

Public Accounts Committee

Oral evidence: Access to General Practice in England: HC 673

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Members present: Meg Hillier (Chair), Mr Richard Bacon, Deidre Brock, Chis Evans, Caroline Flint, Kevin Foster, Mr Stewart Jackson, Nigel Mills, David Mowat, Stephen Phillips, John Pugh, Mrs Anne-Marie Trevelyan

Sir Amyas Morse, Comptroller and Auditor General, National Audit Office, Adrian Jenner, Director of Parliamentary Relations, National Audit Office, Laura Brackwell, Director, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Witnesses: Professor Maureen Baker, Chair, Royal College of General Practitioners Council, and Neil Tester, Director of Policy and Communications, Healthwatch England, gave evidence.

Chair: I warmly welcome everyone to the first Public Accounts Committee session of 2016. Today we are considering the National Audit Office's Report on access to general practice in England. I should stress that it is not about physical access; it is about getting an appointment when you need one as a patient. Clearly it is a very important topic, and I have had a lot of feedback from colleagues from all parties across the House about experiences in their areas, so I may indulge them later and mention some of those.

The GP practice is, of course, the first point of contact for many people using the NHS. About 1 million people consult their general practice every day, which perhaps underlines why it matters so much. It is clear from the NAO's Report that although people's experience of access remains generally positive—and I think we would agree that the GP service in this country is something to be admired and something we all support—the trend for positivity is one of gradual but consistent decline. We want to hear today how the Department and NHS England plan to reverse that decline and reduce the variation in access between different patient groups and practices.

We also want to hear a bit more about the vision generally for general practice, both from our pre-panel and from our panel members from the Department of Health and NHS England. I have to say, Neil Tester, thank you for what Healthwatch has done. I saw a particularly good bit of mystery shopping you did in Slough, which showed that three GP surgeries did not even have a

website, which is a pretty basic thing. If it wasn't for the work that you and your colleagues were doing, we perhaps would not have known that, so thank you.

I am going to hand straight over to Caroline Flint, who is going to lead our questioning with Kevin Foster today.

Q1 Caroline Flint: I thought that trying to find a good energy price was a hard thing to do and then I tried to find the opening hours of GP practices in Doncaster, which I represent, and found it incredibly difficult. I tried not only through NHS England; the information was not available through the clinical commissioning groups either, and I have had my office on to it this morning. Apparently it is there somewhere but, as the Chair has said, in terms of website access it seems from the NAO Report that while we can be really positive about so much that happens in our health service, including in GP practices, the perception of getting an appointment is getting worse. I think the figures show that more than a quarter of patients—27%, up from 19%—struggle to get through to their GP's surgery to make an appointment. Basically, if you are older, white, middle class or in a more affluent urban area, you get better access than anyone else. Professor Baker, why are patients reporting this worsening access to GPs?

Professor Maureen Baker: The basic problem is a mismatch between supply and demand. Demand for GP services is rising for a number of reasons—partly demographics and partly case mix. An increasing proportion of patients we see are older and have multiple, ongoing illnesses, so they are more complex. There has also been a baby boom. So there are a number of reasons why the demand for services is increasing. At the same time, we have failed over the last 10 years to invest in the service of general practice, and the number of GPs per head of population has fallen. The small rise there has been in headcount has not kept pace with population or the complexity of cases. Basically, the service is struggling to provide the level of access that patients are looking for.

Neil Tester: What the people who have spoken to their local healthwatch or to us have told us quite clearly is that the way that general practice and the wider primary care system is organised to deliver access to GP services has not kept pace with the speed at which people's lives have changed—their living environment, working environment and family commitments. There is a real opportunity now, which is coming through very clearly, particularly from the recent deliberative work we undertook with people, to use the transformational processes that NHS England and other arm's length bodies have under way to listen well to people—to really engage with them—and to shape services and access to services around them.

Q2 Caroline Flint: On the point you were making about resources, Professor Baker, we have seen a rise and a fall in resources over a period of time. The Report indicates that, compared with other parts of the NHS, support resources for general practice have not kept pace. Having said that, how does your profession account for the fact there are such wide variations in what is happening in general practice, particularly when the service is not as good in some of our areas of highest need—our most deprived areas—as it is in the most affluent areas?

Professor Maureen Baker: We have been saying for many years that distribution of the general practice workforce is a health inequalities issue. Those areas that are the most deprived have the fewest GPs, nurses and pharmacists per head of population, and there has not been the mechanism to distribute the GP workforce fairly or equitably over the country since the demise of the Medical Practitioners Committee about 15 or 17 years ago. There has been no mechanism that

allows a fair distribution of the GP workforce, nor have there been any levers to support GPs and other primary care staff to work in areas of greater deprivation. Without push or pull factors, it is no surprise that this is what has happened. I would not say it is a professional failing; it is a failure of the system to support an equitable distribution of the GP workforce.

Q3 Caroline Flint: So you don't think it is anything to do with doctors preferring to work in the more affluent, leafy, less challenging areas?

Professor Maureen Baker: Well, it is not just doctors—it is everyone. In fact, many of my colleagues explicitly choose to work in deprived, struggling areas, when they could get jobs that were easier and better paid in other areas—kudos to those colleagues who make those choices—but, as I say, there really needs to be some mechanisms that support GPs who are at least interested in taking up these roles. At the moment there is nothing there for them.

Q4 Caroline Flint: The Government have a plan to increase the number of GPs by 5,000 by 2020. In your submission you suggest that it should be nearer 8,000, I understand. Say that happens, how will we ensure that those 5,000 GPs will go to the places where they are most necessary?

Professor Maureen Baker: The college is now working together with NHS England, Health Education England and the general practitioners committee of the BMA on a 10-point plan for a GP workforce. One of the aspects of that plan is to attract GPs and other professionals to areas that have fewer doctors and are more deprived. So we are working with colleagues to see what schemes there may be that can help to pull doctors differentially into areas of greatest need.

Q5 Caroline Flint: Mr Tester, are you optimistic that these 5,000 doctors will go the places where they are most necessary?

Neil Tester: That will depend on how well the broader system—those who are commissioning services—thinks through what people are saying at the moment. What they are saying is that they understand that there are resource constraints and the challenges around some of these workforce issues. What they are asking the system in its broadest sense to do is to think as creatively and as boldly as people are prepared to do about who the best people to use are, and for which services, and about the challenge that that presents for the system in enabling people still to have somebody holding their interest all the way through those pathways—navigating people through with the right mix of professionals. So people we have spoken to are not remotely precious about whether or not they see a nurse, a physiotherapist, a GP or another professional when it is the right thing to do. Interestingly, also, they are saying that some of that navigation role could be played by people who are not necessarily clinicians themselves.

There is, however, that responsibility on those who are taking a whole-system approach to commissioning. That comes back to some of the things that can potentially be explored for the vanguards and the other big transformational changes at the moment, in order to get the right kind of patient and public engagement in those processes so that people do not make assumptions about what will work for local communities, but actually test out that thinking and co-create a new workforce mix with the communities that those professionals are there to serve.

Q6 Caroline Flint: Would you agree with the NAO Report that in meeting the sort of ideas that might help with the problem that is clearly here—public perceptions, sadly, are getting worse with regards to access to general practice—it is important to have data, evidence of data, basically to underpin new policies?

Neil Tester: Data comes up in almost every issue that we look at. I do not think that anybody would argue with that. The challenge is always determining what is going to be the right data to help to deliver the right understanding and drive the right change. Again, in rooting those questions about the right data to collect, it is as important to consider people's needs and future aspirations so that the right data collection can be got in place ahead of time. For the technical issues and the things that people might not have a personal view on, they might be prepared to leave that to clinicians and managers.

Q7 Caroline Flint: May I ask Professor Baker about the question of data? There seem to be huge gaps. A lot of data that used to be asked for stopped in around 2008 or 2009. There seem to be huge gaps in our understanding of the variations between one general practice and another. Some seem to offer—I think only about 18%—something like the 8 to 8 offer currently being put forward by the Government. About 40% of GP practices do not offer anything beyond the core contracted amount, from I think 8 to 6.30, and even with the 8 to 6.30 we have no data exactly on what is going on within those core hours, because it is left to GPs to decide. Given this absence of data to inform us about what is actually happening from one GP practice to another, the perceptions of the public as to what they want and the fact that the NAO Report clearly shows that there are quite a lot of differences in terms of access between different groups, but also the wants and demands of different groups, do you think it is wise for the Government to have a look at this prior to embarking on a five-year aim of an 8 to 8, seven days a week service?

Professor Maureen Baker: It would certainly be helpful for everyone to have an appropriate collection of data that does not impose an additional bureaucratic burden on the service. Basically, the data is there. Pretty much everything that happens in a general practice is entered into a computer and coded, so in terms of the way in which professionals enter data, that is there. The extraction of that data and then how it is analysed and used is a different matter.

In terms of variability between practices, again there are a number of reasons for that. Practices are in different areas. They have different patient groups, different demands on them. Some practices are fully staffed and some practices are not. There is a whole lot of reasons why there are variations between practices, never mind the fact that there are about 8,000 of them. You are obviously going to get variation when you have those sorts of numbers, but certainly the data and the entry of the data is there; it is just not being collected and analysed.

Q8 Caroline Flint: Do you think it should be? Do you think they need to come to some sort of agreed position on what data is essential to provide a good general practice service and reduce the variations?

Professor Maureen Baker: Yes, that is perfectly reasonable. If you have data that is collected as a by-product of the service, as it is in general practice, it is perfectly reasonable to collect that data in an anonymised, non-patient identifiable way and then to be able to use that for further enhancements to the service.

Q9 Mr Bacon: Professor, could you clarify one thing you said a moment ago? You said that of the 8,000 or so practices, some were at establishment; some were understaffed. Are you saying that that information—about whether they employ all the GPs they should or whether they employ fewer GPs than they should be doing—is already stored somewhere on a computer system at the GP's? Is that what you were saying?

Professor Maureen Baker: No, it is not what I was saying. Ms Flint said something about opening hours—some are open 8 to 8; some are open for their contracted hours of 8 to 6.30—and why there might be a change. I would submit that if you do not have enough GPs and nurses in the practice, it is going to be extremely difficult to extend your opening hours.

Q10 Mr Bacon: Yes, I understand that Ms Flint was asking earlier about opening hours. I was talking about your comment that pretty much all the information that one might need is available on a computer somewhere already and I was simply asking, regardless of whether it was what you meant earlier: is it the case that the information about which GP practices are at establishment and which are below establishment is already on a computer somewhere?

Professor Maureen Baker: No, because I was talking about the clinical data, which will include numbers and length of consultations, the sort of conditions that are dealt with, whether it's a GP, whether it's a nurse—all that data is on. I am not aware that vacancies as such are recorded on practice computers at the moment.

Q11 Caroline Flint: It has come to our attention through the Report that with our having gone from GP services being commissioned by PCTs and then it being reorganised to NHS England, something like 63 clinical commissioning groups are now solely contracting for GP services and another 89, I think, are contracting jointly with NHS England. Are we seeing a drift back to more localised GP commissioning of services, and what do you think of that?

Professor Maureen Baker: I think we are seeing a drift back and I think that is an appropriate direction of travel. One of the biggest problems we had with the move from PCTs to CCGs was that CCGs were not able to commission primary care or aspects of primary care. That may have been one of the factors that has led to the continued decline in the share of NHS funding that has gone to support the service of general practice.

Q12 Kevin Foster: What I find interesting, at a time when we are working longer, and when pensions are being reformed to reflect that, is figure 22 on page 47. The trend is for doctors to leave the profession more often and earlier than the retirement age of 65. There have been quite marked increases in those who are perhaps more experienced leaving in their 50s. What factors does the RCGP see as driving that?

Professor Maureen Baker: There are a number of factors. The retention of doctors towards the end of their careers is a hugely important issue. Don't forget that until recently the normal pension age—the normal retirement age—in the NHS was 60, not 65, so the doctors coming up to retirement are those who had been planning to retire at 60, rather than 65. But of more concern is the group of doctors between, say, 55 and 60.

Kevin Foster: That was actually the group I was referring to.

Professor Maureen Baker: Probably the main factor is just the pressure that practices are under—the extreme workload pressure, the fact that it is difficult to encourage people to come and work with us, and the feeling of lack of value, which is really quite important.

Q13 Kevin Foster: Is that a lack of value in a financial sense, given that we have had various debates about the salary doctors are now on, or a lack of value in a professional sense?

Professor Maureen Baker: It is about a feeling of being undermined and the derogatory comments. There is an article in the *British Journal of General Practice* this month, which we would be happy to send to the Committee. It was commissioned by Health Education England, and it looks at those factors that lead GPs to retire earlier. The analogy it uses is boiling frogs: the temperature goes up and up, and eventually you get to the stage where people are leaping out. One of the factors there was the sense of being undervalued.

Q14 Kevin Foster: Are people leaving medical practice completely, or are they moving into other types of medical practice?

Professor Maureen Baker: There is a bit of both. Some people just say, “That’s it. I’ve had it. I’m burned out. I’m not safe. I’m leaving.” Other people say, “I’m not going to continue in full-time general practice,” but they will still do some clinical work or other work related to medicine, such as appraisals or CCG work.

Neil Tester: In the work we have done with local healthwatch organisations, and in the deliberative research we undertook last year, people very clearly said to us that they see GPs as being hard pressed—they see them as being hard working and having too much to do. But they put a challenge back to GPs and their practices by saying, “You can do something about this. If you help us to use a different mix of resources, so we don’t always have to come back to a GP, we will respond to that.” In particular, people who had experience—either themselves or through their family—of dealing with long-term conditions often highlighted how impractical some things seemed. If a diabetic had been managing their condition for five years, they would know when they needed to see the dietician, so it was a waste of their GP’s time for that person to go to them and say, “Please can I go and see the dietician?” So people are full of very practical solutions to ease some of the pressure, but they absolutely recognise that pressure.

Q15 Kevin Foster: There is perhaps a role for pharmacists or others. Is that being looked at?

Neil Tester: Very much so. People have a very good experience of that. That is probably one of the areas of our work where there is least variation in how people respond: everybody seems to have a very good response to the changing and developing role of pharmacists. People get what the new offer from pharmacy is, and their experience of how it is being implemented is really positive.

Q16 Kevin Foster: Reading the Report, it is interesting to see that GP job satisfaction is at its lowest level since 2001. Has the change from PCTs to CCGs, where doctors, in theory, collaborate to

deliver certain services, had an impact on that, or is this part of an overall trend? What is the RCGP's view?

Professor Maureen Baker: It is not a main factor, but it may be part of a factor, in the sense that that is more work for practices. If you are going to participate, it will involve having members of your practice—whether a GP, the practice manager or a practice nurse—engaged in CCG work, and they are not then there in the practice. Overall, I think it is just one of a number of factors that are leading to more and more work—not just clinical work, because I would suggest that the administrative burden in general practice has increased significantly, particularly in the last five years. It is a factor, but one of many.

Q17 John Pugh: One of the arguments for CCGs rather than PCTs—because PCTs were not necessarily the things that GPs best loved most of the time—is that they empowered the GPs more than the previous system did. Is that a perception you share or have recorded, and if so, why are people less satisfied with their jobs than they were before?

Professor Maureen Baker: I think that was an aspiration for CCGs, and in some CCGs people would say, “Yes, we do feel that as practices we have more input,” but many do not. Again, there is a lot of variability. I think part of the trouble is that if we had enough doctors, nurses and managers, and there was more flexibility in the system to allow more participation in CCG work, you would probably get more of the satisfaction, but it is all just a squeeze at the moment.

Q18 Chair: Professor Baker, have you done any analysis at the Royal College of General Practitioners about how much time GPs now spend doing the commissioning work and taking time out of face-to-face time with patients, because of the way the CCGs are set up compared with the PCT model?

Professor Maureen Baker: I don't have that information. I don't think we have that.

Chair: If you have anything that would help us in that train of—

Professor Maureen Baker: We have done a lot of work on the GP workforce and how GPs are using their time, and it may be that we have that information somewhere. If so we are happy to send that to you.

Q19 Kevin Foster: Although it is welcome that women now make up 50% of the full-time equivalents, should we be concerned, given what was said earlier, that 22% of doctors and 28% of nurses working in general practice are aged over 55? Is this a reflection of young people not joining the profession, for example, or of people looking to work later into life?

Professor Maureen Baker: I do think there has been a problem, both in general practice doctors and general practice nursing, about attracting recruits into our profession. Again, that partly relates to perception of lack of money for the service, lack of support—all these things that we are now trying to rectify. I think the issue of nursing general practice and indeed community nursing is also really important in terms of the effectiveness of primary care.

Q20 Kevin Foster: In terms of bringing more people in, looking at the figures in figure 21 on page 47 around the number of training places, while the number of training places has gone up there is a sense, that gradually over the last few years the actual percentage of them being filled is falling. Do we see that trend reversing or not?

Professor Maureen Baker: Well, we need to see this year's figures and how the first round of recruitment for this year has done. There were indications at round three in the recruitment last year that things were starting to improve. We certainly hope that that is the case and we hope that we do see a rise in recruitment in the first round this year, but I have not seen those figures yet.

Q21 Chair: Given, though, that there is an aspiration to have 5,000 more GPs, and you want more than that, if we cannot fill the current training spaces what two or three things would you say we should be asking the Department of Health and NHS England to do to resolve that issue in workforce planning?

Professor Maureen Baker: We really need to focus on retention, as I was saying, of the GPs in the older age group, and I think we can do more work on returners. Again, GP returners is part of the 10-point plan work. I feel that the current system—the new, revised system—is still too bureaucratic.

Q22 Mr Bacon: Sorry, could you just say that again? GP—

Professor Maureen Baker: Returners.

Mr Bacon: What is a returner, for the avoidance of doubt?

Professor Maureen Baker: Because we have the performers list, over the last seven to 10 years, if you have left general practice and have not worked for more than two years—perhaps you have gone abroad or for family reasons—it has been incredibly difficult to get back on to the performers list. I think it has been a disgrace in that we desperately need GPs—

Mr Bacon: Even if you have been working as a doctor, but abroad?

Professor Maureen Baker: Oh yes—and in systems that are very similar to our system.

Mr Bacon: How mad is that?

Professor Maureen Baker: You may say so. I couldn't comment.

Chair: You can. You are speaking here for GPs.

Mr Bacon: You are protected from libel, by the way.

Professor Maureen Baker: It's been an incredible waste of money, workforce and commitment. We have started to improve that, but there is still a long way to go. I had correspondence from one of my colleagues in Scotland telling me of people who wanted to leave Scotland and work in England, and it was taking up to a year to get on to a performers list, even though they are GPs in Scotland.

Q23 Mr Jackson: I am sure the Permanent Secretary has heard your comments about men and women wishing to come back and retrain briefly to go back into general practice. You spoke earlier about push and pull factors that would induce medical students and newly qualified clinicians to go into general practice. Whose responsibility primarily is that aspect of workforce development? What comes out of the Report is the need to close the gap between different groups, and it seems to me that the issue is how we get GPs into areas with a very challenging demographic profile. Do you need to pay them more? Do you need to change the bureaucracy, the paperwork, the management, the commissioning? What are the two or three things you would say that the Government need to do?

Professor Maureen Baker: I don't think it is just about pay. It is more about an attractive, valued job, where people can feel that they can spend some time—although they may not wish to spend all their professional life there—in challenging areas and get a lot of professional satisfaction from that. I suppose it is like the Team GB cycling approach—it is about finding every little thing you can do that might improve things and putting them all together to try and make the whole package more attractive. These initiatives are being taken through the 10-point plan workforce group and we have been working on this for about a year now, but they are still starting to feed through and they are not all in place yet.

Q24 Mr Jackson: How important is the receptiveness or otherwise of NHS England? I ask that because in my experience, I had to intervene directly two or three times in a very big project—the amalgamation of two existing GP practices into one, which I had the honour to open in October, called Boroughbury in central Peterborough. That project almost went off the rails two or three times because of delays and bureaucratic stasis from NHS England. Is that still a problem, because it was an issue historically—responding to capital bids and ongoing debate about expansion or merger in federations?

Professor Maureen Baker: Our experience is that senior colleagues in NHS England—those who work at national level—are very engaged and keen to participate in discussions and suggestions and see how things can be made better. However, at local level, that is not always the case. No doubt there are reasons for that, but it can seem as though there is a blockage. Certainly, the systems and processes—I mentioned them in relation to the performers list, but I think they are there at all sorts of levels—act as barriers to things being done reasonably quickly, and that is something that we do see.

Q25 Mr Jackson: What do we need to do to unblock that?

Professor Maureen Baker: Could we do something about freeing up the bureaucracy in different areas? It is not just NHS England. Take, for example, appointing a new partner. There are various bits of bureaucracy that you have to do in relation to NHS England—they hold the performers list and various other things need to happen with them—but there is also now an incredibly tortuous process that CCGs have about appointing a new partner. Some of the things that they look for are the same as some of the things that NHS England look for, but you have to do it twice anyway. That is just one example, so there is a lot of bureaucracy with different organisations that practices really struggle to cut through.

Q26 Chair: David Anderson, the MP for Gateshead, sent us some interesting information. The Oxford Terrace and Rawling Road Medical Group says that an example of some of the challenges that you have highlighted, Professor Baker, was that contracting and performance management had previously been undertaken through one organisation and now it is through five different organisations. You are nodding your head, so you recognise that? It is not just in Gateshead.

Professor Maureen Baker: It is national.

Q27 Chair: Neil Tester, I suppose this didn't come across through your work, because you deal with patients mostly, who would not notice what was happening.

Neil Tester: It wasn't what we were looking for, but I think one of the themes that comes through both from our specific work looking at primary care, and from our general interaction with the local healthwatch network in terms of trying to work with local system partners to help bring people's voices through into change programmes, is that where those who are leading change think simultaneously and in a joined up way about what people are telling them and how they engage with clinicians and the managers who will need to implement the change—I had a really fascinating discussion in December in Manchester about how they are doing precisely that as part of the devolution experiment—there is a real opportunity to get everybody at least starting from the same place and trying to get to the same place, and it is then much easier for people to find ways to unblock the bureaucracy.

Chair: It is interesting that you say that. It is very much the mission of this Committee to put service users' needs at the heart of the services that Government deliver and put that back to Permanent Secretaries and other heads of service. David Mowat is going to finish our questioning on this panel.

Q28 David Mowat: Professor, I have been thinking about your use of the word "value" and your concern that your profession is not valued as it should be. At one level I am surprised. If you were to compare the average view of a member of the public to a GP, a lawyer, an accountant or even an engineer, I would say that your status or perceived value would be higher. I am interested in where you think this lack of value that is at the heart of the issues we are discussing about numbers comes from. Is it that you are in a big bureaucracy and somehow that bureaucracy does not respond to the things that you do?

Professor Maureen Baker: Very fortunately, patients value general practice. They value general practice and want more of it. That is quite clear. The lack of value comes from the GP-bashing we see nearly every day in newspapers and on television and it is demoralising. The ills of medicine, even to the extent of global antimicrobial resistance which is a real problem, if you read the media—the newspapers—it always seems to come down to being the fault of the GPs and it is cumulative. People are working incredibly hard, are very committed and really want to do their best for patients and the people they serve, but every time they open a newspaper, all they see is how rubbish they are. That really does get to people. Also, in the wider health care system, there is a lot of derogation of GPs, which again undermines morale.

Q29 David Mowat: It's interesting, because I am an MP and have been for five years. We get far worse treatment in newspapers than GPs do. I kind of shrug my shoulders and get on with it—they have to sell newspapers. I don't feel that makes me undervalued. I think it is such an important word that you used as the explanation why people won't go into your profession and why people are leaving. This is really serious. I am just trying to probe. I cannot believe it is just that the *Daily Mail* does articles on overprescription of stuff, sometimes.

Professor Maureen Baker: As I say, it is not just that, but that is part of it. That is what people tell me and what is coming through in academic articles. You may feel they shouldn't feel like that, but they do. It is part of the wider system as well. For instance, only last year we heard about students at their very first lecture in medical school. The first words they heard were, "The bad news is about half of you will end up as GPs."

David Mowat: Well, that is just poor practice.

Professor Maureen Baker: Yes, I am pulling out anecdotes to try and make the point. My colleagues do feel that they are being undermined and run down from a number of areas and it is damaging morale.

Q30 Mr Bacon: It just sounded to me as if you were damning your own profession for teachers standing up in medical schools and condemning GPs. That is plainly a problem that the profession itself needs to solve, isn't it?

Professor Maureen Baker: Indeed, and I have written to the General Medical Council and to the Medical Schools Council asking what they feel their contribution is to the production of a balanced workforce, because that is really important.

Q31 Mr Bacon: Because I would have thought that for the public as a whole, although of course they deal with consultants from time to time, their primary focus is with GPs—just as the primary focus of members of the public is with MPs not Ministers—and they regard their individual GP as a person of enormous importance and do not devalue them at all generally on a one-to-one basis. If that is the case, it is something the profession needs to take very seriously.

I want to ask you a quick question about the performers list. The Report says there are around 37,000 full-time equivalent GPs. How many GPs are there who are on the performers list, both part time and full time?

Chair: You can write to us if you do not have the answer.

Mr Bacon: No, I want to know the answer, and you must know this. There are around 37,000 full-time equivalent GPs, including trainees. I presume that also includes people who are working part time and full time, added up to make full-time equivalents. I am asking how many GPs there are.

Professor Maureen Baker: That data is available from HSCIC, and I believe it is in the order of 44,000. I have probably got it—

Q32 Mr Bacon: Okay, but NHS England has the performers list so it would know.

Professor Maureen Baker: Yes.

Q33 Mr Bacon: Do you know, of the non-performers—this again may be a question for NHS England—how many GPs could there be if all the leavers, as you call them, including those who are still working as medics, came back and became performers?

Professor Maureen Baker: We have no idea, because there has never been a system to track medical workforce.

Q34 Mr Bacon: Given the percentage who are leaving, as referred to in the Report, it could be quite a large extra number.

Professor Maureen Baker: Yes, it could be. Some of these people do come back. They can go through major difficulties and expense taking their career back up again in general practice. In terms of the number of doctors we train, those who leave for whatever reasons such as going abroad, we just don't know. There has been no system to collect that.

Q35 Chair: Can I ask a factual question? If we were all working as GPs, if we carried on working in medicine in the NHS, would there be a number following us to show that we were still working somewhere in the system?

Professor Maureen Baker: No.

Q36 Chair: Not even if you just leave?

Professor Maureen Baker: No.

Q37 Chair: That is very interesting, thank you.

I want to ask a final question of Neil Tester. I have a good set of information from Healthwatch Slough, which the Slough MP Fiona Mactaggart passed on to me. In Slough, the mystery shopping exercise I mentioned at the beginning showed that three GP surgeries did not even have a website, and five had good websites, rated 8 to 9. Healthwatch Slough is keen for those examples of good practice to be shared with other surgeries. The top ranking was 10 to 11, so five had very good ones but no one had an excellent one. Is Healthwatch doing anything to try to share best practice? If you have a brief comment on that, what do you think the Department or NHS England should be doing to ensure that we do not have any such as the three here with no website? Not that a website is everything, but it is a proxy for good access.

Neil Tester: Very satisfyingly last year we were brought into the National Information Board, so that we could bring people's views straight into that strategic level and get all of these technological and information issues right across health. That finding from Slough has been found by

other local healthwatch bodies, but also some real bread and butter stuff. Healthwatch Liverpool did a survey of people's experience of just phoning up to get an appointment: 47% of people had an incredibly poor experience and one woman said she had been on the phone for 47 minutes trying to book an appointment.

Some of this is really complicated technical stuff that will take years to resolve as the capacity of the system develops, but some of it is quite basic stuff. Often the local system working together can fix it. For example, Healthwatch Bradford identified a real issue with people's experience around receptionists and spoke about that to the CCG, which organised customer service training for receptionists right across the patch, which has had a really positive influence. Part of what we do is spread that good practice through the local healthwatch network.

Q38 Chair: Do you find that GP practices take it seriously? Or is just another burden for them? We have heard a lot from Professor Baker about a lot being thrown at GPs and that they are not all happy about that. I think it was the Slough stuff that showed that not everyone even had a proper message on their answerphone. Is that something you have come across more widely?

Neil Tester: Absolutely. While the solutions are looked at practice by practice, you will always find that some people have more of an aptitude and take more of a lead and more of a personal interest than others. The more people's needs can be considered across a whole population area in the way that they are by their local healthwatch, the more there can be a patch-wide response from all of the practices and commissioners in that patch. Then every practice does not have to reinvent the wheel or, in this case, reinvent the website.

Q39 Chair: To be fair, I should throw that back to Professor Baker, who is here primarily representing GPs as doctors. Would you say that it is acceptable in 2016 for surgeries not to have an answerphone message and a website?

Professor Maureen Baker: There certainly needs to be an answerphone message, for reasons of patient safety. In terms of websites, yes, it is good for practices to have them and I would encourage them to do so. For those who do not have a website or whose websites are not felt to be particularly good, it is probably a question of what their top priority is, given all the things that they have to do. Websites may not ever get to the top of the list.

Q40 Caroline Flint: Apparently 27% of GP appointments are avoidable. Wouldn't it be helpful to use communications to make sure that people see the right person in the right place at the right time?

Professor Maureen Baker: That depends on what you call avoidable. There was the question about, for instance, someone going to see a dietitian instead of a GP—if only they could. Or they could see a physio instead—again, if only. Counsellors would be fantastic, along with citizens advice services, benefit services, housing services and community mental services. If we were to have those services that patients could get to, preferably without actually having to go through the practice, that would be great. It is not the case that practices are sitting there blocking access to these services. We would be desperate to have them in place so that patients could access them.

Chair: Lots of things short of that which might be helpful could be put on a website. We could go further down that route, but the Health Select Committee is looking at this as part of its wider inquiry about GP services. I am sure that if you have not given evidence to them already, they would be keen to receive that. They are very keen to hear about access and the sort of things that we are discussing today, although we are primarily looking at funding.

I thank our first panel, Neil Tester of Healthwatch England and Professor Maureen Baker, chair of the Royal College of General Practitioners, for coming along. You are very welcome to sit in and listen to our main panel. The transcript will be out in the next couple of days, uncorrected and straight on to the website, so if you have any corrections do let us know. You are very welcome to feed anything back if you feel you have missed anything today. Thank you very much.

Examination of Witnesses

Witnesses: Simon Stevens, Chief Executive, NHS England, Rosamond Roughton, Director of NHS Commissioning, NHS England, Dame Una O'Brien, Permanent Secretary, Department of Health, and Ben Dyson, Director NHS Group, Department of Health, gave evidence.

Chair: Good afternoon. Welcome to our second panel looking at access to GP services. We have as our witnesses this afternoon Rosamond Roughton, the director of NHS Commissioning for NHS England; Simon Stevens, the chief executive of NHS England, one of our frequent fliers, whom we welcome back and wish a happy new year; and the same to Dame Una O'Brien, the permanent secretary at the Department of Health; and Ben Dyson, director of the NHS group at the Department of Health. At least a couple of you were here for the pre-panel, who gave some interesting evidence about access. Simon Stevens was not here for that, so I repeat that a lot of MPs have written to me with detailed experiences from around the country and expressed their concerns about access. It is an issue that they are worried about and that our constituents are worried about. I am sure that that will be taken on board. At the beginning I said that we were hoping to look at the vision for the future of GP services as well as at what is in the NAO report about access. I will now hand over to Caroline Flint, who is going to lead off on this.

Q41 Caroline Flint: You have all read the Report, and you have seen for yourselves some of the statistics which show that, while there are some very good parts of general practice about which the public feel very positive, the trend seems to be going the wrong way in terms of satisfaction with getting a GP appointment and access to services. For those of you who may not have been here in the previous session, it seems that if you are older, white, middle class and living in an urban area, you can get pretty good access, but if you are not in one of those groups it is not a good story at all. Perhaps I could start by asking Dame Una and Simon Stevens why overall satisfaction with access to general practice seems to be on the decline.

Dame Una O'Brien: I will say a few words, if I may, and then pass you over to Simon. We are absolutely determined to support GPs in reducing the pressures they are under, and we want to make it an attractive and valued job, just as Maureen Baker was saying in the earlier session. We are very mindful of the expectations of patients and of the inequalities that you referred to. Right at the centre of this, picking up Mr Mowat's point from the previous session, is that you cannot get away from the fact that 92% of patients trust their GP. Those are levels of trust that we civil servants or politicians can only aim for at some point in the future.

We know that we have got a service that is profoundly important to people and fundamentally important to the country, and I want to say at the outset that the Government are completely committed to the steps that need to be made to improve general practice. We have a four-pronged strategy of investment. Simon will say more about the rate of increase of resources that NHS England has now committed to on the back of the spending review. Secondly, on workforce, we have committed to 5,000 more GPs and, crucially, 5,000 more staff in practice by 2020. Thirdly, abatement of the workload has got a lot of detail around it which my colleagues Ben Dyson and Rosamond Roughton can talk about. There has been a lot of activity under way in relation to that, but we recognise some of the features that Maureen Baker described earlier. Bearing in mind, of course, that general practitioners are at the hub of a whole set of events in a local economy and a local society, there is much that happens around them that, if it were addressed—urgent and emergency care, for example—would alleviate some of the pressures on general practice.

The fourth dimension of our work is measures to support innovation. Principal among them is the effort that went into the Prime Minister's challenge fund in the last Parliament. Since the NAO reported, we have had the first evaluation report on that. I think it is very interesting to see the pace and type of innovation that is occurring within those practices that have had that additional support. That is information that we are keen to share today.

I just want to conclude my opening remarks by saying that there should not be any doubt about the very high value that we place on general practitioners as individuals and on general practice. Indeed, as I have said before to this Committee, improvements in out-of-hospital care and in general practice are absolutely fundamental to the long-term sustainability of the NHS.

Chair: If your answers could be shorter, that would be very helpful.

Q42 Caroline Flint: Thank you for that, and perhaps you can answer the question. Why is overall satisfaction with access to general practice declining?

Dame Una O'Brien: I think that it's happening for a number of reasons, one of which is the pressures that general practitioners are under. I think that that is reflected in the survey.

Q43 Caroline Flint: What has caused that?

Dame Una O'Brien: A range of things. Obviously, there are, in some parts of the country, workforce pressures. There are also rising expectations and, as Maureen Baker described, changes to do with the morbidity of the population, particularly the rising numbers of elderly people with multiple complex conditions, all of which contribute to a growing intensity of the workload.

Q44 Caroline Flint: There seems to be quite a lot of variation across GP practices when it comes to providing services—something between 0% and 52% of patients unable to get an appointment. The NAO Report suggests that that is not down to demographics; it is more to do with what is going on in the practice and how it is being managed. I will come to Mr Stevens for NHS England, but how do you see the Department of Health addressing that fundamental problem about how the practices are managed and whether they have the staff complement within them—not just

GPs but others, including administrative staff—in order to provide the outcomes that it would undoubtedly seem some practices are able to achieve better than others?

Dame Una O'Brien: Clearly, that is the case. This is a good point for Simon to pick up on some of the things that NHS England have been pioneering. The Prime Minister's challenge fund practices have started to reveal the significant steps that can be taken within practices to improve the way in which work flows and is managed.

Q45 Caroline Flint: Mr Stevens, why is satisfaction going in the wrong direction?

Simon Stevens: I agree with Una's analysis. The nub of the matter is that the demands on general practice have been going up, and the relative resourcing has not kept pace with that. Alongside that, the opportunity to change the clinical model, the business model and the career model of general practice is, at best, unfinished business.

Because people's backs are against the wall, they are now willing to contemplate doing things quite differently in primary care, and if we can provide the resourcing and some of the support for that, I think we will see quite substantial change over the next 24 to 36 months. That is what GPs want. They don't just want something on the never-never, five years out; they want to see the cavalry arriving now, and it is our collective job to bring that about.

Q46 Caroline Flint: Are you wedded to the idea of every general practice providing an 8-till-8, seven-day-a-week service to meet the problems we are having with the public getting appointments when they want?

Simon Stevens: No.

Q47 Caroline Flint: Why do you say that?

Simon Stevens: Because I do not think that that is what the public, or indeed the Government, are asking us to bring about.

Q48 Caroline Flint: What is the evidence used for that? Presumably, you believe that policies should be evidence-led.

Simon Stevens: Yes. That is not the ask being made of NHS England through the mandate that the Government have set for the NHS or, indeed, my interpretation of the Government's manifesto, nor is it something that, framed in that way, would be feasible, given the workforce constraints in general practice. Instead, there is a real opportunity to get practices working together more collaboratively locally. That is what the access fund—the Prime Minister's challenge fund—brought about for 18 million people in 57 parts of the country. Building on that kind of opportunity is, frankly, how we are going to get this expanded access.

Q49 Caroline Flint: I have not seen the report that Dame Una referred to, but I did look at something that the RCGP produced, which suggested that in a number of the pilots, for example, of opening on Sundays and even on Saturdays, there was very little demand for appointments at those times. Some pilots have therefore now restricted or contracted their offer. Is that the case?

Simon Stevens: The evaluation of phase 1 of the Prime Minister's challenge fund showed that demand was higher for weekday evenings and Saturdays than for Sundays. As we have said previously, when we talk about the seven-day service in the national health service, we are talking about three different things: first, the things we have to get right in hospitals and emergency cover; secondly, urgent out-of-hospital services for families that are easy to access and understand, combining what GPs do with what 111, urgent care centres and all the rest do; and thirdly, access to routine appointments. The solution to the second of those may be different from the solution to the third.

Q50 Caroline Flint: Coming on to the commissioning of services, both as it is happening now and thinking about the future, as I said in the previous session, it has come to my attention that having moved GP commissioning from PCTs to NHS England—I have to correct myself on this: 63 CCGs are now providing sole commissioning in that area, and 86 are doing it jointly with NHS England; I think I said 89 in the previous session—are we seeing a drift back to more localised commissioning of services? If so, why is that?

Simon Stevens: We are. One of the reasons is that we are actively encouraging it, and one of the reasons we are actively encouraging it is that we think it will help with the service redesign across primary care, hospital out-patient services and, indeed, some specialised services if we can take a whole population view as to how things are working in a particular town or county. There obviously are important protections that we need to bring nationally to some of those decisions around conflicts of interest, and the Committee and the NAO have reported on that in the past.

We expect a further number of CCGs to take up that opportunity from this coming April, so we will probably have about 55% of CCGs with full delegation on primary care decision making from April 2016 and a further third doing dual key control. The vast majority—more than nine out of 10 CCGs—will be taking the opportunity to look in the round. In parts of the country you can already see the benefits that has brought: for example, in Tower Hamlets the ability of the CCG to make these kinds of decisions has enabled it to deal with some of the difficulties that have arisen as a result of changes to what was called the minimum practice income guarantee.

Q51 Caroline Flint: That is a big change, it seems to me. It suggests that the move from the PCT to the NHS England model of commissioning may have been rather rash, since we seem to be going back to a PCT type of commissioning all over again, albeit with some changes. Is that the case?

Simon Stevens: As you say, with some changes—some significant changes. One of the significant changes is that where CCGs work well they have much greater clinical leadership than did their predecessor PCTs. As I understand it, the judgment was made in the transition from the old arrangements to the new, at least in the first instance, so as not to overburden these new CCGs with the full range of responsibilities but to get them focused on commissioning local community and hospital services. As they mature, subject to the safeguards that we apply through the assurance oversight, they will have the opportunity to take on more responsibilities, one of which will be primary care.

Q52 Caroline Flint: May I ask about the basis on which decisions are made about what is good practice and what should be expected? The NAO Report identifies gaps in data as being a problem for being better able to share good practice, which is currently clearly out there in parts of our general practice service, and also for being clearer about what the demand is for access to GPs and, within that, to the primary care family that may be within a practice but may be outside the practice as well, in the form of pharmacies, opticians or anyone else. Do you believe that there are significant gaps in the data that is required to provide advice—I put this question to Miss Roughton as well—and if so, what areas of data do you feel should be asked for? I think it is there in the system, but what data should be extracted from the system to better allow policies on access to be evidence-led?

Simon Stevens: I agree with the thrust of that point, including the recommendation that the NAO Report gives on data in this area. I have sometimes been a bit critical of the proposition that we should just keep sending out Excel spreadsheets to all and sundry and getting them to fill them in every 10 minutes. When the BMA asks GP practices what they find most irritating about life, or what would make the biggest difference, three-quarters of them say more GPs and more funding, but two-thirds of them say, “Cut the bureaucracy—the number of questionnaires we have to fill and the responses we have to send,” so we have to be cautious about asking for more of that, but, particularly when it comes to the question about workload and consultation, we do think that having more granular tracking of what is changing would be useful. As you know, the national dataset was discontinued in 2008, so we have commissioned the National Institute of Health Research to look at a longitudinal sample of 250,000 patients over the past 10 years and to show us how workload and the consultation rate has changed. We will get the results of that study later this spring and I think it will be very important in filling in some of the data gaps that are referenced in the NAO Report.

Caroline Flint: Miss Roughton, do you want to add anything in terms of data and evidence leading policy?

Rosamond Roughton: Yes. It is not just about what we have nationally, it is also about what practices have locally. We have commissioned a software tool for the practices that are part of the second wave of the Prime Minister’s GP access fund, so that they can track demand and are therefore able to match capacity to the peak times of day and peak days of the week when that demand exists. That should enable us to collect all that kind of activity data, not just at national level but for practices to use, so that they can design the services that their patients are expressing that they need.

Q53 Caroline Flint: May I ask you about the differences between groups of people? The NAO Report indicates that among older people, within the context of this discussion, there is quite a lot of satisfaction about their access to GPs—and there should be, because apparently they get more access than anybody else. Also, however, it seems that that older age group are much more willing—perhaps because they have a long-term condition that they are part of the management of—to wait a couple of days to see the GP or maybe the practice nurse, or even the pharmacist to get a repeat prescription. That is very different from the younger working-age group, who may not go to a GP that often, but when they do they find that there are very few opportunities to get an appointment at the time they want and outside their working hours. So how does extending opening hours to seven days a week for every patient show real value for money and how is it going to meet the needs of that younger age group?

Rosamond Roughton: All the evidence we have shows exactly that age and working status is the biggest correlating factor with satisfaction. If you are full-time employed, you are likely to be most dissatisfied with getting access to general practice. The experience we have had through the Prime Minister's GP access fund scheme shows that there is huge untapped potential around the use of technology and the wider workforce. Some of the schemes have implemented at scale telephone consultations, which has great opportunity for people to have a phone consultation potentially at a much more convenient time for them, or call-backs to work out whether they need a face-to-face appointment. In terms of opening hours, it is a question of matching that to the demand. For some people it may be more convenient to have appointments on a Saturday morning or after work in the evening, if they work traditional working hours. The other aspect of that is that we have seen that, with the rise of telephone consultations, it has freed up GPs to have longer appointments with patients with more complex needs, where a longer appointment time is needed. We are going to build on what we have learnt from the experience of the last year and a half from these schemes about not just thinking of general practice as being seeing your family doctor. General practice is a much bigger service than that.

Q54 Chair: Can I say, Rosamond Roughton, that some of these things are not new. There have been lots of initiatives under pretty much every Government to do some of those things. Every Government has someone who has got an initiative with their name attached to it and money has been chucked at it. We are looking at this Report and the work we have done preparing for this, but it is not rocket science that where there is really good practice, it could just be rolled out. What is NHS England doing to make sure that the best practice is rolled out?

Rosamond Roughton: Two things. First, in terms of what we have learned from wave 1—and you are right; we are building on some of the experience from the past 15 years—we have been running a series of webinars. We have buddied up practices that are doing innovative stuff with the practices coming on stream to do it. Secondly, now that we have got the settlement from the spending review, we are looking at what we have learned, including from the NAO Report, about the best way now to improve access in order to meet the mandate we have been given to meet the Government's manifesto commitment on access.

Q55 Chair: Apart from the numbers of GPs, which obviously is costly, surely there is some saving potential if there is a good website and good phone contact; you are saving the time of GPs. Has that been properly evaluated?

Rosamond Roughton: In some of the schemes we have seen, phone consultations typically have been probably about half the length of a face-to-face consultation. Some of those phone consultations do then translate into face-to-face, so it is not a straightforward sum, but yes, we will be factoring in what is the impact of technology of being able to reduce the workload as well as technology being able to meet the needs of a wider range of the population than is currently the case.

Q56 Caroline Flint: As the Chair said, some of this is not new. I seem to remember quite a lot of discussion about this when I was Public Health Minister. I am a big primary care person, because prevention is sometimes better than the cure. I am trying to think about webinars and other ways in which you can train and share information, but sharing best practice across public services, not just

the NHS, seems to be one of the most difficult things. I suppose the webinars and what have you, are the carrot, but what about the accountability? GP practices are businesses. They are contracted for services. The Department of Health gives the NHS a mandate to ensure that certain things are done. Where lies the accountability in this on those GP practices that are not meeting the best of practice? This question may be to Dame Una as well: should there be a different model for providing these primary services in the 21st century that looks beyond the contracted services to something else—possibly more salaried GPs who do not want to run a practice but would love to spend part of their early career involved in some of our most hard-pressed communities, which so need very good access to healthcare?

Simon Stevens: Exactly.

Caroline Flint: Oh good.

Simon Stevens: To some extent that is beginning to happen all over the country, and what we have to do is accelerate and support that trend. Obviously, there has been a steady increase since 2004 in the proportion of GPs who have chosen to be salaried, but the fact is that partners play a very important role in anchoring practices and having an ongoing relationship with their local communities. Through the so-called vanguard programme on the back of the NHS Five Year Forward View, we are sponsoring groups of GPs coming together in scaled primary care, making better connections with community nursing and the community health services and social care in their areas. We have 14 of these across the country. We expect to see big adoption of a new voluntary contract which GPs have asked us to produce in time for April 2017, so we are working with groups of GPs who want to have that on offer. It will bring together a much wider range of services than just the core traditional general practice.

I think we are going to see really significant change in the way in which primary care is organised, as long as we stick with the piece that people really value, which is list-based personalised care, recognising that different patients have different expectations. The NAO data drawn from the GP survey, as you said Caroline, shows that while that older people or people with long-term conditions may value continuity, the working-age population with an urgent need probably just want it sorted and are not too fussed exactly how that's done, so we have to be more differentiated in our offer.

My reading of the last 10 or 15 years is that part of the problem is that we have had some one-size-fits-all solutions via the national contract, which has not been sufficiently sensitive to some of the differential pressures or starting points in different geographies around the country. We have then layered on top of that individual initiative funding streams and so forth; each has its own logic, but when you turn up in Leicester, Manchester or Swindon and ask, "What does this really mean for this community?" you find all these legacy initiatives running side by side, to some extent contradicting or cancelling each other out. We are not getting the best value for the money and it is not really working from the GPs' point of view. Simplifying and bringing coherence to the primary and community care piece is the big task before all of us over the next two or three years.

Q57 Caroline Flint: Politicians of all parties like to have simple answers. They want access for everyone within 24 hours, 48 hours, seven days a week, 8 to 8. I think that is a combination of Labour and Tory Party policy putting them together. You have given a very important answer about policy being evidence-led as to what works and ultimately what improves health outcomes. Do you feel that, regardless of—I wouldn't say target—the parameters you have been given, you are going

to be enabled to provide for diversity that meets need, rather than the dogmatic approach, which may not in itself provide good value for money? We and those listening to this should not go away thinking that there is going to be a one size that fits all; it's going to be much more flexible than that.

Simon Stevens: It is and that is at the heart of the whole Five Year Forward View proposition about how the health service needs to redesign care. It will need to be horses for courses. That said, there are some big things we have to get right nationally. We have to get the GP workforce expansion that we want—go hell for leather to get ourselves 5,000 more doctors in general practice. If we can get more, we should get more. That is an important part of it.

There is a really interesting report—I don't know whether the Committee has seen it—that was published in October by the NHS Alliance and the Primary Care Foundation, looking at the way in which GP consultations are used. As I was looking at it again over the weekend, I thought that one sentence captured the argument beautifully: "The strength of British general practice is its personal response to a dedicated patient list; its weakness is its failure to develop consistent systems that free up time and resources to devote on improving care for patients. The current shift towards groups of practices working together offers a major opportunity to tackle the frustrations that so many people feel in accessing care in general practice." It goes on to offer some practical propositions for how to do that. I think that that is the right diagnosis.

Q58 Caroline Flint: Dame Una, going back to the issue of data—you may want to comment on some of the previous questions—why have you not collected any data on activity in general practice since 2008-09? It is not a matter of data for data's sake, but data on the nature of the workforce, on what the public want and on what works, in terms of why some practices are doing better than others with equally challenging catchment areas, is surely all crucial to providing the best sense of direction for what works for the public and to sharing best practice. Why has that data not been collected in all this time?

Dame Una O'Brien: The precise thing that was stopped in 2008-09 was the collection of data on consultation rates. It is equally true to say that there are other sources of data about different aspects of general practice, so I would not want the impression to be left that somehow we have been in a data-free zone since that particular collection was stopped.

In the course of the past 18 months, as the pressures on general practice have intensified, it has become evident to us that we need a much more comprehensive understanding of what goes on within general practice. That is why we have supported the commissioning through the National Institute for Health Research of the work to be done by the Universities of Oxford and Bristol that Simon Stevens touched on earlier, to look at all these aspects of workload and consultation rates. When we have the results of that, we are going to consider how we can maintain that flow of data into the future; we are not going to do it as a one-off.

The second thing to say is that the GP patient survey is a hugely rich source of data—indeed, it is widely quoted in the NAO's Report. It has been a very powerful proxy indicator of the pressures on general practice, and we have used it in our planning, along with other data and information. It is important to put that on the record.

The third thing to say is that there are currently well developed plans to strengthen the data about workforce, in particular—this was mentioned earlier—absence and vacancy rates within general practice. That has been in development over the past year, and during 2016 we expect to

have much more comprehensive, granular data from HSCIC, giving a more comprehensive breakdown of what is happening in the workforce within general practice. I am sure my colleagues can comment in more detail on what that involves.

In summary, there has been a hiatus in that level of inside-practice data but I would not want there to be an impression that we somehow have planned without data, because we have many other sources of data on which to draw.

Q59 Chair: On that point, the NAO Report tells us that 24% of female GPs are part time, and 7% of male GPs are part time. This may be a question for Ben Dyson, as I gather you are the workforce planner. When you are looking at full-time equivalents and planning how many bodies to get into slots and how many consultations patients will need, are you factoring in that trend of part-time work? It is about a quarter of female GPs, which is quite significant.

Ben Dyson: Absolutely. The workforce modelling that is done to tell us how many GPs we need to see come out of training and how far we need to increase the workforce through improving retention and return to practice takes into account those trends, including rates of part-time working. As Dame Una says, the workforce minimum dataset, which will be collected from all practices this year, will give us much more granular information about the different staff who work within general practice, how many sessions they do and levels of vacancies.

Q60 Chair: So it is not an issue of concern. You have got it all in hand. Is that what you are telling us?

Ben Dyson: It certainly remains a challenge to make sure that we grow the workforce at sufficient pace to meet the growing demands that have been described earlier. I don't think anybody is at all complacent about the range of efforts that we need, across increasing the number of training places, boosting the number of doctors in training who want to go into general practice, increasing rates of retention and supporting those who want to return to practice. We need to take faster action on all those fronts in order to make sure we have got 5,000 more doctors working in general practice by 2020.

Q61 Mr Bacon: On this point, I asked earlier, but you as NHS England—I am sorry; you are not NHS England but the Department, but one of you will know the answer to the question: how many performers are there on the Performers List, whether they are full time or part time?

Ben Dyson: We have data on both headcount and full-time equivalent GPs.

Q62 Mr Bacon: There are 37,000 full-time equivalent GPs. I would like to know: how many GPs are there, whether they are working full time or whether they are working part time, who are actually recognised as on the Performers List?

Chair: Professor Maureen Baker thought—though she acknowledged she might not be accurate—in the order of 44,000 individual GPs.

Ben Dyson: We know there are 40,500 or so GPs in headcount terms, which translates into the 36,920 in full-time equivalent.

Q63 Mr Bacon: That's people who are on the Performers List?

Ben Dyson: The Performers List would, I think, also include some other GPs—for instance those working in out-of-hours services. I think we would need to go away and check how far the Performers List marries to the number of headcount GPs.

Q64 Mr Bacon: I would like to know how many people are on the Performers List. I would like to know: how many GPs are there extant who are currently recognised by the NHS in England as being capable of working as a GP now, today? We can get on, perhaps, later, to the question of people working in Scotland who take a year to get recognised in England, if, of course, that was not just a story that the professor read in the *Daily Mail*; I do not know. I am just trying to find out how many GPs there are.

Dame Una O'Brien: Can we write to you with that precise detail? The key thing is that we match the number to the Performers List and, as Ben has said, we need to take account of GPs who are working out of hours who may not be working in routine general practice.

Q65 Kevin Foster: It sounds interesting to have a look at: a group of people where we are having expansion and more people coming in, with, in theory, investment, and the idea—a few years back we were told—that they would be more empowered over the services they are delivering. Yet at the same time we are seeing increasing numbers leaving the profession, and the rate between 55 and 64, which I touched on earlier, has approximately doubled in about a nine-year period. Why, in your view, are more and more GPs leaving the profession, and what analysis are we doing to really drill down into those reasons? Perhaps Simon Stevens would like to start.

Simon Stevens: Well, I think that the GPs I speak to would say it is a combination of workload pressures and a sense of not controlling your own destiny but being done to, rather than being able to shape what their future looks like. That, I think, is the perception that a lot of GPs have, and to some extent that is the reality; so part of what we have got to do is change that through the mechanisms we were talking about in response to Ms Flint's question around the new care models, around the practices that are coming together now, so that there is shared support for individual practice units and people are not just left to fend for themselves, often under quite difficult circumstances. I think that is part of what GPs want to see.

I also think they want to see a dialogue with the public about the circumstances under which it is right and sensible to seek to go and see your GP as against interacting with other parts of the healthcare system or, indeed, get advice and support on looking after your own health. Those are some of the things that GPs say to me they think the future should represent.

Q66 Kevin Foster: I am conscious that it is very easy to go into a lot of stuff being done, and that we can look at anecdotal examples. We can all look at the example of the story that was in the paper last week, and I think those are very much the sort of points we had picked up in the earlier

panel; but have we actually done anything to get any qualitative data, perhaps from exit interviews from those leaving general practice, to find out the exact reason why they have left?

Rosamond Roughton: We are in the middle of doing some work with the Royal College of General Practitioners, doing structured interviews with people of that age group. That is more about the circumstances in which they would they be encouraged to stay in general practice, so as to understand that.

We have not got the final findings of that, but the early work shows things like being able towards the end of your career maybe not to have such a full workload, so perhaps doing more mentoring or supporting in a practice. Someone might stop being a partner but remain a doctor within the practice and perhaps do fewer sessions a week. So we are doing some more structured research around it, rather than just anecdote. That will shape what we do in terms of the retention, which was Ben's point earlier. That is an important element for us to be thinking about.

Q67 Kevin Foster: I can see Mr Dyson nodding. Perhaps he would like to add something.

Ben Dyson: Just to back up. There are two facets to this. The first is the targeted action that Ms Roughton has described, to understand the reasons for the GPs in the age group 55 to 60 in particular, of what would encourage them to stay. That does appear to be a mix of quite specific things about more portfolio careers, opportunities for coaching and mentoring. It is also about putting alongside that these more generic factors that colleagues have described, to encourage people to remain within the workforce.

For me, one of the things that we hear time and again from GPs is that some of the frustrations lie in the interactions between them and other parts of the healthcare system, which is why we think there is such promise in the work being done, particularly by the vanguard sites, to bring together general practice with community nursing and other health services, to break down those rather artificial boundaries between different parts of the health service that have existed over time. Obviously, predominantly for the benefit of patients but also to provide better working lives for everybody within local health services.

Q68 Kevin Foster: Finally, Dame Una, are there any thoughts you have on that particular point?

Dame Una O'Brien: It is the right question, to ask people what it would take to keep them here, rather than walk away hopelessly and think people are just going to drift off. A general practitioner in his or her 50s is a highly experienced and deeply wise person, we would hope. The younger people coming into general practice will benefit hugely from having people like that in local federations and practices. The work we are doing on retain and return is very much part of the endeavour to reach the 5,000. We think that potentially 1,000 of those GPs will be from that category so we are focusing on that.

Q69 Kevin Foster: Returners to practice rather than as we normally assume 5,000 people coming into practice.

Dame Una O'Brien: Return and retain.

Q70 Kevin Foster: I am interested in whether any analysis has been done on the impact on patient care of so many of the most experienced leaving the profession.

Rosamond Roughton: We collect about 70 indicators about outcomes by practice. What we can see of the trend over the past three years is an improvement in terms of the patient outcome indicators. At the moment we are not seeing a huge deterioration. What we are seeing, though, is this workload pressure reflected in access. Access is a significant quality indicator but, in terms of once people are with their GP, we are not seeing deterioration at the moment in any of those indicators.

Simon Stevens: The number of whole-time equivalent GPs is actually going up. It is higher now than it was five years ago. It is a fifth higher than it was a decade ago. The point is it is not going up commensurately with the extra demands that have been placed on primary care. That is why we have had 5,900 whole-time equivalent GPs up over a decade. We want almost that amount over the next five years, not over a decade, so almost double the rate of acceleration over the next five years to try to make good on that cumulative gap that has arisen.

Q71 Kevin Foster: Probably that gap is producing the figures we see about job satisfaction among GPs being the lowest it has been since about 2001. What change do you see being made to deal with that? What analysis have you done to get to the bottom of why people's job satisfaction is falling compared with what it used to be?

Rosamond Roughton: To reiterate some of the points made by Professor Baker earlier, workload is probably one of the biggest issues. I know that the BMA did a survey last autumn to which 15,000 GPs responded, and I think workload was the No. 1 thing. The things that we need to do to support that are around workforce. It is not just about more doctors. It is about the wider workforce: we launched a scheme last month about clinical pharmacists in general practice. It is about technology: we are making funding available to enable more practices to do online, phone and web-based activity, which helps with workload. It is about working at scale to build resilience: where practices can work together more, they can build their own resilience.

It is also about what we can do to support and enable self-care. All that kind of work is building on a general trend, but we have now been able to fund things, working with the voluntary sector, to divert patients away from general practice. Workload is probably the No. 1 thing, in all the different ways in which this has been analysed, that we need to tackle.

Simon Stevens: It is important to draw out that by workload, we also mean the composition of the work. What a lot of GPs say, as well as the GP work-life balance survey, is that 62% of GP time is spent in face-to-face clinical care. Add in another 20% or so of indirect patient care, and one fifth of the time, equivalent to a day a week, is still spent dealing with other requests, burdens and reporting, looking at paper-based letters that have come back from the hospital and so forth.

Those kinds of non-value-added demand on GPs are a source of both frustration and opportunity. If we can engineer them out of the system, it frees up time for doing the distinctive clinical work with which GPs really make a difference, and which is frankly what brings people into general practice in the first place. Citizens Advice says that a fifth of GP consultation time is tied up with welfare claims, counselling, personal relationships and so forth. All of that is our opportunity, in that there are a lot of expectations on GPs that are not about what they came into medicine to do.

Sir Amyas Morse: Just a couple of reflections, looking back over the last few years. Surely a lot of this growth in workforce is in fact due to requirements that have been placed on them from the centre. Isn't that right? Are you planning to actually measure the amount of admin and requests you are making as a whole that are coming to them from the Department or from the health service, and to drive those down? That is my first question.

The second one is whether you think that the pension arrangements provide a kind of trigger for people to think of retiring. I have quite a lot of medical connections, and they seem to talk about it an awful lot. The people I see retiring seem to retire at just about the time when their pension maxes out. Then they might go back into clinical care, or do something different from what they were doing before. Those are just a couple of thoughts.

Rosamond Roughton: On the first one, the report that we commissioned last autumn showed that some of the additional workload is a burden resulting from national systems. The two things that we particularly want to do are to streamline reporting requirements with the Care Quality Commission and the General Medical Council, so that of the three bodies that might ask for data, if one of the other bodies has it, we are not all asking the same question three times or in slightly different ways. We are working on a concordat with them, to be clear about that.

The second area is about payment systems. We are looking at the feasibility of creating a simpler payment system for general practices, so that they do not spend time chasing down payments from all the different bodies with which they are contracted. I would say that that report showed that there was huge potential within the practice itself to manage its demands. In the audit that they did, 20% of consultations could have been handled by a different part of the system.

Sir Amyas Morse: It is just that they do mention it. The only variation that I would suggest would be to stand where the GP stands, as opposed to where the various Departments and the CQC stand, and say, "Never mind where it's coming from. What's the whole basket of things?" Might I ask you to comment on the pension point as well?

Simon Stevens: Since pensions are a matter of Government policy rather than that of NHS England, I will ask Una to explain.

Dame Una O'Brien: This is not about general practitioners. The Committee knows very well that the tax on pensions is a policy that applies across the workforce. If I have understood it correctly, you are referring to the lifetime allowance. Is that correct?

Sir Amyas Morse: Either that or if, for whatever reason, when they reach the point that the money they put into their pension—the added years they can buy, or whatever it may be—reaches a maximum, there seems to be a change in thinking in quite a number of people one comes across. Whatever the Government policy may be, I am just asking what the effect of it is, rather than trying to ask about the policy.

Dame Una O'Brien: Currently, we do not have any evidence that people are leaving in droves because of this, and it certainly isn't showing up in the numbers. My experience is that people—

Mr Bacon: Sorry, but could you just say that again?

Dame Una O'Brien: We haven't got evidence in detail that people are leaving in droves precisely because of this pension issue.

Q72 Mr Bacon: How much evidence of that kind have you looked for?

Dame Una O'Brien: Well, as I say, it is not—

Mr Bacon: I have found it.

Dame Una O'Brien: It is not showing up in the numbers that we have an excess of leavers over joiners.

Q73 Chair: There is the age profile. They are leaving at 55, rather than 60.

Caroline Flint: And the people working as locums are over 50.

Dame Una O'Brien: Any more than might have been the case in the past. The contemporary issue that people raise is the one about the lifetime allowance and that that hits much earlier than when people are maxed out on their pension contributions. So, it is a risk, but it is not one that we currently anticipate is going to lead to excessive numbers of people leaving, although we have taken account of this in the modelling on the numbers of leavers and joiners.

Sir Amyas Morse: It is great if you take account of that in your modelling.

Ben Dyson: May I just add that the lifetime allowance doesn't mean that they have to stop paying into the scheme? As you know, it means that they are no longer subject to the same tax relief arrangements. In a number of cases, it will still be financially beneficial to continue to contribute, particularly if they take advantage of the "scheme pays" arrangements.

Sir Amyas Morse: I am only a little surprised. I am not trying to argue with you. If you are doing all this survey work, why don't you just ask the question? I am just astonished by how many people tell me that.

Q74 Mr Bacon: I find this absolutely extraordinary, to be perfectly honest, Dame Una. You don't have any evidence. A great burden of what we have been talking about is GPs not staying, being burnt out, feeling undervalued and leaving earlier and earlier. I have had GPs in East Anglia who are in their early 50s—not 55 but 51—say to me, "It has got so bad that people like us are thinking of leaving." To which my response, although I didn't say it to them, was, "My, you can afford to, then, can you?" The reasons are because they have earned enough money, they have bought extra years and they can afford it. It is not necessarily that they will be lost to clinical practice. Mr Dyson, you made the point that other financial options are open to them, too. Yes, there are, but those include leaving and coming back as a locum at a very healthy day rate, costing taxpayers a great deal more—a huge amount more—without the responsibilities that they hitherto had. You have no evidence that this is what's happening. I can tell you from the ground that that is what's happening. It is happening now.

Dame Una O'Brien: Sorry, I was answering a question in a different way. I had understood that the question was, "Are the changes in the pension rules, in a sense, making people feel forced to leave?" I was explaining that they weren't. I do not deny what you have just said.

Q75 Mr Bacon: They might not be forced to leave, as in with a gun held at their head, but you place incentives in front of people to do x, y or z—or p, q or r. It is hardly surprising, when the incentives point in a particular direction, that they do it. By the way, while I am at it, I should exempt Mr Stevens from any of this. He mentioned the cavalry earlier and, in the Waveney valley, Mr Stevens is regarded as the principal man in the cavalry. While I am at it, may I just thank you for what you did just before Christmas in relation to our community hospital? It was very, very well received. If you come to our area, we will find garlands of flowers for you.

Chair: Mr Stevens, it doesn't get any better than that. You have reached the high point of the Public Accounts Committee.

Simon Stevens: It is going to be downhill from now on in 2016.

Q76 Chair: I am going to go back to Kevin Foster, who has been patiently waiting. The point, as you will gather, is that in preparation for this sitting we were exercised by the age profile.

Dame Una O'Brien: I accept that.

Q77 Kevin Foster: Going to the other end of the careers spectrum, looking through and seeing the slow decline in the percentage of spaces being filled on the training course, the numbers are actually staying remarkably consistent even with the places going up. What has been done to make the job of a GP look more attractive to those thinking of coming in the door? We can talk about those going out, but if we are to meet that target of 5,000 extra GPs, we need more people coming in the door at the other end.

Ben Dyson: I am happy to begin, but colleagues from NHS England may want to add to this. The first part of the 10-point plan that Professor Baker referred to earlier—which is a joint plan between NHS England, Health Education England, the Royal College and the BMA—is to make general practice a more attractive career option. Two specific things happened last year. First, a number of regional roadshows were undertaken, which were specifically targeted at people who might be thinking about choosing general practice as a career. Secondly, and on the back of that, a major campaign was launched in September called Nothing General about General Practice. Again, this was specifically aimed at those foundation-year doctors who are coming to the point of having to make career choices.

A lot of that is trying to correct some of the myths and misinformation that have grown up over the last few years about what it means to have a career in general practice. Some of the anecdotes were referred to earlier. It is still very early days, but there are some encouraging signs that it has had an impact. In round three of last year's recruitment, there was a fourfold uptake in the number of people applying for general practice places. We ended the year with a higher fill rate than we had the previous year, and with 100 more people taking up GP training places than the previous year.

Q78 Kevin Foster: Has any work been done with that cohort to find out if there are particular reasons for this and what might have attracted them? Was there was a particular strategy which might have encouraged them to think that general practice was the right route?

Rosamond Roughton: In designing the campaign run by Health Education England and the RCGP, there was a lot of work with both young doctors and doctors in their first five years after medical school. That is what shaped that campaign.

Q79 Kevin Foster: I am interested in whether some analysis was done after people have made the choice, either the exit interview we talked about earlier or in this case an entrance interview. Was any work done to ask doctors why they made their final decision and which factor tipped them towards this, rather than the other choices they had? Is that sort of work planned or being done?

Rosamond Roughton: I would assume that that is part of the HEE and RCGP work planned.

Simon Stevens: But we will follow that up specifically. As you know, Mr Foster, the talk about the percentage fill rate can leave slightly the wrong impression, unless you get under the numbers. The number of GP training places has been going up, but the number of people going on to GP training has been fairly constant. So in proportional terms it looks like the fill rate has been going down, but actually the point is that we have been creating more training places but we have not been able to fill them. However, as Ben said—

Q80 Kevin Foster: That is exactly the reason why I asked the question. If we are increasing the number of GPs, of course we want to increase the number on the training course by upping the places. However, if we then do not fill those places, we do not get new GPs.

Simon Stevens: Which we are doing and have succeeded in doing. As Ben said, the good news is that over the last round we have actually seen a meaningful increase. We want to reproduce that result going into the next round for 2016 as well. That is obviously really important if we are to get 3,250 places filled. There is also a geographical piece to this, which is not very straightforward to answer. As I understand it from HEE, we could basically create GP training slots in London and fill them as long as your arm, but if we try to do the same thing in parts of the east midlands or parts of the north-east, all we get is lots of vacancies. There is the question how we make it geographically attractive for top quality new doctors to choose general practice in parts of the country where otherwise we would have real supply problems. There we are going to have to look at financial incentives. We are doing that with HEE, and we are going to have to look at other ways of making that a really attractive thing for people who want to combine GP training, maybe part time, with flexibility for women going into general practice and so on. It is a spatial question across England as much as an aggregate question in terms of the overall numbers.

Mr Bacon: May I answer your question?

Chair: No, not now. We know you will tell us that self-build is the answer. Let Kevin Foster get in.

Mr Bacon: We need a self-build and custom housebuilding Act, Mr Stevens.

Q81 Kevin Foster: In terms of analysing the demand—the need for those types of solutions—I can think of a GP surgery in Torbay that wrote to its patients to point out that it had taken about a year to actually recruit someone, and it was still going through the process of authenticating them. How do we analyse where that demand will be? Again, it is easy to tell anecdotal stories of being able to fill up London as long as our arm, and I accept that that is the case in other parts of the country. You only have to look at the map in the Report to see that some areas across the country are actually quite well resourced—a higher percentage of GPs and nurses—yet other areas that are very similar or close at hand did not have that. How do we see it? There is always a danger that it is a broad brush. Some areas are doing well. It is about finding out why those areas are doing well and whether there is a particular attraction to them that perhaps could be spread.

Simon Stevens: Without being Panglossian at all, it is worth noting 7.15 of the NAO Report, in which it is pointed out that we have been narrowing the inequalities and the distribution of GPs over the past 10 years and the past five years. York University will be publishing a piece of research later this month showing that there has been a faster reduction in the number of patients per GP in poorer areas than in the rest of the country over a decade, as the NAO reports. But it was the case in 2010 that if you were in a poor area of 100,000 people, you were 19 GPs or nurses short in primary care. We have got that number down to just under five over the course of the past five years. There has been some important progress there, but we now have to go all guns blazing to get the training places and the recruitment into the parts of the country that might otherwise be underserved when this retirement bulge hits. A lot of GPs who were recruited in the '60s and '70s, including those from south Asia, are coming up to retirement age. That will give us a real set of issues to solve in places like Birmingham, Leicester, and parts of the north-east and north-west.

Q82 Kevin Foster: I was going to come to whether we should be concerned about the fact that 22% of doctors and 28% of nurses in general practice are aged over 55, and whether there are any particular demographics that play into that. You have partly touched on that, Mr Stevens. In terms of the decline in the gap between the least deprived and the most deprived, have we done analysis to see why that is? I tentatively say that it has been doctors who are older and who are retiring in the least deprived areas. That is not necessarily a sign of great success in other areas—that is, reducing one would inevitably eliminate the gap. Have we got some clear ideas about exactly why that has been the case?

Simon Stevens: I think it is the result of a succession of deliberate policies that have produced a result. During the period 2000 to 2010, there was a deliberate effort to target extra funding for expanded primary care in areas that were short. Since 2010—indeed, this is the approach that we just signalled on 17 December to CCG allocations—we are including needs-based primary care into the overall formula alongside the CCG commission stuff to improve the equity of total spending for the health service in a place. That combination has produced a result. For once, we should feel good about that—10 to 15 years of effort to address a problem that was there from the get-go of the NHS.

Q83 Karin Smyth: We talked earlier, in relation to Caroline Flint's question, about where we are now and where we want to get to with the vanguards. I am concerned about what we lose in the meantime through some of the changes in funding. Although the NAO Report does not mention core

funding particularly, there obviously have been some changes. For example, in south Bristol there are lots of very deprived wards with some of the greatest problems with life expectancy in the country—they are in the lowest 5%. They have the highest incidence of CHD, cancer, diabetes, COPD, asthma and so on, but the funding formula, which has recently been changed in the PMS reviews, does not take account of deprivation, and money has come out of some of our practices.

Now, I appreciate that some of that goes back in, as you say, through the other sorts of routes. Some things, such as the challenge fund and the new collaboration we have, are helpful in that sense. How are you mitigating the risks of practices going out of the system in the meantime? We have one that has closed already and I have two lots of lists closed. We talk about “lists closed” and I am concerned about managing that risk, particularly in areas of deprivation, in the meantime between now and the future vanguard programme.

Simon Stevens: We could come at that in two parts. I completely agree with the second part. This is what I would say about the first part: on the point about PMS reviews—that is about trying to get a fairer allocation of primary care money within Bristol South or within a CCG. No money is being taken from a CCG area on the back of those PMS reviews to give to some other part of Avon or Gloucestershire; it is just about divvying-up between practices within the CCG—that is the basis on which the PMS reviews have been done. So in terms of our overall approach to CCG allocations, we have really put our thumb on the scale pro equity, in that we have cut the number of CCGs that were more than 5% below their fair share from 34 last year to 17 this year, and for the funding allocations we will making from April for 2016-17, no CCG will be more than 5% below its fair share of funding—not just for the CCG-commissioned services, but also taking into account primary care and specialised services as well. On both tests we will be within 5%.

So on the first part of your question, I think the way money is being allocated is fairer than it has been hitherto. On the second part of your question, I think there is a really important question about what support we give to individual practices that are struggling. We are putting in £10 million of earmarked money, working with the Royal College of GPs, including for practices that have come out of the CQC inspection processes, but one thing we have to do, with the GPC and with the Royal College, is to get a better offer to individual practices that are struggling. We are testing the idea of whether, for GPs who are nearing retirement, we should think about an itinerant group of GPs and senior practice nurses who could go into a practice and help to stabilise them when they have, say, a partner off or a partner retire, and help them to migrate. That is a very practical thing that a lot of practices around the country are experiencing.

Q84 Karin Smyth: I accept and understand that the money comes out and it is good that the money goes back into the geographical patch, and that individual practice funding is a very complex thing. The wider point is that when the funding formula changes in the next couple of years, it may start to include deprivation. You still have a period of instability and uncertainty for individual practices which are still, in the here and now, businesses looking to survive in the next five or 10 years. My point still stands that uncertainty exists for individual practices, particularly in areas of deprivation. Money coming in from different angles will help the baseline, but it does not help with overall planning to meet the problems that we have, in south Bristol and other areas, of real, severe health needs. I appeal to NHS England to look more carefully not just at changeover of personnel, but at the survival of those models of general practice in the meantime.

Simon Stevens indicated assent.

Q85 Kevin Foster: As we are coming up to 6 o'clock, looking at the issues we have discussed today, what do you see as the future of general practice, in terms of ensuring we get the maximum health outcomes for the taxpayer's money we spend on it? Briefly, how do you see some of the issues we have discussed today being resolved, allowing us to get, bluntly, the most bang for the taxpayer's buck in terms of improved health in the country?

Simon Stevens: First, the core offer which general practice makes is that it is available for routine consultations and handles 90% of the face-to-face consultations of any patient interaction with the national health service and does so on less than 10% of the budget, a proportion that obviously needs to increase over the next five years. We spent a lot of our time talking about sharing best practice and redesigning what the core primary care offer looks like so that it works for GPs and, most importantly, for patients.

How do we then test whether that is actually producing the benefits we want? I go back to some of the other conversations we have had with the Committee. Are we able to demonstrate improved cancer outcomes? Are we able to demonstrate rational use of urgent and emergency care services? Are we able to make progress on mental health services in the way that NHS England and the Government are talking about today? There are a series of high-level health outcomes that we want to see improve over the next five years. Primary care is going to be a core part of doing that, so we have to connect the means with the ends. All of that said, 85% of patients say they are satisfied with their general practitioners. Those are satisfaction ratings that most of the rest of the public service would die to have, and you cannot find many private businesses that would do better than GPs are doing, often in very difficult circumstances.

There is a lot to be very proud of, but the problem is that that cannot complacently allow us to just assume we can carry on as we are. I suspect that we have collectively been too complacent over a decade or more, living off the back of that great sense of good will on the part of GPs and the affection that patients have for their practices. Those chickens are coming home to roost, which is why we now have to act.

Dame Una O'Brien: I can hardly add to what Simon has said, other than to say that the burning platform he described at the end is recognised by the Government. The decision to prioritise investment in general practice is very clearly stated in the mandate and is also in the early evidence of NHS England's decision at its recent board meeting. Can you see those words translated into practical action? Yes, you can—the next stage in the Prime Minister's challenge fund. Significantly, what we touched on here was the multi-speciality community provider and the role that those types of provider could play in the future.

To sum up, there is a very strong future for general practice. Young doctors should be prioritising it. Our aim is to make general practice top of the tree and to really confront some of the cultural norms we heard about in the first session, because general practice is the place to be for the healthcare service in the future.

Q86 David Mowat: Could you go to figure 22 on page 47 of the Report? I will come to Mr Stevens first. The stand-out thing for me in that figure is not the over-65 bit; it is the under-35 bit. I think I am right in saying that the figure is telling me that 7% of doctors who join your organisation leave every year at that age, which means that of the 3,000 trainees who will be employed by your organisation, you will have lost about 1,500 within eight years. Is that correct?

Simon Stevens: This is obviously about leavers, so it does not take account of new starters or returners.

Q87 David Mowat: It does not take account of new starters, but—

Simon Stevens: If I am a woman and I go off and have a baby, I will show up as a leaver, but there is no part of the chart showing me as a returner.

Q88 David Mowat: The 3,000 trainees who your organisation takes in are very talented people who have been very expensively trained. You are right; the analysis does not take into account people who have left and come back. Nevertheless, let's say that those people represent 2%; you are still losing half of the trainees within maybe 12 years, rather than eight years. That is extraordinary. Who is accountable for that number?

You mentioned the private sector. You are right; patients are generally very happy with the service they get, although that is partly due to the nature of the service. In the private sector, there would be very clear accountability in an organisation that was taking in 3,000 people every year—talented people who are very highly and expensively trained—and had then managed to lose 1,500 of them 10 years later. Who is accountable for that number and managing it down?

Simon Stevens: Well, this is an answer you won't like. The reality is that there are just under 8,000 practices across the country. We do not have directed labour, so individuals are free to make their own career choices. Our job is to try to make it as attractive as possible to stay in general practice. You are right to point out that the fact that the yellow bars are higher than the red bars in each of these age cohorts shows that things have got worse on that front. That is the underlying point behind your question, and you are right about it.

Q89 David Mowat: It was not the underlying point, actually. That is true as well, which makes it even worse, but the underlying point in my question is that that level of failure to retain people would cause a huge level of concern in most private sector organisations. Given the nature of the people you are failing to retain—as we have said, in their cohorts at school they are often the best and the brightest. They go into medical college and study for six years. There is all the money they have to pay back, and all the rest of it. They then join your organisation, and you seem to manage to get rid of half of them within 10 years. My point is that is disappointing. I wonder who in your organisation feels personally bereft by that number—or do we just shrug our shoulders and say it is a national dilemma?

Simon Stevens: We all do; the whole national health service does. When we say that we are aiming for 5,000 more doctors in general practice by 2020, what Health Education England is saying is that at least 1,000 net of those have got to come from tackling exactly the problem you have rightly identified. That is holding everybody's feet to the fire. The 5,000 is a net increase number that people are going for, of whom 4,000 will be new, and at least 1,000 have got to come from improving the retention and return rates. So your analysis is well made; the only way we will succeed is by doing something about the issue you mention.

Q90 David Mowat: I just note that the answer you gave to my question—who is accountable for this and who is worried about it or feels bereft by it?—is the whole NHS. To be honest, that is not a very good answer from the person who is chief executive and has executive responsibility for it. I just say that there is a haemorrhaging of talent here, which is of concern to the country, and it should be of concern to you and your colleagues.

Simon Stevens: And indeed it is. The bulk of the hearing we have just been through has been about precisely how we are seeking to address that.

Q91 David Mowat: Although—since you have come back to me on that—I am not sure that the bulk of the hearing reflected the fact that we are losing half our entrants to this profession within 10 years, if these numbers are right.

Simon Stevens: I don't think that analysis is necessarily correct, because it takes no account of returns.

Q92 Chair: I think you will have picked up that we are concerned about the ability to count returners and the difficulty with the time it takes to get returners. It is up to the Committee, but returners might feature in our Report.

I want to wrap up with a couple of quick-fire issues. One is that the Report highlights differential access by area and background of patient. We have talked a bit about the telephone system, websites and so on and spreading good practice. What are you doing centrally about that differentiation? I cannot remember the figure or where it was, but it came up that 14% of Asian women found it very hard to get an appointment.

Laura Brackwell: I think I have the figure.

Chair: Laura will find the figure—you will probably know without me referring to it. Are you analysing that centrally and how are you getting practices to understand how they need to behave in order to make sure that all patients, whatever their background, get good access?

Rosamond Roughton: What we are doing at the moment is making this part of the indicators when we talk to practices about how well they are doing. Along with other outcome indicators, we are using satisfaction with access as one of those four indicators. The CQC is also picking this up in its inspections. Through the schemes we have got going we are trying to make sure that people see where things that are working have been put in place. For example, in Sheffield they are doing particular work to address the needs of the Traveller population—that kind of thing. We are trying to make sure that is shared with all our local teams, when they are having those conversations with practices, to say this is how you could make a difference.

Q93 Chair: So if I was a practice manager and I identified a problem—I was new to the job and thought, “This is funny; we have a differential in people accessing appointments here.”—where would I go to get the advice on best practice?

Rosamond Roughton: First, the practice-level data may not be specifically by ethnicity—

Chair: But you might get a feel for it locally, as a good practice manager?

Caroline Flint: You must know the demographic of your area.

Rosamond Roughton: The place you would go in the first instance is the CCG, the local team, and potentially the LMC. We are trying to make sure that all that material is available to those parties.

Q94 Chair: So do I click someone through, or do I make a phone call and someone will say, “We are doing a really good job in this part of the country”, and then we can learn from them? How easy is it get that granular information about how, as a practice manager, I can make sure all my population is getting access?

Rosamond Roughton: It is probably not as easy as it needs to be.

Simon Stevens: On the comparison by ethnic group, I think it is worth noting that you have mentioned, Chair, the response of Asian women, but actually a study looking at the worst experience of Asian patients found that, in fact, it correlated with the practices. So for white patients in those practices—half of the difference was explained by the practice, rather than by the experience of Asian patients in particular. You have got to look at the cross tabs.

When you look at the differences between different ethnic minority groups across the country, you see that we have got pretty extraordinary differences on the GP patient survey. The least satisfied BME patients, at 57%, are those from Pakistani backgrounds, and the most satisfied, at 76%, are patients of African or Irish background. The interesting question is this: how much of that is about the cultural appropriateness of the primary care offer, and how much is explained by other underlying variables around being younger, working age, from more deprived communities, or other practice characteristics that do not directly relate to the ethnicity of the patients themselves?

Q95 Chair: My point is that we all want to see good equal access. I will give a couple of examples in a minute, but I have just one last question. Research from last year estimates that about a fifth of GP consultation time is spent on other matters—this is in the Report, in paragraph 2.3 on page 17—

Simon Stevens: That is Citizens Advice Bureau research, I think.

Chair: Yes, and on issues other than health, so while someone is seeing their GP other things are picked up. One fifth of GP consultation time is a lot. What are you doing to reduce that part of the workload for GPs?

Simon Stevens: One of the points that I think the Citizens Advice Bureau have made is that by embedding counsellors, money clinics and other support in primary care, you can produce places where GPs can refer patients to people who can help them with those wider problems. This all goes to the point that primary care, and indeed primary medical care, is not just about what GPs do; it is about the wider team. The workload figures here actually show a very dramatic increase in the range of health professionals other than GPs working in primary medical care. As part of the new care models and the new voluntary contract, frankly, we want to be able to incentivise a big expansion in that—pharmacists and nurses, but also these other kinds of offers as well.

Q96 Chair: GPs and MPs are two of the relatively few people—vicars, perhaps, as well—you can just go in and see without a gatekeeper, so it is heartening to hear that, but the proof, of course, will be whether it actually works.

I just want to finish by highlighting why this is important to us and colleague MPs. I quote from Laurence Robertson, the hon. Member for Tewkesbury, who says that patients can get GP appointments on the same day as they call if the matter is very important, otherwise they can wait up to three weeks, which he does not think is good enough. I think we would all agree with Mr Robertson. Ruth Smeeth, the MP for Stoke-on-Trent North, says that it is alarming that a number of people who could not book an appointment at their local GP surgery, where she says there are particular problems in her area, simply attended A&E to get to see a doctor or nurse, even if this meant waiting up to three hours. That is just a snapshot of the many examples I got from MPs across the House. This is probably the most responses I have had to any request for information before an inquiry.

I am sure I do not need to tell you—I hope I don't—why this is, therefore, very important. It affects people right on the frontline, so every decision you make has an impact on a patient at the frontline as well as the GPs who serve them. We will be producing our Report in the next few weeks, and our transcript will be out in the next couple of days. Thank you very much for coming along. We will be watching this very closely in the future.