safety. You can visit a practice that may be perfect today. The same nurse that Professor Field has mentioned may work in a different practice and do the same thing. That is not actually a system of assurance. It is a system where many practices will prepare on the day to perform well, and, once the visit has finished, life resumes as normal. We need to build in quality assurance on an ongoing basis. It is not difficult at a local level to have, for instance, through a co-commissioning arrangement, practices assuring themselves and the local community of practices that they do once-a-month checks on X, Y and Z or whatever, so it is much more professionally owned. It will give you much more real-time assurance. Also, unlike the PCT days, CCGs and NHS England have far more data about practices, and, if they are not doing what they should do, you do not then just introduce a completely different regime. Remember that Wales, Scotland and Northern Ireland do not have the CQC, and it is not as if the patients in those nations are living in hugely unsafe environments.

I come back to the point that there are simpler ways of dealing with this. It needs to be targeted. We need to have an ongoing ability to assess quality. It needs to be much more locally owned and, where there is concern, there should be a targeted inspection. The idea that an inspection process every few years tells you that everything is fine is, by its very nature, not going to be accurate. Of course there are these examples that Professor Field has mentioned. They are not justifiable and not defensible, and they need to be tackled, but I do not believe you need this current inspection system that is disproportionate in its nature. It is a system that is interested, to a large degree, in monitoring the minutes of meetings, certificates and policies on recruitment, right down to the detail of the dates on which people attended various courses. That is not about fridge temperatures, and yet you can speak to any practice and find that 80% to 90% of an inspection process is around that preparation of bureaucracy. We need to have a sensible approach that is much more locally focused and real time.

Professor Field: I would agree with Chaand wholeheartedly that the monitoring is important. Once we have been through the baseline in practices, if we can improve on the data and if local CCGs co-commissioning, which is where I agree with Chaand, would bring in better monitoring of their practices—for example, in Corby, Lakeside vanguard, which is a large group of GP surgeries, or Modality in Birmingham, where they monitor the quality of the practices—the CQC could work with the bigger, new organisations, the monitoring function becomes more important and the inspection can be done less frequently.

People complain about the fact we ask for DBS checks or certificates to ensure that people are doctors. We found a practice in Brighton where the patients thought that an osteopath working in the practice was a GP. The local CCG did not know anything about that and we found it on an inspection. As we build up the confidence and—you are right, Chaand—as we build up with the local NHS, we are committed to looking at how the model develops in future, which will include assessing and monitoring not just the quality of provision in a practice but the quality of care, cancer care or mental healthcare across a geographical area. In your constituency, Emma, you have had a surgery with a very prominent GP from the LMC who was inadequate, which we have just inspected. We have not published a report yet, but they are now out of special measures as soon as the report gets published. We can demonstrate improvement in the worst, but we know that practices now take seriously what might seem trivial, such as recruiting real doctors to surgeries or ensuring they have DBS checks for nurses. It has been painful for some practices, but in our recent survey three fifths of practices and out-of-hours services said the inspection report had assisted in their improvement. The evidence seems to be that we are having a positive effect.

Q286 Andrea Jenkyns: I chair an all-party parliamentary group on patient safety. I also lost my own father through patient safety issues. I would like to come back to Dr Baker's comments talking about a bureaucratic system, a burden on GPs and comparing your inspection with Ofsted. I am quite shocked by the comments, in all honesty. How can you compare yourself, as GP surgeries, with schools? Yours is literally a life-and-death situation. Let me finish, please. I also have recent issues in my own constituency with a particular GP surgery where three people have died, where these three people have been misdiagnosed. Do

you not think that GP surgeries should get more rigorous inspections than educational institutions? I certainly do.

Dr Baker: First, the comparison with Ofsted was made by Mr Bradshaw and I was responding to that comparison. Secondly, as to patient safety—and I have worked professionally in patient safety now for 13 or 14 years, so I have a good solid background in patient safety—effective safety in any domain, in any industry, relies on safety culture, safety awareness, constant thinking ahead and risk management.

Q287 Andrea Jenkyns: Do you not think it also relies on a place of consequence when things go wrong? I certainly do.

Dr Baker: If I may. In most, if not all, industries that have effective safety cultures, they do not rely on inspections and regulations. That is defined in safety terms as a bureaucratic culture that does not protect the public as effectively as a properly functioning safety culture does. The point I am making about the inspections and the areas that they look at is that that does not really relate to safety; because someone has not recorded they have been on a course, it does not mean that a practice is unsafe. Safety issues in practices arise—as safety incidents in any industries do—from a collection or sequence of events. It is a sequence of events that leads to an adverse incident occurring. When you look back at the sequence of events, they tend to be things like organisational factors, human factors, support and whether it is an open culture. Relying on tick boxes and inspections will not give you safety and it is a false assurance to the public. At the moment, our service is so stressed, demoralised and overworked that that is the threat to patient safety—not whether you have minutes of meetings. It is these things that need to be addressed. There must be better ways of helping practices to be safe, learning and effective organisations for patients. Whether you have checked the temperature of water in the taps does not mean a practice is safe or not.

Dr Nagpaul: Can I come in on safety?

Chair: Very briefly.

Dr Nagpaul: We surveyed the profession. We had a response of over 15,000 GPs earlier this year. Nine out of 10 GPs themselves say that the system they work in does not allow them to offer quality care, or the system is damaging their ability to provide quality. We need to look at the real issue here. The real issue is: how can you provide safe, quality care at 10-minute intervals, 22 times over in the morning; have a volume of test results to read, probably a bigger volume of hospital letters to go through, each of which will give you instructions that could affect the care of a patient; then do home visits; come back without lunch—the norm for most GPs—and do the same thing in the evening? I do not think that is possible.

Q288 Chair: Can I make a point? You have made the point very powerfully that being under pressure and stress is a quality issue, but the other thing I would reflect is that we have known for years that there is a tail of very poor practices that have not been picked up by the kind of quality and assurance processes that you have talked about, Dr Baker. Do you accept that bringing in the CQC has at least provided a mechanism to pick up those severely failing practices?

Dr Baker: These quality assurance processes that I have been talking about have not been in place. The comment has been made several times—and certainly by Professor Field—that people have known which those practices are. If that has been known by the PCT, NHS England or whoever the responsible body was, the failure to deal with that lies with those organisations that apparently had that information or knew about it and did not act. I am talking now about how we provide a safe, learning environment in general practice where practitioners feel that they are practising safely, are supported, that they are able to do the thinking, the planning and the risk assessment and to provide a safe culture to work in for patients. It is these things that make a difference to safety and outcomes.

Chair: I am going to bring Andrea in briefly.

Q289 Andrea Jenkyns: Thank you very much. Dr Baker, you say you cannot see the relevance of the so-called tick boxes, of whether someone has been on a course and yet you then talk about a learning environment. Surely, in any organisation, the personal development of any team member is important and making sure that there is a place of consequence when things go wrong. To me, with an organisational head on, it is right that you have to find out whether someone has been on a particular course, especially if it relates to patient safety. I cannot see how you cannot understand the relevance of this.

Dr Baker: Which course—all courses? You know, is it—

Q290 Andrea Jenkyns: You said it was all about a learning environment.

Dr Baker: Yes, and—

Q291 Andrea Jenkyns: Is that not about learning and development?

Dr Baker: I am sorry, but you are not letting me respond. We are generalists and there is whole range of important areas that we work in. There are courses and educational tools that people will select at the moment, through a process of appraisal and revalidation for GPs, as to where they are going to put that learning effort over the next year. Professionally, we also have a system of significant event audit where we discuss where things have gone wrong, learn from that and we might put that into our personal development plan. Having to go on a specific course and record that does not make patients in that practice any safer, because there are hundreds of courses that you could go on. I am not saying don't go on courses—of course not. We need to be learning continually, all the time, but the fact that you have been on—I do not know—a CPR course is definitely less germane to the safety of patients in that practice than whether the doctors have breaks for drinks and lunch and do not work excessive hours. That is what keeps patients safe.

Andrea Jenkyns: Thank you.

Q292 Dr Whitford: My question is on the same theme. My impression is that you feel the challenge is the burdensome nature and how GPs are feeling when they are close to the edge. Starting with Professor Field, is the CQC, having done this first inspection, looking at streamlining some of the processes and therefore limiting some of the demands? When we got the chance to visit some vanguards, you had people who were trainers—who were

obviously the GMC, the CQC—being asked for similar information but with a slightly different denominator and having to do three or four huge visit processes.

Professor Field: Thank you for the question. That is very helpful. It is exactly where we are moving. The direction is to work with other organisations. We have started a piece of work already with the General Medical Council. Some of the information that Maureen was describing about courses and CPD is collected for revalidation purposes through the appraisal system. We think that that should be collected, but only once. We have started to look at how we can collect information with the GMC and with NHS England so that each year the practice provides a return on that. We just have to add the Nursing and Midwifery Council in to cover the nursing.

Q293 Dr Whitford: Are you going to include deaneries, because training practices felt that they then had another whole hoop to jump through?

Professor Field: Yes, you are right. In a former life I was the postgraduate dean for the West Midlands. Our methodology is based on the training practice inspection methodology, where you have a trained inspector with a GP so the GP can use their professional experience more. As to Health Education England, which is the English deanery system now, the way they assess training practices varies in each of the geographical areas in the country: some inspect; some do not. Our plan would be to work with all the other organisations and the medical students through the Medical Schools Council, so that we collect data once. The hub inspection would be ours for clinical, which would mean that the medical schools and the deaneries would look at the educational expertise and would not have the burdensome nature that people accuse us and them of—and, as you quite rightly said, duplication. We are quite a long way towards that.

The other part of my professional job is looking after 11,500 dentists. General practice, numerically, is smaller than that. We set up last week a regulatory board with the General Dental Council and NHS England so that we can do a similar thing in dentistry and reduce the duplication. There is a necessary administrative load, but if we could do that on a return every year and use the data, as Chaand quite rightly says, inspecting is only just one part of it; it is monitoring that is important. You are absolutely right.

Q294 Dr Whitford: I was chair of setting up the breast cancer standards in Scotland, which are very much clinical standards. Is there work going ahead to define clinical standards that would cover items such as safety and interactions with multimorbid patients that the profession and the regulator would respect? The ideal is if people all see we need to achieve really highly against this. Then, if people do not, you do not need a stick; you automatically have a driver. It is very difficult in general practice, but is that work going ahead?

Dr Nagpaul: I speak to many audiences of GPs and every time I speak I ask for a show of hands of GPs who believe that they are practising safe medicine. I have yet to see a hand go up. I come back to the elephant in the room: you can have all the systems you like, but you simply cannot see a patient with multiple morbidity, who is 80 years old, may have memory impairment, diabetes, heart disease, be arthritic and on 10 different drugs, and do it in 10 minutes. It just cannot be done safely, it is not being done humanely, and it is not being done with quality. If every GP was to practise safe quality medicine, they should be giving such patients, and out of pure decency giving people the time they need, 20 to 30

minutes. Would the public, would the Government, accept a four to six-week wait to see a GP if we did that? These are trade-offs.

Q295 Dr Whitford: Is that being done in a targeted area? In Glasgow, they have identified that 40% of hospital admissions come from 5% of patients, exactly the multimorbid patients you mention, and they are now automatically earmarked for a double appointment of 20 minutes.

Dr Nagpaul: We have looked at that, and I think many practices have looked at that, and that would simply result. The largest numbers of patients we now see, which is one of the good things, are those with very serious ill health and multiple morbidity. If we give them the time they need, the stats will show you that it will take probably twice as long to see your GP. It may be a decision we need to make. Again, when we surveyed the profession—the GPs—most said they would rather patients wait longer so that they could provide quality safe care, albeit you would still see emergency patients on a same-day basis. We are currently colluding with a system where, as I said earlier, nine out of 10 GPs themselves say that the system they are working in is damaging quality. We need to come back to the fact that the interaction between the patient and GP cannot be done in the way we currently provide general practice. You cannot provide quality care.

Q296 Dr Whitford: Is it not the case that, if the support was there to initiate that, time would eventually be recouped because the patient would not bounce back so often and you would have the time to solve their problem?

Dr Baker: We need to work differently in general practice and across the NHS. As to the Five Year Forward View and new models of care, it is very much the intention that we will work differently. Certainly in general practice we need to be working with a wider team with different skills so that we can identify those patients who really will benefit from the skills of the expert medical generalist—the GP—and that appropriate time can be dedicated there. The frustration that we all feel at the moment is that people are on this hamster wheel of trying to get through the work, get through the day, the sort of day that Chaand described. We know we need to work differently and that there are different ways of doing it, but it is about getting the headspace, the support and the opportunity to meet with colleagues, to work with them and to come up with different mechanisms. That is a huge frustration for colleagues at the moment.

Q297 Dr Whitford: I totally understand that. Different aspects of that will be explored as we go on this afternoon. This bit is particularly around the bureaucracy because that is what came out of what you were talking about and how to tackle bureaucracy.

Dr Baker: Indeed, and, if I may come back on that, the frustration of feeling that you are spending a lot of time on bureaucracy that does not lead to patient benefit and does not support patient safety is one of the things that colleagues are so demoralised about.

Q298 Dr Whitford: Has there been any evidence of how many sessions GPs identify where they are no longer doing clinical work—in total—so their appraisal, paperwork, things like the CQC, the GMC, et cetera? Has there been any survey of that?

Dr Nagpaul: The GPs do all that on top of their clinical work, and that is the problem. They are overworked: they do it on weekends and at night. The BMA does a tracker survey of all the denominations of doctors—hospital doctors, juniors, et cetera. This is an impartial survey from the BMA, and GPs fare the worst in terms of poor work-life balance and record levels of stress. It is interesting because we are often portrayed as having a limited workload, but it is unlimited and that is the problem: they will do it at night and on weekends.

Q299 Dr Whitford: The Government said they were going to reduce the quality and outcomes framework by a third to reduce the bureaucracy. Has that gone ahead and has it had an effect?

Dr Nagpaul: The BMA negotiates the contract with the Government. There were some changes made two years ago. We would very much want the bureaucracy of QOF to be removed and for that resource to pay the GPs to be able to run the service, looking after patients. I come back to the issue that QOF is, to a large degree, about ticking boxes. That has been my issue around the CQC: you are ticking boxes to demonstrate what you do rather than just doing it, with an element of recognition that you are providing the service. That will make a difference. Having said that, the collection of data around what we do will continue, so I would not say that would be the biggest change.

Ultimately, it is a simple mathematical issue: we have too few GPs for the volume of care we are trying to provide. That is because of the large movement of care out of hospitals and into the community. Any patient will tell you that 10 years ago they used to go to the hospital for follow-up appointments and they now see their GP; they were in hospital for a week and now they are out within one or two days and told, “Go to see your GP.” The other issue is the demographic change. Patients are living longer, they have four or more multiple problems, and those problems do need the attention of the GP much more often but for much more time. It is much more complex. The imbalance of not having enough GPs compared with that demand is a result of very poor planning from successive Governments. We have fewer GPs per head today than in 2009. We have seen that the proportion of GPs as a total of NHS doctors shrink while we have seen an expansion of doctors in other sectors. That is completely the wrong way to plan the health service. We are suffering the consequence of this disinvestment or lack of resource in general practice. We cannot magic up GPs tomorrow, but we need more GPs, so we need to find ways to ensure that we remove excessive burdens on GPs—the bureaucracy—but there is a lot of care that could be done by other professionals too.

Chair: We are going to come on to that later.

Q300 Dr Whitford: The quality and outcomes framework moved from the per capita, “How many bottoms on seats?”, to what service you provided. The Scottish Government had reduced the one in Scotland and in actual fact are announcing today that they are getting rid of it altogether. Do you think it has had its day?

Dr Nagpaul: The quality and outcomes framework, which was negotiated with the Government back in 2003-04, had a very useful purpose at a time when data around the measurement of quality was not commonplace in general practice. It has achieved its purpose. In my view, now is the time, when we have computer systems that provide such

data, to allow that resource to be used for patient care rather than ticking boxes. I commend the Scottish Government in making that decision and very much hope that the Secretary of State in England will do similarly.

Q301 Mr Bradshaw: I am sorry, Chair, but can I pick up on a fact that Dr Nagpaul used about successive Governments not increasing GP numbers? Did the Labour Government between 1997 and 2010 increase GP numbers by 8,106 from 27,000 to 35,000 or not?

Dr Nagpaul: I will be honest. I do not have the stats in front of me.

Q302 Mr Ben Bradshaw: Please get your facts right when you throw around such wild accusations before a Commons Select Committee.

Dr Nagpaul: I said that there are fewer GPs per head today compared with 2009, and I also did say that—

Q303 Mr Ben Bradshaw: You did not just say that.

Dr Nagpaul: I also said that the number of GPs as a proportion of NHS doctors has shrunk. That is a fact: over 20 years, it has gone down from 35% to—

Q304 Mr Bradshaw: The fact is there was a massive increase in the number of GPs between 1997 and 2010. Please concentrate on the facts when you are giving evidence to a Commons Select Committee.

Dr Nagpaul: I will check this, but maybe Maureen can help as well.

Dr Baker: I can certainly say that the number of GPs per head between 2009 and 2014, according to HSCIC, has fallen in terms of full-time equivalents. That information from Dr Nagpaul is correct. In terms of numbers between 1999 and 2007, again, I do not have those numbers with me, but it is important to talk about full-time equivalents, because general practice, more than any other branch of medicine, has part-time doctors. We have far more female doctors as a proportion in general practice, some of whom do work in different ways. They are not all full time. The full-time equivalent number is very important.

Q305 Chair: Dr Nagpaul, perhaps it would assist the Committee if over the next couple of weeks you would be able to provide us with the data on full-time equivalents as held by both the BMA and the RCGP.

Dr Nagpaul: I am happy to do that.

Chair: We can compare that with the data and we can have that data here. That would be helpful. We have a lot of questions to get through, so can we have really quick questions and answers?

Q306 Andrea Jenkyns: Regarding the BMA, you say there is a shortage of doctors and GPs, which I think we will all agree on, especially with an expanding and ageing population. Looking at the BMA website, you talk about leadership. You talk about what

successive Governments have done, but what are you doing as a powerful organisation to help rectify the situation?

Dr Nagpaul: First of all, it is important, as I said earlier, to identify what the problem is. I started by saying that the way in which GPs are currently trying to provide care is not allowing them to do their best for patients. That, at the heart of it, is the problem.

Q307 Andrea Jenkyns: What about the recruitment? That is what I am getting at.

Dr Nagpaul: We know we need more GPs, but we know that we are not recruiting more GPs, largely because it is a negative spiral whereby those who are in the job want to retire early and those who are looking at the job feel it is too pressured so they do not want to become GPs. Our approach needs to be, first, that we make sure we have a manageable workload, which allows GPs to do their jobs properly. There are a variety of ways that can be achieved in the short term. One is that you can certainly reduce the bureaucracy we mentioned. There are multiple factors and that is one, and I can give you plenty of examples later if you want to hear our ideas on how that can be achieved.

Chair: We are going to come on to that.

Q308 Andrea Jenkyns: Do you think it is important to change your rhetoric to something more positive on why it is a good profession to get into? All I have been hearing for a long time from the BMA is lots of negativity. It is a great job that you do as GPs and surely you should be selling the benefits as an organisation.

Dr Nagpaul: I find the website somewhat impenetrable myself, but, if you go beneath the website into the pages that we have, you will find a wealth of positive ideas of how we would like general practice to operate in such a way that GPs have a rewarding career.

Q309 Andrea Jenkyns: Can you promise me that you will put that out to the press and start having some positive rhetoric to get through to the public? Then we might attract more people into the profession.

Dr Nagpaul: Positive ideas of what needs to be done and how we can all do this together. Yes, I will be happy to talk to you later about that.

Chair: I am going to move us on to another thorny issue—seven-day access. Philippa is going to lead with this.

Q310 Dr Whitford: There has been a lot of discussion about seven-day working and in particular with regard to general practice. It is seven-day routine working; obviously in a hospital it seems to be kind of a bit of both. Dr Baker, do you feel that there is the demand to have routine appointments on Saturdays and Sundays as well as evenings? I know that the RCGP survey suggested evening working was more important and the pilots do not seem to have shown great uptake.

Dr Baker: We do not believe that there is a demand from the public for routine service, certainly on Saturday afternoons and Sundays. That seems to be the evidence coming through from the Prime Minister's Challenge Fund Pilot. That is what patients tell us. We have done a recent survey of patients through ComRes, and 66% of people surveyed said

that they would prefer that in-hours—the existing service of general practice—was better supported rather than to extend appointments to across the weekend.

The other thing is that we do not have the resource. We are struggling with medical nursing and other workforce in general practice to provide the service Mondays to Fridays, and to provide extended access in the evenings, which we do know that patients want, and Saturday mornings as well. This is about how we most effectively use the resource we have in order to give patients what they need. One concern we have is that by focusing on provision of routine services seven days a week we could be running down the essential out-of-hours service. Even if you did provide routine general practice eight to eight, Monday to Friday, 12 hours a day still need to be covered by an out-of-hours service. At the moment, where schemes are providing extended access in the evenings and weekends, the doctors that they bring in to do those are doctors who would otherwise work in the out-of-hours service. So some out-of-hours services are finding they are becoming extremely unstable in being able to provide doctors for that service.

Q311 Dr Whitford: That was certainly what we heard back when we were in Leeds and Halifax and that there seemed to be a price differential, so the doctor would get paid slightly more for doing one of the routine sessions rather than doing the out of hours.

Dr Baker: Extended access, yes. It carries less risk for the doctor in many respects because you are seeing people who have come to see you well lit, and you have things in place rather than in the way in which you work in out of hours. In terms of the attractiveness of the two options, it is not surprising that, if they have the choice, people will choose to work in those settings rather than in the out-of-hours service. But it is essential that we have a GP out-of-hours service.

Q312 Dr Whitford: What kind of length of day are GPs commonly offering? Is there any extension into the evening or early starts to allow people who work to access their GP?

Dr Baker: Indeed. Our information is that between 50% and 60% of practices in England already offer extended hours. Increasingly—and it has already been mentioned—practices are working together in federations and networks, and it is easier, logistically, to be able to provide extended hours' services when you work in that way. Our feeling, from what members and the evidence are telling us, is that practices are in fact doing their best to provide access. There is a legitimate need for people who are working to be able to access the services that they require, but practices are working very hard to try and meet that need. What annoys people is the thought of having to put on a service on a Sunday afternoon that patients do not want and in order to provide that they have to take somebody out of, say, a Thursday morning.

Q313 Dr Whitford: The pilots seemed to show that there was a much better uptake on a Saturday morning, and clearly both your survey and other surveys have suggested extended work during the week. Do you think that there would be an acceptance, providing we have enough staff, to have an extended day and something like going back to the Saturday morning services?

Dr Baker: There is a recognition about a demand for appointments at those times and there are people, as I have said, who struggle to access services in normal working hours. Where practices can come together collectively in a locality, it is already happening. Most practices are already providing extended access in the evenings and/or Saturday mornings.

Q314 Dr Whitford: There have been comments about the confusion for patients out of hours of knowing where to go. They phone a number, hang on and wait; eventually they give up and go to A&E. Do you think there is a potential if you have federations of practices, where it is a different surgery open every week or every weekend, that that will add to that and that it is maybe better to make the out-of-hours GP centre bigger and more robust so that people would know where to go to start with?

Dr Baker: I agree with you that the information for the public on how to access out of hours, or even extended hours, is patchy. We already know that almost half the people in the patient survey—I think it was 46%—did not know that a GP out-of-hours service even existed. There is something there about trying to make sure that patients—the public—know where to go to for help and that clear and consistent information is provided for them. As to whether the out-of-hours service could do it, if you consider that those services are often groups of local GPs providing service out of hours, and extended access through federations is groups of local GPs coming together to provide those services, in some ways it does not matter whether the service is commissioned through the practice of the federation or through the out-of-hours service, so long as that service is there, safe and reliable, and people have the knowledge about how to get there.

Q315 Dr Whitford: Do you think it should be co-located near accident and emergency so that there is more room for redirection in both directions?

Dr Baker: We have recently produced a joint statement with the Royal College of Emergency Medicine to say that co-location of GP out-of-hours services with A&E services, where there is suitable opportunity to do so—it does not work everywhere—is, in general, helpful, useful for patients and leads to better use of resource.

Chair: Thank you. That brings me on to Andrea and a follow-up question.

Q316 Andrea Jenkyns: This is to the whole panel. Do you agree with Katherine Murphy of the Patients Association, who said that the pilot schemes revealed low demand because patients were not made aware that seven-day GP services were available? It was not publicised enough.

Dr Nagpaul: In the first-year pilots there was a huge promotion, like all pilots, and huge efforts made. I think patients themselves do not feel they need to attend a GP on a Sunday for routine problems. That has been replicated in many different settings, so much so that the pilots that had been given money to do this had to cease providing those Sunday surgeries. They were certainly trying to promote it.

Q317 Andrea Jenkyns: How were they publicised?

Dr Nagpaul: In each local area, where there was a pilot, the practices themselves promoted it to their patients.

Q318 Andrea Jenkyns: Was it leaflets or newspapers?

Dr Nagpaul: I do not know the exact details of how each of them did it, but there was widespread awareness. I do not think it is wrong that patients and the public choose not to be spending their Sundays going to a GP surgery if they can go on other days, but we know that people fall ill and need to see a doctor on the weekend, that they have chest infections and may have asthma and so on, and it is vital to have access to an urgent care GP service. The commonest things we hear about in the press and the media—and, for that matter, from our own patients—is that they want to know that, if they fall ill on a weekend or in an evening, they can see a GP or any other health professional. It comes back to urgent care, the paradox being that what you could run the risk of—and we are running the risk of in some areas—is taking GPs who would be available for urgent care away from being available for urgent care. You want a system that gives the public confidence that they can see a doctor—a GP—seven days a week if they are acutely ill. That is what we need to be focusing on. I am not suggesting that we do not need to provide services beyond the core hours, and, as Maureen has said, 50% to 60% of practices do that. But certainly we know the demand is for urgent care on Sundays.

Q319 Andrea Jenkyns: You are speaking to a retailer who worked across seven days for 20 years, Boxing day and new year's day; so, to me, life has moved that way anyway. You talk about urgent services on a Sunday. What about those people who have busy lives, who cannot get an appointment during the week, and it could be an important diagnosis, but they might not know at that stage? It could be delaying somebody who has cancer, for example. There are real-life examples of that. Do you not think the public should have that option to be able—

Dr Nagpaul: We have to start from the reality that we do not have enough GPs. That is a fact. Also, you have to start from the reality that, if you do not have enough GPs and you do not have enough resources, how can you make that resource—the GPs and the resources you have—work best to reach out to those patients who most need it? If we had double the number of GPs, double the amount of resource, one could have a very different conversation, but, when you do not, you should not be having unintended consequences of taking GPs away from those patients that most need them.

If you were to ask about need, I would say that the patients who are most in need of healthcare are those who cannot visit a GP surgery; they are the housebound patients. They are the ones who often need the greatest input on a weekend. They need a doctor to visit them and not be in a surgery where they may see three patients an hour, which is the sort of demand that we found. Unlike the retail industry, which may have an incentive to provide more services because there is the potential for income generation, remember we are looking at a service in the NHS where we do not have enough GPs, we do not have enough resources and they need to be put to the most responsible and effective use.

Mr Bradshaw: When we had enough resources and we had enough GPs, the BMA still opposed extended opening. You still opposed the 12-hour-a-day, seven-day-a-week NHS GP-led walk-in centres. You have always opposed better access to patients.

Q320 Andrea Jenkyns: Also, unlike retail, you are paid for by the taxpayers. You are civil servants like the rest of us here, so surely the public has a right to have that access.

Dr Nagpaul: Absolutely. What we need to do with the public purse is make sure that it is used most effectively in accordance with clinical need. That is what we would like to see happen. That is my answer. It is just trying to make the best use of it.

Q321 Chair: You think it is an issue, as you say, about the resource being stretched, as far as you are concerned—that the resource will not go far enough.

Dr Nagpaul: Given that we have a limited resource, that we have just started by saying we do not have enough GPs, we are trying to see people at 10-minute intervals and we cannot do that job properly, we need to make sure that that resource of GPs is used most effectively. One area that we know where you need GPs is for urgent care. We need to make sure that that service is responsive seven days a week and, if you are to be looking at routine care, you need to make sure that you use GP time where that demand is greatest. If there is not the demand, it cannot be right for GPs to be sitting in a surgery on a Sunday seeing very few patients—it cannot be right to do that—when in fact those GPs could be providing an urgent care service in a responsive way. I am not saying it is black and white, but it is about matching the resource to the demand and clinical need.

Chair: I am very conscious of time because we have a lot of questions to get through; so thank you very much. We are going to come on to the issue about building that workforce and James Davies is going to start the questions.

Q322 Dr Davies: Before I ask my couple of questions, the issue of 10-minute appointments keeps coming up, and rightly so, in my opinion. Increased complexity of cases in primary care is part of that, also successes in multidisciplinary teams seeing some of the simpler cases. Do you think that that issue, apart from requiring more GPs, should be addressed at a practice level, CCG level, regional or national, and, if national, by the royal college or Government? Who should be driving on changing that key issue?

Dr Baker: Was this addressed to Chaand?

Dr Davies: Either of you.

Dr Nagpaul: The question is: who should be addressing—

Q323 Dr Davies: If we are going to change the structure of the working day of a GP and try to increase more firebreaks or consultation lengths—whatever the solution may be—who needs to drive that, because there is little progress being made? In my practice, we did put in increased catch-up slots and we increased doctor hours, which, of course, results in a pay cut, but not every practice can do that. Is it right that this is being addressed at the practice level or does there need to be better instruction or driving from above?

Dr Baker: If it helps, the RCGP over the last two years has looked at areas such as access to appointments and out-of-hours care. We have looked to see what practices are doing, the pros and cons of different approaches, and tried to support colleagues with options and examples of how things can work well. We are preparing a position paper from the college on multimorbidity. We have already produced a statement on patient-centred care for the 21st century. In terms of the thought leadership, to use a phrase, the college is certainly

working in this field, exploring the options and trying to set out advantages and disadvantages of different ways of doing things.

I come back, though, to the point at which you are deciding in a practice how you are going to operate; what sort of appointment system you are going to have; and whether you are going to do triage. There is a lot of thinking, preparatory work, testing and engagement with patients and a lot of work there about changing in a fundamental way at the practice level how you do things. One of the biggest obstacles at the moment is the lack of time or the lack of external support to help practices do that work so they can make those changes.

Q324 Dr Davies: So it is at a practice level but with external support, which implies some national direction really, does it not?

Dr Baker: Yes.

Q325 Dr Davies: If we are considering how we might put that into place, for instance, through building the workforce, the Government have pledged an additional 5,000 doctors in general practice over the next five years. Is that number sufficient and do you think it will be delivered?

Dr Nagpaul: Again, the elephant in the room is the fact that the Department commissions what is called a work-life survey, and the one that was produced last month by the University of Manchester says that 38% of GPs are likely to retire in the next five years. That will totally wipe out any potential increase in GP numbers. That is a very serious statistic. Our own statistic in the BMA was 36%, so it is even worse through independent analysis. We know that is happening. We see it in front of our own eyes when we meet colleagues who are retiring early. I would say that the 5,000 GPs is an issue, but those retiring will be a bigger issue.

We need to come back to why people are retiring and why younger doctors are not choosing general practice. We know that over 600 training places were unfilled last year. An even more worrying statistic in our survey is that one in five doctors who choose to train in general practice in their trainee year say that, when they qualify, they want to work abroad. That is sad and it is a reflection—I come back to this—of the job. The job has to become more manageable. I come back to the 10 minutes' bit. If nine out of 10 GPs say that, that means a trainee GP is witnessing a pressured environment and not following a role model; they are following a GP who is saying, "I am too tired. I am not able to do my job properly." We need to manage the workload. It is a multifactorial approach—multilevel.

The Government of each nation can do a lot in ensuring that the public make sensible use of a GP's service. They did that for A&E. Do you remember the big campaign "Say no to A&E"—go to A&E only if you have to? You can signpost patients to the right service. There is a lot of potential in self-care. When I say self-care, it is not about trying to turn patients away; it is about empowerment. There is a lot of scope for empowerment. Patients who have chronic conditions can be more empowered to manage themselves, rather than sitting in a GP's surgery for a long time. Those are measures that can be taken to reduce some demand on GP services. There are other healthcare professionals who can see patients. I see, for example, as many GPs see, babies with feeding problems, for example: they could go straight to a health visitor rather than a GP. You can also have better

integrated teams around a practice. We speak too much about a GP practice in isolation. A GP practice is part of a continuum—it should be, rather—with community nursing staff. I mentioned the older patients, many of whom are housebound. A lot of those patients need a nurse as the first point of contact, whereas what happens now is the GP visits the patient and says, “You need a nurse,” and the nurse comes the next day. There are things like that.

We have also uncovered, courtesy of NHS England—which commissioned some work on bureaucracy, and the Government are minded to implement it—that there is a considerable amount of work that is inappropriate that comes through our door that can also be ceased. There are patients who see us simply to be re-referred to hospital after they miss an appointment. There are patients who come and see us to have other processes and admin in other parts of the sector expedited. I could go on. I think there are ways of both managing demand and having general practice supported more effectively.

Q326 Dr Davies: But you think that 5,000 is—

Dr Nagpaul: To be honest, if you look at the facts in front of you, I cannot see how that can mathematically play out. Even if it did, looking at the trends, you will have a net deficit if 10,000 GPs retire in the next five years.

Dr Baker: We say that we need at least 5,000 GPs, but 8,000 would be better. When we were doing this modelling work two years ago we thought that pushing all the levers, getting all the things done, mathematically it was possible to get 8,000 more GPs by 2020. What has happened in the last two years, though, has been the haemorrhage of older GPs, GPs over 50—certainly over 55—and that, again, largely comes back to the way in which they are working, the types of job they have, the stress and the pressure. In order to get the 5,000 GPs by 2020, we need urgently to address this problem of pre-retirement—the loss of GPs in that age group.

Dr Davies: I think 1,000 of the 5,000 is meant to be from trying to retain those who have entered retirement or are threatening to do so, with regard to Health Education England—

Chair: We are going to come on to retention separately.

Q327 Dr Davies: That also includes GP registrars. You could argue that that is not providing additional workforce at the time, although it will do into the future. If we just consider the fact that fewer GPs are now entering partnerships, with more working as locums or wishing to do so, or salaried GPs, what is your view on the impact of that?

Dr Nagpaul: This is a symptom of the pressures in general practice. If I can say slightly in jest, even the CQC inspections are putting many doctors off from wanting to be partners, because they seem to be a huge burden in running practices. This leads to CQC inspections because many practices cannot recruit partners, and in running a practice you need partners. These are choices some doctors are making because it is the only way they feel they can limit their workload, but there are some positive reasons why more doctors want to have a portfolio role in their lives, mixing general practice with other career interests. This is certainly a very changed demographic from the general practice that I entered, and it does have an impact on the ability for practices to provide the same sorts of

services that they had in the past because they do not have that stability of general practice workforce. Patients also find that they are seeing different doctors each time.

Dr Baker: One of the biggest reasons for doctors not choosing to become partners is lack of confidence. They do not know where general practice is going, and it is difficult to commit financially, personally, to what partnership requires without having confidence that the practice will be viable, that you are not going to incur huge amounts of debt that you will not be able to pay off. There have not been sufficiently strong signals coming across that it is worth while investing in partnership. Many of us who have worked as partners feel that it is a good way to work, giving personal investment and the ability to make decisions at the unit where the change is going to be. But if people coming into the profession are asking, “Can I do this?”, they are not getting the messages that give them that confidence at the moment.

Q328 Dr Davies: I know there is a large number of questions, but I have one more about undergraduate teaching—the service increment for teaching, the SIFT payments, which are, I think, still at a similar level to what they were over 10 years ago. Do you have a view as to by how much they need to increase so that there is capacity in practices to train the GPs of tomorrow?

Dr Nagpaul: I do not have a figure.

Dr Baker: We know with SIFT, as you say, that the amount of funding has not changed over the past 10 years. Even then, there was no rational basis to determine what general practice needed to support its teaching activities. It was just a way to distribute the money. Nowadays practices that would like to teach and are enthusiastic about it find that they cannot afford to. They are basically taking people away from front-line work to support teaching. They do not have the capacity to do that. Even though they recognise this is the future and is something we need to do in general practice, they just cannot do that. That is really unfortunate and something that needs to be addressed.

Chair: We have so many questions to get through. We are going to have a very quick question here and then from Philippa.

Q329 Andrea Jenkyns: I wholeheartedly agree with your comments, Dr Nagpaul, regarding personal responsibility; I have been saying this for a long time. All stakeholders, including the public, have to look at what is sustainable in the future for our NHS. You have come up with some fantastic suggestions.

Dr Nagpaul: I told you I would be positive.

Q330 Andrea Jenkyns: Fantastic, yes—10 out of 10. You have come up with some great suggestions on what is needed to help ease the pressures on the system. I would like to turn this back again, and I will be very quick. You talk about personal responsibility with the public, so can I ask Dr Nagpaul and Dr Baker, if you are doing anything to implement such changes that you have discussed, and, if you are not, can you commit to doing this with your members?

Dr Nagpaul: Yes—

Chair: We, unfortunately, have a Division in the House. I am going to give you a few minutes to think about that because the Division bell has gone. We will suspend the sitting and everyone can have a jump up and down for 15 minutes.

Sitting suspended for a Division in the House.

On resuming—

Chair: Because time is short, we are going to crack on as we are quorate. We are going to lead off with the answer. In case you have forgotten, we will have a quick emergency recap from Andrea.

Q331 Andrea Jenkyns: Very quickly for a change. I agree with your comments about personal responsibility. You have come up with fantastic suggestions, which I back 100%. Are your two organisations doing anything? If not, will you do something in these areas, because I think we have to pull together with this?

Dr Nagpaul: Sure. First, we have produced two documents—one on managed workload, which has a whole section on patient empowerment. We also produced a document a few months ago on the future of general practice, again forward looking, where patient empowerment features as a large component. In our contract, we have negotiated that all practices have patient participation groups at practice level. There is a lot that can be done in involving patients in that interaction. We also believe there is a role for the Government as well to publicise, promote and support ways in which patients can be more empowered. There is the technology. We have looked at systems where there can be much more information on the practice website that can lead patients to know much more about their condition and make the right choices. In many cases, those choices will be either self-care or seeing another professional, but being more empowered. That is important. There is also probably an underutilisation of patient self-help groups. I recently met someone from the British Heart Foundation and was amazed that the patient-focused information on that website was so comprehensive that in fact, if a lot of patients had looked at that information, they would not have needed to come and ask their GP simple questions about their medication or their condition. So there are myriad ways where this can occur, but we need to make it a concerted approach. We have been in dialogue with NHS England as to some of the ways in which this can occur.

Dr Baker: We now have a section on our website called “bright ideas”, which is a forum for people to share their experiences. One example is group consultations, which have been tested out in a few areas, where you will have a number of patients with a condition—such as epilepsy or asthma—and the surgery will facilitate bringing them together. It is a group session with the GP, the practice nurse and the group of patients. These have been found to be valuable by patients and reduced their need to keep coming back for further consultations.

Q332 Andrea Jenkyns: Could you get to the stage where you do reports as well?

Dr Baker: Yes.

Chair: Andrea, we really have to move on. We will take Helen next and then Emma.

Q333 Helen Whately: Earlier in this inquiry we heard from Professor Roland about the proposals in the Primary Care Workforce Commission, and you, the RCGP, have costed those proposals to a £1.65 million annual cost by 2020, which is very helpful.

Dr Baker: Yes, we have.

Q334 Helen Whately: The other thing that you and others have said is that the primary care budget, as a proportion of the NHS budget, should increase from where it is now at about 8% to 11%, which you have calculated in your submission is £3.1 billion per annum. Could you explain what the additional £1.5 billion—we have £1.65 billion on the workforce—would need to be spent on?

Dr Baker: Thank you. In doing these costings, we concentrated on salary costs—what you are paying the individual and the on-costs. We have not factored in there the infrastructure costs, such as the rooms or the areas for these people to sit in, the equipment they will use, the training they will need and how you will provide new services. This is just salary costs.

Q335 Helen Whately: The additional £1.5 billion is literally salary costs.

Dr Baker: Yes.

Dr Nagpaul: In terms of infrastructure, we conducted a comprehensive survey of the state of GP premises. As we speak, only four out of 10 GP surgeries feel they can offer core basic services. They do not have the space—enough rooms—to provide an adequate level of general practice services. Seven out of 10 say they do not have space to provide extended services. If you look at the agenda to move care into the community out of hospitals, there just is not the space, and you and I know that if you walk into a GP surgery most are overstretched, there is not enough reception space or waiting room space, and the doctors are hot-desking. There is a real need to expand the infrastructure estate.

Going beyond pure general practice, the movement of more integrated care in the community cannot occur unless there is an investment. If you have less care provided in hospitals, you have to have some facilities in the community. Again, in our survey, looking at things positively, three out of four GPs want to work in settings with other healthcare professionals. There is an increased recognition that you cannot look after older patients just as a GP. You have to look after patients in an integrated fashion with a team of professionals. They cannot be housed in current GP surgeries. They can only be housed within the community estate, so there needs to be real investment in infrastructure.

Q336 Helen Whately: We may come later to some questions about the premises, so that is helpful. If that additional money is spent, could you say what the impact of that investment would be on the health system, on patients, and when would that impact be felt by patients?

Dr Baker: We are all looking for high-quality services for patients at or close to home to avoid extended stays in hospital, which are not necessary medically, and to avoid medical admissions where, medically, you can look after that person in their own home if you have

the support around there. We should be looking to gain many more patients looked after in or close to home and the way in which we can bring other skills that are available to patients. For instance, we have done a lot of work on pharmacists in general practice and having practice-based pharmacists. Pharmacists have hugely important and valuable skills that they can bring into the primary care setting and into consultations in primary care. We need to employ these people, put them somewhere and give them equipment and IT. The impact we are looking to get from this is a better quality service with better outcomes for patients: better experience, better outcomes and lower per capita costs—the triple aim of healthcare. That is what we should be aiming for.

Q337 Helen Whately: This amount of investment is not required just to keep general practice functioning but would lead to improved outcomes and better care for patients.

Dr Baker: We need the money to transform the way in which we work. Not just in general practice—in fact, less so in general practice in some respects than in other areas—we are still stuck in a 20th century healthcare model, with single-disease conditions, episodes of care. Increasingly in the 21st century, people live with multiple ongoing conditions, and not just the elderly: a significant number of middle-aged people will have two or more ongoing conditions. We need to work in different ways as generalists so that we can provide care centred around the patient and preferably out of acute intensive settings. They are incredibly important and we need them for patients, but only when that is the right place for patients to be. Otherwise, we look to be providing high-quality medical, nursing and other clinical care for patients in communities, which is where people want to be.

Q338 Helen Whately: Some of these changes will require IT investment, and that is one of the things that was mentioned in the evidence. There is a need for an upgrade in IT. Is that costed in the estimate of the amount of money that is needed as well?

Dr Nagpaul: As Maureen said, the estimate from the college is around salary. If we can look at it from a patient and a GP perspective, would it not be great for a patient who has multiple problems, and who is older, to see their GP and have 20 or 30 minutes to be looked after properly? The GP spends the time caring for patients in a way that will reverse the statistic that I mentioned earlier—that nine out of 10 say they cannot do their job properly. They are supported by a team where the patient can see the nurse or a pharmacist where appropriate. That is what we want to get to—the multiprofessional.

Q339 Helen Whately: I get that. What I am coming at—and have been doing this repeatedly through this inquiry—is trying to understand, when we are told that primary care needs an increase from 8% to 11%, what that money should be spent on. If it is being spent here in primary care, it cannot be spent somewhere else. It has been very helpful to have the costings of the salaries. It would be helpful—I would certainly love to see it—to know a fuller costing of what primary care reckons it needs. It might well not be available here and now.

Dr Baker: If you look at the difference between the salary costs and where we are with the £3.1 billion, we need to have appropriate premises. For instance, if we are going to bring in this new model of medical assistants to work with the GP to make the best use of the GP's time, in order to employ and work with these people, we need to have more rooms to

put them in and we need to have more rooms to put patients in so that doctors and others can work between patients.

Q340 Chair: Dr Baker, could you perhaps write to us with your fuller costings? You are saying that, moving up to 11%— to check that I have heard you correctly—all that would go in salaries. Could you perhaps write to us?

Dr Baker: No; about half of that would go in salaries. The rest, I am trying to say, is infrastructure, IT and new services for patients.

Q341 Chair: It would be helpful for us to have a more detailed breakdown of what the increase to 11% would be spent on.

Dr Baker: Indeed. We would be happy to do that for you.

Q342 Emma Reynolds: I want to go back briefly to the questions on increasing the number of GPs and, crucially, retaining. We have discussed in previous hearings the issue of recently trained GPs moving abroad. Is it your view that there is an increasing trend in terms of the numbers? Do you have an accurate picture of the true number of those who recently qualified choosing to move abroad, and, if it is a trend that is increasing, what do you think we could do about it? Someone suggested so-called golden handcuffs, probably nicer than it sounds. Others have suggested that recently trained GPs should be required to pay back the cost of education or training. I am sure there are other solutions and perhaps more positive ones too. What can we do about this trend if it is something you are concerned about?

Dr Baker: I have some figures of people moving abroad. One way to determine numbers is to look at applications of certificates of good standing that the General Medical Council produces. To work elsewhere, you need to demonstrate that you are still in good standing with the GMC. We know that applications for certificates rose by 22% from 2008 to 2013. I understand that that figure in 2013 was around 4,800 applications. We understand from the GMC that the figures from 2013 have increased, but I do not know that definitive figure as yet. There is objective evidence that doctors are, sadly, moving abroad and that doctors aged between 24 and 27 are the majority of these applicants.

As to what we can do to keep them, I suggest we look after them better in the first place; we make them feel valued; we give them confidence in a medical career in the UK and in working in general practice, and make it a better job again. First and foremost, that is what we need to do. Bear in mind there has always been an element of moving backwards and forwards and that doctors do go to other countries, have good medical experience and bring that back. Having doctors who have travelled is a positive advantage to the NHS, but that is if they come back. We have to try and make sure that we bring as many back as we can.

Can you stop them? In a free society I do not think we can. Can you make them pay back a proportion of their training? I suggest that that might be the biggest barrier to bringing them back. If they have gone, you cannot get at them. If you say, “You are going to have to pay us back £100,000,” they are never going to come back. You can only put things in place that you can enforce and that are sensible. I suspect the best way to get these doctors back is to make it a good job for them once again.

Dr Nagpaul: When I applied to be a GP, there were 180 applicants for two trainee places and 80 applicants for one partnership position. Why was it the most attractive career option back in 1986? There is nothing inherent about general practice that makes people not want to become GPs. We find that young doctors are shunning the environment that general practice is working under rather than the discipline itself. If you want to attract people, if you want to attract trainees to remain as GPs when they qualify in the UK, the job has to start to sell itself, and that can only occur, in my view, if the Government of the day makes it very clear that this is the priority. We have heard many statements made. Simon Stevens was very clear in the Five Year Forward View when he said—this is not me—that general practice has been disinvested in, and Jeremy Hunt said similarly, and made a real commitment to wanting to redress that. If GPs and younger doctors have heard this, they need to see that become real. They need to see some reality to a real push towards ensuring that the infrastructure of general practice is going to expand and be supported. If we begin to see that trajectory, then young doctors will make those choices. They will say, “This is a profession I want to enter because I can see there is genuine intent in putting right what is wrong about it. I am not going to worry about the discipline but the environment.”

You have to start to see that reality. If you have a spending review that is front-loading investment in the NHS, and if at this moment we do not see proper investment from that front-loaded investment, why would any young doctor have any faith that this is a profession worth going into? They will probably say, “I can’t see any light at the end of the tunnel. All I can see is 10-minute hamster wheel consultations and overworked GPs who do not want to be running their practices.” You need to show a tangible change, and I believe it needs to come from the centre and we, collectively, will then work with that resource to make a difference.

Q343 Emma Reynolds: I am sure we all have a responsibility for promoting a positive vision of people working as GPs.

On another issue, Professor Field, I would be interested in your view. We talked earlier about quality, and in your evidence and today you have suggested there are many reasons for poor quality care. Do you think the shortage of candidates to fill posts in some areas is a root cause of that poor care? Is that something that you have come across?

Professor Field: It is very difficult in some areas to recruit, but, interestingly, one of our outstanding practices in Weston-super-Mare, which is largely a nurse-led social enterprise, has been able to recruit GPs since they became outstanding. There is something to be said for celebrating the good. If I could link this answer into the one before, we are all in this together and we all need to celebrate great practice, but this goes back to school. We need to select people to medical school with a real commitment to working with people in the community in general practice. We need to look at how we select schoolchildren. In Birmingham medical school you cannot even be shortlisted without getting 8 A*s at GCSE. That discriminates against those from poorer backgrounds, and it positively discriminates in science against those who want to be academic researchers, and probably, according to some of the research following students, you get more specialists out of that. At medical school, we still have students who come to my own practice who have been told by specialists that general practice is an inferior career. While most medical school

time is dominated by placements in hospitals, you are going to bring out hospital consultants at the end.

We have an opportunity in this crisis—and it is a crisis. I agree entirely with Chaand about investment. When you are putting money in to build it up, you have to start right from the beginning. Some of the following of medical students goes back even to choosing sciences aged 13. You want to get people through, but the placements they go into at medical school need to show great leaders in great environments, and, frankly, many of the poor practices we are finding are in awful buildings—converted houses and corner shops—and the environment is dirty and horrible. Why would anybody want to go and work in a place like that? The Five Year Forward View, for me, is an opportunity for us all to rally round. There is too much focus on the hospital side. Some of the vanguards—I am a partner of Modality in the west Midlands, which covers almost on to your constituency—are looking at different pay structures and different ways of using physician associates and nurses to make it a really exciting, buzzy place where you want to work. That is okay in the sort of environment in which we work. Down in Exeter in the more rural areas, as I said, in Exmoor, north of you, they have practices working together loosely in federations. As a profession we need to be leading this change, but we need some investment to try and oil the wheels to make that happen.

Q344 Emma Reynolds: Geographically, do you think there is a problem in filling posts outside London and the south-east, and what can be done about that?

Professor Field: Historically, starting again with medical school, they were in the wrong place. That is why we now have medical schools in Stoke-on-Trent, Hull, Coventry, Exeter and Plymouth to try and retain doctors. Those medical schools need to have a focus on primary care. Half of the students we train should be going into general medical practice, and they are not. The recruitment problems mostly—they are all over the country—are on the periphery of the country. When we go to where Maureen does her clinical work, to Lincolnshire and to the east coast, it is poor. Undoubtedly, there needs to be investment and leadership there to make those jobs more attractive. But it is like going back to the very good question about seven-day working. We are talking in a very linear way. The patient comes and sees a doctor in the surgery. Younger people—the millennial generation—have a different idea of access to general practice from my parents. It is not going to be just in a surgery seeing somebody. It will be via mobile phone and Skype. Care home patients are stuck in care homes and nursing homes. The model of providing primary care could well be very different to them. We need to look at this very differently and, for me, letting some of these vanguards flourish is one way of doing it.

Q345 Chair: Thank you. Could you elaborate on your views on the Roland Commission work and how we can move that forward at scale and pace? The purpose of this inquiry was not to reproduce the Roland Commission but more to look at how we move it on and who is going to be responsible for putting that in place at scale and pace. I do not know whether, Dr Nagpaul, you want to lead on that.

Dr Nagpaul: Yes. I will start with something very simple and practical around the use of clinical pharmacists in GP practices. We know that many clinical pharmacists are independent prescribers, so they can see the patient, prescribe and manage. They have experience in medicines management. They provide a role different from, say, a practice

nurse. In Northern Ireland, the Government, together with the GPC Northern Ireland, have agreed to resource, through federations—and these federations are nationally agreed with the Government—pharmacists who will be employed by the federations, with each practice in Northern Ireland having a clinical pharmacist provided in their practices for clinical support.

Q346 Chair: Is that one in every practice or one for all the federations rotating around?

Dr Nagpaul: The federation will employ them, but the end result will be that each practice will have a nominated pharmacist to support them. The details are being worked through as to how much presence there will be, but each practice will have the support of a clinical pharmacist. That is being developed as we speak.

In England, a three-year pilot has been put forward that involves part funding, which would end in three years. It is not the same because it is only for a selected number of practices. What I would suggest could occur is this, and we came back to the point of where the resource would go from the front-loaded investment from the spending review. That would be a simple way of implementing a resource. We know we have a workforce of pharmacists who can be employed and we can provide that resource to GP practices to ease pressures. Instead of it being a pilot for a few, it could become, as I said earlier, a national scheme, and that would be one way to make a difference with the Roland review recommendations.

Q347 Chair: Thank you. Another aspect about widening the workforce team was around physician associates. One area that has been raised with us as a barrier to the uptake of physician associates are the issues of registration and indemnity for practices. Is there anything you would like to say about that, if we are going to achieve the ambition of having 1,000 physician associates?

Dr Nagpaul: There are some very real and understandable concerns about the role of physician associates in terms of their qualifications, the indemnity and the regulation. This is the problem. Rather than starting with some target of 1,000 physician associates and looking at it in terms of physician associates, why not look at the skill mix that can support general practice? We can be flexible about that. In practice A they may wish and need to be supported by a clinical pharmacist; in another practice it could be an advanced nurse practitioner, a healthcare assistant, a physician associate or a community nurse looking after older patients. There are ways in which the Roland Commission can be used as a vehicle for the new investment, which, as I said earlier, if there is new investment, is where it needs to go, into supporting general practice. Being simplistic and saying it is about 1,000 physician associates is probably not the way to interpret it. The physician associate is one of a range of professionals in a skill mix that can support general practice.

Q348 Chair: Thank you. Did you want to add anything to that, Dr Baker?

Dr Baker: If we think about the terms of reference for the Roland Commission, they were asked to scope the workforce to deliver the Five Year Forward View in primary care. It is not just about the Roland Commission and their findings; it is the ultimate aim of making the Five Year Forward View a reality. That is very much about working in different ways,

using our resource differently, looking after patients close to home, as I have said earlier. In order to do that, we need to bring wider skills in. We need to provide patients with access to these skills in the community and we need to house and support them. One thing I get concerned about is that we tend to think about doing these things and applying them to the general practice of today.

The Five Year Forward View is a very different way of working in healthcare in England. Increasingly, we need to be describing what those ways of working might look like. We have not traditionally had multidisciplinary team care in general practice in the way that they have in some services in the acute sector, for instance, but that is very much a feature of the Five Year Forward View and of Roland. A few places are doing the whole thing of integrated care and working together across boundaries around the patient, but we are not doing it at scale and we are not doing it consistently. We need to be thinking about how we make this a reality within a very short space of time.

There are four years left of the Five Year Forward View. In order for that to happen, there is an urgent need to see what the workforce is; that is what Roland has done. Then it is about how we are going to recruit and train them, where we are going to put them, how we are going to work together effectively, as described in the Five Year Forward View, and where we go with integrated care. There is a whole bunch of work that we need to be thinking about as to what it is going to look like in four or five years' time, while we are still supporting general practice as it is today, so that we have the people to take with us to the Five Year Forward View.

Q349 Chair: How confident are you that those recommendations will be taken forward?

Dr Baker: As to the Roland Commission, I am only confident if they are funded. Everyone can sit around and say, "Jolly good, yes, we need that and we need these skills." Chaand was giving an example in Northern Ireland of an actual commitment to funding to bring those skills in. At the moment we do not have that. Would it not be great if we had pharmacists working in general practice? Where is the money going to come to pay them, to train them and to do their career development? It comes with a cost and that needs to be identified. When I was talking earlier about confidence, colleagues need to see that this is going to happen. Colleagues at both ends—those coming in and those who are thinking, "Will I stay on for another five or seven years?"—need to see that this will be a reality and it is not just documents and presentations, that there is an actual mechanism to take us there and the money to pay for it.

Q350 Chair: If the money is forthcoming and it can be taken forward that we broaden the workforce, could you set out your views on whether, for example, physician associates should have an extended role, including in prescribing?

Dr Baker: The physician associate is a role that we are not very familiar with in general practice. It may well work and be a useful role, but we do not have that experience yet. Take, for instance, pharmacists. You talk about pharmacists in primary care, and the practice-based pharmacist is a new role. We understand pharmacists, the skills they have, what they do and how those skills can be applied in the general practice context. For physician associates, for a lot of colleagues, the case is still to be made. Will they be of

value? Is it worth while a practice investing in a physician associate as opposed to an advanced nurse practitioner, for instance? Particularly with respect to physician associates, the jury is still out. The case is not yet made. If the case is made, if people say, “We have tried, we have invested, and we have found that this role is a useful addition to our skill mix in our practice,” and those messages start getting out there, then we will see take-up of that role, but people are still not convinced as yet.

Q351 Chair: Thank you. Can I quickly come on to the issue of indemnity for medical professionals and the extended role professionals? We have been hearing in some cases that it is the cost of indemnity that is driving some GPs to retire, or indeed to stop some GPs taking on out-of-hours roles. Is that something that you could comment on?

Dr Nagpaul: The cost of indemnity has rocketed in recent years. That is because of a substantial increase in pay-outs as a result of claims. For GPs, unlike doctors working in the hospital sector, the cost of indemnity is borne personally. GPs pay for that and it affects their income when they pay more, and they will make choices around that. The cost now, through one survey, has gone up to about £11,000 per GP. It becomes even higher for some GPs who are doing out-of-hours work because that has another premium attached to it. We know that this is putting off significant numbers of GPs from doing out-of-hours work. We also know it is not just a case of doing it or not. A lot of GPs are reducing the commitment they are putting in because it becomes cheaper if you are doing fewer sessions as opposed to doing more sessions. So you may still be in work but you have reduced your capacity. It will become perhaps a bigger issue when GPs work at scale because many of the indemnity organisations will look at the same sorts of premiums as for out-of-hours care.

There is an additional problem that is not just about indemnity of GP costs but about nurse costs and other healthcare professionals, because that is also borne by the practice in many cases. We have heard now of examples where premiums for an advanced nurse practitioner could be as high as £8,000 a year, when it used to be very low in years gone by. This is a very real and serious issue that impacts on the workforce in terms of the capacity and sessions that doctors are doing but also in regard to the staff they are recruiting, or rather being dissuaded from recruiting because of those costs. It needs to be addressed. NHS England is very much aware of this issue. It announced yesterday some support or reimbursement for additional out-of-hours sessions this winter, which is good, but it does not solve the problem. The real problem is about a much wider burden that needs to be tackled. It needs to be seen as an opportunity cost, because by addressing that indemnity burden you will then liberate and increase the capacity of GP workforce as a result. It has to be tackled, in my view.

Q352 Chair: Would you support moving to the Welsh model of having a Crown indemnity basis for general practice as well?

Dr Nagpaul: I do not think the Crown indemnity approach in Wales is a replica of hospitals, and there are other offshoot approaches. At the BMA we have had discussions about a range of options. That is one of those options. I absolutely would agree with a central approach to ensuring that indemnity is managed in a way that does not become a personal burden on doctors working in the NHS.

Q353 Chair: Thank you. Did you have anything you wanted to add to that?

Dr Baker: In terms of maximising the workforce, increasingly it is a barrier. Chaand mentioned about doctors who potentially would be interested in doing more sessions but they are effectively out of pocket by the time the indemnity goes up. It is also a potential barrier to returners, and we have not talked much about returners. When people are thinking about coming back, as we were talking earlier, from Australia, New Zealand and Canada, to work in England and they are looking at the various aspects, it is another factor that deters people. Finally, we are worried about the viability of out-of-hours services because of the premium. That is putting people off working in out of hours.

Q354 Chair: Do you have any examples of out-of-hours services that are at risk of collapsing altogether because of both the points that you have raised—this one and the one earlier about stretching staff?

Dr Baker: I do not have an example of a specific out-of-hours service. I do have some costings on indemnity that suggest that in one area the extra indemnity premium you pay, if you do more than two out-of-hours sessions a week, is £6,000.

Chair: Thank you. I do not know whether other members of Committee have any additional questions they would like to ask. Ben, you have a final question, and I know that both Philippa and James want to say something at the end as well.

Q355 Mr Bradshaw: Professor Field, have you thought whether it would be easier for you to achieve the reforms and improvements that you want if we looked again at the status of GPs as private contractors and not NHS employees?

Professor Field: Gosh. It is the organisation that we are looking at rather than the individual, so it is difficult to answer that. The problem with smaller practices, as Chaand would probably say, is that the amount of work you have to do to organise and run a single-handed practice is quite large. If you are then at scale, you can dilute that back-office function and support. If you are working with other doctors, you are more likely to share data and get involved in improving quality. It is about the human bit rather than the contractual status. In this city we have one of the biggest practices—I think it is a four-doctor practice—with 100 or so salaried doctors working in it providing very good care. Our own practice in Birmingham has gone down a multipartner model. I do not know what the answer to the question is. I think it is about how the practice is organised rather than whether it is an independent contractor or a salaried model.

Q356 Mr Bradshaw: Are you satisfied in your long experience of trying to achieve improvements in primary care that the status of GPs and the historic resistance that we have had from GPs to successive Governments trying to improve that care is not a factor?

Professor Field: I think general practice is the best job in the world. It is an amazing role where patient satisfaction is very high, the public esteem is high and you can get involved in education, research or medical politics. At the moment we are not selling that job and working systematically from school onwards to make it a better place for the youngsters to come in. Part of that is about investment. I have different views on contracting. I have seen fantastic small practices on the independent contractor model, as in 1948, through to larger

providers. The most caring practice I have ever been into in my life is in Leicester; it is a social enterprise run by two young women looking after all the homeless in Leicester. It is a different model. The contracting system needs to be based on what the need for the patients is more than anything else.

Chair: Thank you. Philippa.

Dr Whitford: It is on the website, but I probably should have mentioned earlier that I am a member of the BMA as a doctor, as many doctors are.

Dr Davies: I am a member of the BMA and the RCGP.

Chair: Thank you for clarifying that. Are there any further questions? Thank you very much all of you for coming this afternoon. We really appreciate it.