



# The Select Committee on the Long-Term Sustainability of the NHS

## Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 15 November 2016

12 pm

Watch the meeting

Members present: Lord Patel (The Chairman); Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Lord Mawhinney; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner and Lord Willis of Knaresborough.

Evidence Session No. 19

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Questions 185 - 190

### Witnesses

I: Professor Maureen Baker, Chair, Royal College of General Practitioners; Sir Sam Everington, Chair, NHS Tower Hamlets CCG, and Dr Clare Gerada, General Practitioner and former Chair, Royal College of General Practitioners.

## Examination of witnesses

Professor Maureen Baker, Sir Sam Everington and Dr Clare Gerada.

**Q185 The Chairman:** Good morning to our witnesses. Thank you for coming today. It gives us an opportunity to widely explore, I hope, the future of primary and community care, as you see it, and how it could be a system of delivery of healthcare and social care in the future. I hope to hear from the three of you some out-of-box thinking. First, I declare I am an honorary fellow of the Royal College of General Practitioners but not any part of its management, as you well know. Maureen, you and I have been associated for a long time because I taught you at one time.

**Professor Maureen Baker:** You did, sir. Very well, I may say.

**The Chairman:** I have heard that many times, so it does not come as a surprise.

**Sir Sam Everington:** Lord Mawhinney taught me medical physics at the Royal Free years ago.

**The Chairman:** Before we start, if you would not mind introducing yourselves—from your side, Clare, first—and if you have any opening statement to make feel free to do so. We realise, Maureen, you are president of the royal college for only four more days, but we are seeing your new president later.

**Dr Clare Gerada:** Thank you very much. I will not make an opening statement—I am interested to hear the questions you ask—but I will introduce myself. I do not think anybody round this table has taught me, though I have been in awe of many of you over the years. I used to be in Maureen's role but Maureen took over from me three years ago. I am currently a general practitioner and have been for the last 30 years. My organisation, the Hurley Group, runs a very large consortium of GPs across London. We have about 10 CCGs and we hope we are the forefront of innovation in using technology, such as e-health, which I was hearing about before. Other than that, I run a service for doctors and dentists with mental health and addiction problems, so as well as being a normal GP I suppose I am at the front end of seeing the current state of the people who work within our service and are delivering care 1.2 million times a day to the patients of England. I do not see all of them, but I see vast numbers of them.

**Sir Sam Everington:** I am Sam Everington. I started life as a barrister and then trained at the Royal Free as a doctor and started my life as a GP. I have been a GP in Tower Hamlets, at the Bromley by Bow Centre, which Lord Mawhinney was key in getting started originally. I am also chair of Tower Hamlets CCG and clinical lead for our STP in north-east London. I am a director of Community Health Partnerships—which you might know as NHS LIFT—and have been on Sir Robert Naylor's review of

estates that is going on at the moment and is about to report. Most of all, two days a week I work as a clinical GP in the East End of London.

**Professor Maureen Baker:** I am Maureen Baker and I am the current chair of the Royal College of General Practitioners, as you say stepping down on Friday evening. I have been a GP for more than 30 years in the city of Lincoln and in Lincolnshire. If I may, I would like to make a few points by way of introduction.

You are, I hope, aware of the publication of the *GP Forward View* from NHS England and Health Education England. This was published in April. In his foreword, Simon Stevens wrote that there is arguably no more important job in modern Britain than that of the family doctor, quoting a recent *BMJ* headline stating that if general practice fails the whole NHS fails. GPs act as gatekeepers to the wider NHS, accounting for about 90% of patient contact with the healthcare system. If the capacity of GPs to see patients is reduced by only a small amount then services downstream, particularly A&E units, greatly struggle to cope with the resultant pressures.

It is very important for us to state that we see the importance in the centrality of general practice becoming greater as the population grows and ages, and as the incidence of complex multiple health conditions increases. Person-centred holistic care delivered close to home is the model of general practice in wider primary care that will provide a sustainable NHS in the future. My college has produced a position statement responding to the needs of patients with multimorbidity which I would very happy to leave with the secretariat. We believe this is the first position statement on multimorbidity, certainly in the UK and, as far as we know, globally.

Going back to the *GP Forward View*, it recognises the need to move to general practice being able to provide more care to patients in and close to home with GPs deploying their skills as expert medical generalists, leading multidisciplinary teams treating a variety of conditions within the community setting. We feel it is very important to say that the *GP Forward View*, which pledges a £2.4 billion increase in yearly investment in general practice by 2020-21, we see as absolutely critical. We believe it is the right plan for general practice and that we all need to work to make sure those pledges are delivered. That is my introductory statement.

**The Chairman:** Thank you very much. But, as a Committee, we are looking much further on, as to what will be sustainable beyond 2025 to 2030. The questioning relates to what we need to make health and social care sustainable in 2025 and beyond. In that respect, if I ask you to particularly focus in on general practice, what do we need to make primary care and community care sustainable 2030 and beyond? How are we going to achieve that? What are the barriers to achieving that? We heard that the model of primary care and community care, which everybody agrees needs to be a strong part of the delivery of healthcare, and therefore needs to be strengthened, needs to change. Sam, I think

you are on record as saying that primary care ought to change to be able to deliver more care and less management and bureaucracy. How are we to achieve this in the long term?

**Dr Clare Gerada:** I have brought a little gift. It is not for you; I am going to take it back. I came on my bike today, so this is a real treat. These are the documents that I have been involved with or was privy to writing about the future of my profession of general practice. Some of these come from the Royal College of GPs, some come from the King's Fund, some come from my role when I was head of primary care for London and some come from other places, including this place. People have looked at this problem over the last 30 years, and I think you need to turn the whole thing upside down. Unfortunately, we look at models and it is a bit like looking at Lego models; people design a Lego model and then dismantle it and redesign it. What you have to do is say, "What are the needs of the people we are trying to deliver care to?" That is what we did when I was heading up NHS London. We asked Londoners—I thought Lord Darzi would be here because he was part of that process—what they wanted and needed, and we broke that down into they want access and proactive care. In other words, they wanted to stay healthy for as long as possible, and then die with dignity in a place of their choosing. They wanted care co-ordination.

Once you start to put those in and to set standards against those, the model falls out of it and so, too, do the enablers and the disablers. For example, the enablers: e-health. We need to embrace technology. At the moment, less than 2% of GPs use technology for their patients other than the telephone. We heard about Skype. Skype is not the way forward; it takes just as long to consult with a patient using Skype. We have to use technology smartly to stop people coming into the home. We also talked about the other end, the elders. We talk about our ageing population: what do our elders need? They are lonely, so we need an army of people to provide support around them in a health and social care environment.

You are going to have to deliberate over this, but you need to turn it upside down. If you talk about models, the model for rural Cumbria or the far west of Cornwall will be a completely different model of service delivery from where I work and where Sam works, in Lambeth and Tower Hamlets. Then things will start to sort out. The enablers are money, unfortunately, stability, unfortunately, and, as we have heard, issues such as decent premises to consult from. We have ageing premises, as I am sure Sam will tell you. That is what I would urge you to do.

**Sir Sam Everington:** I forgot to mention that I am an adviser to the 50 new models of care nationally for NHS England. Within the new models are fantastic examples of what primary care will look like in 2030, so the issue you have to tackle is how you deal with the variability in what is going on across the country in primary care. What are the sort of things we are seeing in the new models of care? Tower Hamlets is one of the vanguards, and we can now turn around a renal referral within a few days. That means that as a GP I will e-refer to the consultant renal

physician, who can look remotely in my notes in the general practice and in the hospital notes, and then come back with written advice. It is fantastic for patients and fantastic for GPs; it means I get my question answered in real time, not three months down the line when the patient will have gone to a raft of other outpatient clinics, where it becomes increasingly complicated.

What we see in this—I will raise it later—is a massive transformation of the role of the consultant. We have now a forward view for GPs; we need the same for consultants and nurses. What is their future role? Tower Hamlets, one of the most deprived areas of the country, has the best blood pressure and cholesterol control in the country, with early evidence of a reduction in strokes, heart attacks and complications of diabetes. There is a story behind how we achieved that, part of which is complete transparency of data. You can see, in Tower Hamlets, the outcomes on a massive range of measures for your general practice compared to anyone else. That information drives up quality and delivers quality improvement.

The second thing is we contract with groups of GPs, which is 30% dependent on outcome. If my neighbouring GP, with whom I have no legal relationship, does not deliver, I do not get the 30%. Guess what: they all deliver because they are all working together. That is the new way; working together is critical.

Thirdly, we have protected learning time as teams. The idea that it is just the doctor or the nurse for the future is not appropriate, and I will come on later to challenge therefore the medical school training in this country, because it is about teamwork. We are about to involve the Army, in early December, to look at how we transform outpatients. We want to get rid of choose and book; we want choose and consult. We reckon we can empty outpatients by 50% by streamlining and bringing back the old relationship we used to have between the GPs and consultants, along the renal lines. Guess what: I send a referral with my mobile number; that means the consultant can ring me and say, "Sam, that's not a good referral; you should have done this", or they can email me or they can email the patient.

**The Chairman:** That is good, but if we cannot clone you 30,000 times, how do we have a system in place to achieve this?

**Sir Sam Everington:** You can, is the answer. You do it through a combination of contracts with the GPs. That is the first thing. I have hinted at how you do that. You need to get NHS England—and it is in the process—to massively transform "choose and book". The idea of booking somebody in outpatients is as archaic in the modern world as going down to your bank to pick up money or to do some transactions. The answer is you can.

On top of that, you can make the transparency of data available across the country. You can put the emphasis on quality improvement, rather than regulation. Then there are three very quick points; the first is social prescribing everywhere, which is what the Five Year Forward Plan says. It

is about enabling and empowering patients to manage their own care. We now have 500 groups around the country doing that in a network. We have somebody appointed as ambassador to social enterprise, Dr Mike Dixon, in NHS England. It is absolutely about changing the concept. When we were at medical school it was all about, "What's the matter with a patient?". The modern paradigm is "What matters to patients?". Once you start addressing that you start addressing the 70%, according to Professor Marmot, of health and well-being that has nothing to do with the NHS. We can now connect our practice in Tower Hamlets through a referral form to the social prescribing team which can connect them, in turn, to 1,500 voluntary sector organisations in Tower Hamlets. Imagine what that does to their health and imagine what that does to reduce pressure on the NHS.

**Professor Maureen Baker:** I absolutely take your point about thinking ahead to 2025 to 2030, but I think having expert generalists in the community—GPs—is essential to delivering the services that will be needed then. We have to make sure that general practice survives to transform and grow to meet the needs as we are moving on.

I will say just a little more about multimorbidity. It is such a key challenge. People are living longer, thank goodness. Is that not great? I would certainly want to live to be old, and I am sure you all want to live to be old and indeed very old.

**The Chairman:** Some of us look forward to it.

**Professor Maureen Baker:** It is great that this is the case but it does mean that people will be living longer with multiple ongoing conditions. We do not know very well how to deal with that. There is very little evidence that underpins the clinically effective and cost-effective management of multimorbidity. I think you have to put this squarely: how will that be dealt with to have a sustainable NHS in 10 or 15 years' time?

A little more about tech: in healthcare we have been slow to harness the potential of tech. It is not the panacea, it has to be adopted and implemented appropriately, but we have to look, in all aspects of our lives, at how the technology is becoming mobile and miniature and at the proliferation of apps. In particular, if we are to think about self-care and supporting people to look after themselves and their families as best they can, we have to think about how we can best support people with the appropriate tools.

I also agree that there is huge potential in real-time data. Again, there is lots of data floating around the NHS; we do not harness it and use it in real time in ways that can really make a difference to care and quality.

**The Chairman:** I know you all have a lot to say, but we do not have all the time to listen. What we are going to do, because we have a lot of questions, is to try, on our part and on your part, to see if we can keep it succinct but get the message across. First Lord Warner, then Lord McColl

and then Lord Willis. Then I need to move on to the next question.

**Lord Warner:** How do we take the two propositions from Clare and Sam—that is, Darzi and the kind of model that you have evolved in east London, Sam? How do we go to scale on that? How do we go across the country? I would settle for the big cities, for starters. What do we say, as a Committee, to the Government to go to scale for those models?

**Dr Clare Gerada:** You have the experts here that have worked on this. You need to look at some of the key areas in order to go to scale. Premises, which Lord Darzi was looking at, so we need premises fit for purpose; we need the larger premises where we can start co-locating services and diagnostic, and the smaller—

**The Chairman:** You are saying, “We’ve got a model, just get on with it”?

**Dr Clare Gerada:** Not necessarily. If you are talking about London, it is very different from rural Cumbria, but there are models. They may need to be agreed in principle but there are models which you can get on with. There are some things that still need lubricating. There is a lot about e-health, but we have very, very little of it. Again, with my slight conflict of interest with my practice that has developed e-health, which is getting patients to be able to consult online, we now have over 2 million patients who can do this. You need that, and you need to focus on premises. We cannot do anything if we do not have somewhere to consult.

**Lord Kakkar:** I wanted to follow up on something Sam said. You have described the success of your vanguard in Tower Hamlets. How much consultation has there been, and how successfully has the discussion taken place, with regard to other STPs and incorporating that kind of good practice into the models that are now starting to be published? We heard earlier from the Shelford group that they would, if I understood them correctly, like to be very much more in control of how local health economies develop with regard to capitation and the development of more accountable care structures. How would that fit with the transformation in primary care that you have described as a bridge to sustainability in 2030?

**Sir Sam Everington:** STPs are still very early. Everybody is rushing to get everything sorted, and I do not think necessarily the depth of attention is being put into this. We have in our area, because we had a process that was looking at all this before. It has, dare I say, been a little distracting because it is a restructuring of sorts for the last six months, so it has delayed a significant amount of transformation. In terms of accountable care organisation that is critical, but it is about changing people’s sense of their role. There are five things you can do that I would have answered—one, as I have answered already, is the contract. Secondly you need to change the consultants so they become responsible. I am not talking about a consultant contract; I am talking about changing their job to something that is responsible for the population and for the whole pathway, from beginning to end, say, of diabetes. If you want me to take it one step further, I would put them in

charge of the hospitals. Consultants and GPs spend the money on what we do. It seems anathema to have a situation where in primary care we are in charge and we are responsible for managing virtually everything; you need the parallel in hospitals. If you do not do that, I do not think you will sustain the NHS.

Data transparency, which Maureen has talked about, is absolutely critical to all. Clinicians are intensely competitive. If you see that you are at the bottom of something, trust me—it is real-time data—you are going to want to do something about it straightaway. The stethoscope was our tool when we trained; it is not any more, it is the iPad. I put wi-fi in every surgery in Tower Hamlets. The Hurley Group pioneered this amazing webGP. Finally, you need to accelerate social prescribing. Manchester loves it; it needs to be the norm across the country.

**Lord McColl of Dulwich:** As the main problem within the NHS is the huge obesity epidemic, and we admire very much what you are doing, Sam, how are you coping with that in your practice?

**The Chairman:** A quick answer. How do we spell that out?

**Sir Sam Everington:** The classic example of how it is dealt with is in a school in Stirling where all the kids and the teachers go on a mile run every day. In Tower Hamlets we want to apply the dashboards we apply to every general practice to every school. Every head teacher will know how healthy their children are. Trust me; they will drive up health and well-being, which is the education of the children, if they know that. Also, why should that not be given to parents? If you are a parent like me, of five children, what matters most is not the GCSEs or the A\*s, or whatever, but whether my child is going to be happy and healthy in this school. Schools need to play a part.

Q186 **Lord Turnberg:** I am afraid we are going to talk about funding and how we fund the NHS and the social care system. There have been a number of suggested models for funding. Do you have any plans for us?

**Dr Clare Gerada:** I do. I think we should re-look at the national insurance model. You pay national insurance only when you are working and it tapers as you earn more, so it is not a progressive tax, and you do not pay it when you have retired; despite there being a fair whack of wealthy elders who pay nothing. You should look at a hypothecated tax. I know that the IPPR recently published a look at this and looked at the pros and cons of it. I think we need a hypothecated health and social care tax so that the public are aware of what we are going for. The thinking has started and, clearly, a lot of thinking has to be done, but there are two starters.

**The Chairman:** Sam, do you have a different view?

**Sir Sam Everington:** All the things you have suggested. If you take Tower Hamlets, there is an 11-year difference in life expectancy between rich and poor, and 20 years' loss of life quality. That means, in Tower Hamlets, at the age of 55 you are 75. The changes are not going to come

from genomes, cancer cures or anything like that; it is absolutely about lifestyle, which is absolutely about the individual. My challenge is to say that it should be as normal for you to go on holiday as it would be to invest your money in your health and well-being. There is a serious issue about how we, on the whole, have discouraged within the system people investing their time, resources, community and their incomes in their own health and well-being. You can change that. Winter crises are not inevitable.

One of the things we learned from the junior doctors' hours strike was that all the hospitals worked brilliantly in acute care. Yes, there are great delays in outpatients—there is a lesson there—but the other lesson is mass flu vaccination. We go for herd immunity on everything else; why would you not go for flu? Any good business in the City vaccinates all its staff. We do that for all our staff. Why do we not go for mass vaccination? Why should that not be part of what Public Health England and the Government push for?

**The Chairman:** The question is about future funding.

**Sir Sam Everington:** The way to do that is to enable GPs, for example, to charge £10 to vaccinate those patients who are non-eligible in the NHS for a flu vaccination.

**The Chairman:** Who takes the money?

**Sir Sam Everington:** That would go to a general practice. At the moment, a pharmacist can do it but a GP cannot. The GPs can show if you get the incentives right you can get immunisation rates of 80-plus.

**Lord Turnberg:** This is a fee for a service.

**Sir Sam Everington:** A fee for a service that is not available on the NHS.

**The Chairman:** We are getting into a different discussion here about why it should not be available on the NHS anyway. Maureen, do you have a comment about overall funding?

**Professor Maureen Baker:** In terms of hypothecation, there is not much point aiming for hypothecated budgets solely for the NHS. If you are going to do that it should be for health and social care together. We have no formal position on this except that in the previous Labour Administration, when it was suggested that national insurance be increased to fund the NHS, we supported that and my recollection is that there was strong public support at the time for such a move. The funding settlement as currently set out is insufficient. I know that is current and we have to think about the future, but we have to have a public concord—society-wide agreement—about whether we are willing to give NHS and social care the money that is needed, especially to deal with the population as we get older.

Q187 **Lord Warner:** Could we move on to the effectiveness or possible out-of-

datedness of the present model of primary care? How fit for purpose is the GMS contract? How fit for purpose is the small businessman model of providing primary care? Sam does not sound like a small businessman. Particularly the college, can you tell us how this model possibly needs to change over the next 10 to 15 years to deliver what everybody wants delivered, which is more care and prevention outside hospitals?

**Professor Maureen Baker:** There are certainly aspects of the small business model that we would suggest work well or could work well, and certainly could work well in the future. The ability at a relatively small, local structure to make your own decisions about how you will invest, the staff you will have and how you react to particular challenges, I would not like to see lost. It was my college, and in fact me, who wrote the document about what we now called federations. The principle of GPs working collaboratively with each other while still having a base in the community they serve is something we set out in the first place and is now becoming the model widely. Currently we believe that about 60% of GPs are working in a federated model. There is something about collaboration: there is collaboration with other practices or there is collaboration within big practices and new models of care—it does not matter—and there is collaboration with the wider health economy. As we move forward, to work most effectively and to provide the type of integrated, joined-up care that patients need, we need to look at how GPs can work locally, rooted in their communities but linked up with each other and with other services. We see the building on the federated model and moving into the current new models of care which have grown from that, and support these developments.

**Lord Warner:** How does the central contract either incentivise that or get in the way? I am someone who spent some of the best years of his life negotiating with many of your members about this. I have a sense that somewhere in this mix something is not right about the incentives for getting the primary care system we want.

**Professor Maureen Baker:** The current contract we are working to is now 12 years old and there are ongoing discussions about how you can support GPs to work in other structures. Having said that, and I hesitate to speak for colleagues in the GPC, they would say, "Actually, we've got to the stage where 60% or more of GPs are working in federations under the current contract", so it has not helped it but it has not got in the way either. It is good practice periodically to look at how we want to run our system. How do we want people to work and what are the contractual models that support that? We are at that stage currently and it is perfectly reasonable to look at how we modernise.

**The Chairman:** Briefly, Sam, is the current independent contractor status still appropriate?

**Sir Sam Everington:** There are 36 practices in Tower Hamlets, eight confederations, one social enterprise of all 36 practices and a single-handed practice managing within that, and it is very popular with the patients. The answer is confederations. The second thing is definitely a

local contract. Tower Hamlets has a £9 million local contract; the equivalent of 25% of what a GP's national contract would be. If you are to shift that care out of hospital with, as Clare rightly says, different solutions around the country, you have to come up with locally sensitive contracts to make that happen. It will be very different, say, over on the west coast of Scotland from an inner city area. I do not believe you can design that change purely on the basis of a national contract. The key to a national contract is to give the sustainability of primary care while you create the shift. We are talking, in our STP, of potentially increasing the offer of primary care—I do not mean just GPs—by 33% in the next five years, on the back of the new models of care. It is what patients want. One of our vanguards, by the way, has reduced terminal illness death in hospital from 48% to 14%. These are the sorts of fantastic successes you will get with different models of care. It is what patients say to us all the time. If you ask them where they want to die, the vast majority want to die at home surrounded by their loved ones, yet we are failing to give them that.

**Dr Clare Gerada:** Can I pick up on that a tiny bit? I struggled with this independent contractor status when I was chair of council. In more or less the last week of my chairmanship I said I thought the independent contractor status was not fit for purpose. I felt we needed to unpick it, and GPs needed to still be in charge of their organisations, but that could be done in a different way. The different way is exactly as Sam is describing, and ours is to a certain extent, to have an overarching management structure with salaried doctors within it. I think there are moves afoot. Essentially, right across the country, especially in London, we do not have the independent contractor status you probably think about. Many doctors in London are now salaried.

You have to wonder what you wish for because if you get rid of the independent contractor status you have the leases on the buildings to deal with and you have the whole complexity. You can end up with the best model, which is to retain that but still get federations or confederations, or groups of practices, working within a managed structure.

**Lord Mawhinney:** Chair, I had better start by declaring an interest. The Royal Free can look after itself but during my time as Health Minister I chose to devote some of my time and effort to Tower Hamlets. If colleagues have not been to Bromley and Bow, they should go. It is the most amazing social enterprise scheme beyond your fantasy—not just in health but right across the board. As Sam hinted, I had to instruct the local Tower Hamlets NHS in writing to assist the people of Bromley-by-Bow. Whether I had the legal power or not, I have no idea, but I had the real-time power. It was not a one-off; I spent a lot of time with GPs' surgeries, from one person to multiple people, talking about how we could do that. On that basis I raise my question. We all know that one of the things patients most like about GPs is they have their own GP, and maybe he or she has been the family GP for generations. What you do and, probably even worse, what STPs are going to do is wreck that

concept probably for ever. How have you dealt with the fact that you cannot supply the “my GP” concept?

**Sir Sam Everington:** In two ways. If you look at the wider teams, I want to tell you about Christine, who is our phlebotomist. She has no formal education whatsoever. She started as what we call a patient assistant—we do not call them receptionists any more, which is quite a key change—and now she is a phlebotomist. She is a real East Ender, too. She is fantastic at taking blood, relaxing people, giving a great conversation—she knows them all. If Christine rings through to me and says, “You need to see this patient this morning”, she is right. She has made some amazing diagnoses, and that is without any skill. The answer is you can create that relationship within the team.

The other thing is where it matters most. I give my mobile phone number to every one of my terminally ill patients. You have to say, “Where is the continuity really important?” The answer is probably in something like 30% of our population: chronic disease, complex care, the terminally ill, the housebound. That is where it is really important. Our youngsters, our kids, are very different; they are a different generation. They are used to instant. We have four hubs in Tower Hamlets where we provide that service. They have a problem, have been on the internet and learned a lot of things and they want an answer straightaway. Continuity of care is far less important.

We think the answer is what we are doing. We have team meetings every month where we proactively manage 7% of the patients, and it is going up to 30%, where somebody will take a key lead. Our nurse practitioner takes the lead with all the housebound, and it is absolutely fabulous because they know they can ring her at any time, and she will be known by them completely. You are asking for continuity where it really counts, and we are delivering it where it really counts.

**Professor Maureen Baker:** We have looked specifically at this in the college. We asked the question: is it possible to provide continuity of care in modern, emerging general practice, not in how we used to have it? The answer is it is possible for those patients who need and want it, and there are ways in which you can do that. Again, we have a document on that we are very happy to share with you.

Q188 **Baroness Redfern:** What could be done to address issues of recruitment and retention for long-term capacity of the general practice workforce? Ultimately, who is responsible for addressing those?

**Professor Maureen Baker:** Shall I start, if that is all right? This has been a running theme throughout my time as chair. If we want to meet the needs of patients by providing them with GPs—expert generalists—we have to recruit them. At the moment, it is a hard job, and people see that and it puts them off, but we think things will change. We are doing a lot of work to make the job better and more attractive. Again, there is something about inspiring young people at school, medical students and junior doctors about why general practice and being an expert generalist

is a great career in medicine. We know that the prevailing culture in medical school and in wider areas of the NHS is anti-general practice. We know that there is a lot of disparaging and bad-mouthing. It is called banter but it is not; it is insidious and wrong, frankly. We are now addressing that. We are writing and talking about it; we are having discussions with medical schools, with medical schools' councils, with other colleges and with colleagues to start saying it is in our collective interest to make sure we have a balanced workforce with the GPs and the specialists that we need. We need to tackle attitudes of denigration, running-down and bad-mouthing colleagues and ways of working. When you are a medical student and you spend five years in a bubble, and in that bubble you have constant exposure to scathing and denigratory attitudes, that really counts and it does put people off. We have lots of evidence of medical students and young doctors saying things like, "I'm scared to say to such-and-such consultant that I want to be a GP; I will be mocked and humiliated." If you have people exposed to that, it sets them up to have to climb mountains in some ways to become GPs. We have to tackle that and get an accurate picture.

**The Chairman:** Maureen, can you think out of the box a bit and say how we are going to achieve this by 2030? I have no problem with what you say: we need more in medical workforce training to think about general practice when general practice is half the workforce. Some medical schools are addressing the issue about setting targets that 50% of the medical school intake—your previous medical school is doing exactly that—will go into general practice. How do we achieve this? I know what you say, and I read your blog, but how in 2030 is the question we have to understand.

**Professor Maureen Baker:** We have to start now; our doctors in 2025 to 2030 are at school now. There is something about the way we engage with schools and with medical students in their early years, to see what their ideas are, and to paint the picture of what it will be like to be a GP working in these new models of care, working in the wider stream and meeting the challenges we will face in this time. We have to start now; we have to keep thinking about it and, again, keep making sure that it is an attractive job that people want to do.

**Dr Clare Gerada:** Maureen has been instrumental over the last three years in addressing the workforce issues of our profession. She has written an awful lot and I urge you to read it. There are also things we need to look at; we need to look at how we have boxed in doctors at a very early age to choose a career. Many of you round this table who are doctors will not have chosen your specialty till quite a bit further along; we are now boxing them in through the run-through training to have to realise that from the ages of 22 to 70 they are going to be a cardiothoracic surgeon or a neurologist or a GP. We need to make it much more flexible. I do not think we should dumb down our profession but we should have much more flexibility. If you do two, three or four years in one profession, that should be lopped off and you should not have to start from the beginning, which is what we are doing at the

moment. We also need to make sure that we have what was thought through but never happened, which is broad-based training—much broader training in all the specialties together, including general practice, which you can then leapfrog through into general practice, or whatever.

I worry about attracting medical students because I think general practice and, to a certain extent, psychiatry, are jobs you do when you are more mature. They are jobs you do when you do not have to demonstrate your technical skills; you do not have to put your metaphorical white coat on and go boasting and put your stethoscope around your neck, because the tools of our trade and our thinking are in here. We have to make it more flexible, we have to look at how we train doctors and how we are boxing them in at a young age.

Finally, we have to tell people the real secret: general practice is the best profession in the world. It is one that has sustained me for 35 years. It is the best. We have to tell other specialties, “You have missed a treat by not doing my job”.

**Sir Sam Everington:** Some of you will know the research Professor Esmail and I published over the years, which looked at race and sex discrimination in the NHS from cradle to grave. We are about to publish similar research which relates to the parity of esteem of general practice versus “partialists”. I use that word on purpose because one of the things we have seen in the last few years, which we have to reverse, is the partialisation of the roles of specialists. The ageing population, the new models of care and all the evidence shows we have to incentivise everyone to be a generalist. Even if you see an orthopaedic surgeon, they need to be looking at you as a whole person, not just at your knee. You want some solutions. There is a difference in output from medical schools of people who end up as GPs that varies between 7% and 30%. That is, with our previous knowledge of discrimination, way beyond anything that is statistically significant. What would I suggest you do? Incentivise and change the financial incentive. If a medical school is not delivering the type of training, the multidisciplinary team approach or the generalists—whether in hospital or primary care—it gets less money. Trust me, you get their attention that way.

As I say, the second part of it is we have estimated within our STP that we are going to have half the number of GPs in five years’ time. That is not something we choose to do; that is the reality of our analysis of how many GPs there will be around. That is the change that Clare talked about. Some 65% of ours are salaried. They are averaging 35 hours a week because they are so exhausted by it. We know we are not going to have the GPs. What have we done? Our CCG has invested in Barts setting up a physician associate course. We have pharmacists in the practice; we have the phlebotomist doing these things, healthcare assistants—

**The Chairman:** Those are wonderful things you are doing, but we are more interested in national things for 2030.

**Sir Sam Everington:** Your solution is the incentive for medical schools and accountability of the HEE budget to the STP.

**Dr Clare Gerada:** And cap the number of specialists. We have seen—you will have to check the figure—a 200% increase in specialists. If you capped the number of specialists, where are they going to go? They will come into general practice. At the moment, we have an epidemic, as Sam said, of partialists.

**The Chairman:** I listen to you, but I hear also that some medical schools are now stating a target that 50% of their output will do general practice. I have not heard all medical schools doing it, and I take your point, Sam, that we need some kind of incentive for them to do it, but I see Lord Ribeiro, as a specialist generalist—

**Dr Clare Gerada:** I worry about that.

**Lord Ribeiro:** I have a problem here because there was a clear decision some time ago that we should be moving at least 50% of the medical workforce into general practice. That was a clear policy decision. However, I also hear this very clear statement that 65% of your workforce are now salaried, some doing 35 hours, and we have a mix of more women going into general practice and work-sharing, time-sharing and so forth. I do not see how this model, which is based on general practice holding the money and being a private organisation in many ways, is going to be sustainable in 2030 when the majority of the workforce will be salaried and want to work in the same way as those in hospital practice.

**Dr Clare Gerada:** I am the honorary secretary of the Medical Women's Federation as well as everything else. First, we are not private; we must not use that term. We are NHS through and through. We are not as if we were a private organisation. We cannot sell shares, we cannot advertise, the vast majority of our income comes from the NHS, blah-blah-blah. Independent contractor and private are two different things.

With the women issue, it is a fact of life that women have babies and women are carers, but we are trying to tackle this. It may be that you take time out but you have to find your way back in in a flexible way. Nevertheless, with the feminisation of the profession we have to bite that bullet and accept it. We have to find new models of working and we have to extend the hours. The reason we have a shortage now is because we have extended the hours and extended the places, so the same number of people are working over a longer period. There are ways of doing it. I had a debate on Saturday about whether we should have quotas for men into medical school. We are looking very seriously at what is happening to the profession and how we do it. We are where we are, we have women, and well done.

**The Chairman:** Legally, I am not sure—

**Dr Clare Gerada:** We cannot do it legally; no, we cannot.

**Lord Ribeiro:** Chairman, I did not say what my interest was, which I should have stated: I am a retired general surgeon.

**Lord Willis of Knaresborough:** We asked a question about the workforce, and all we have talked about are GPs. In reality you cannot provide a workforce of the future unless you radically look at what we are expecting from GPs and the college gets its act together to say that a lot of the work currently done by GPs, quite frankly, could be done by others just as successfully. You have not mentioned any of that. It is protectionism.

**Professor Maureen Baker:** I completely refute that. The college has done huge amounts of work, particularly over the last few years, looking at the skills needed for modern general practice and general practice as we develop. We are the ones who have led the charge about nursing skills in general practice and the community; we have pointed out how disgraceful the huge drop in district nurses has been. We need high-level nursing skills in the community and we have denuded that workforce. We have led the charge on that. Likewise, we initiated and sold, as it were, to NHS England the concept of practice-based pharmacies, and that has really taken off in the last few years. We are also talking about introducing a model for medical assistance. I am sorry about the name—it is too like physician assistants—physician associates, but this is a model used in the US where you have colleagues who support the doctor in doing a lot of admin, form filling and basic clinical tasks. They are not the same as physician assistants.

We have been promoting the use of all these models, we have been selling this into, if you like, to the Department of Health and NHS England, we have been writing papers about it and we contributed to the Roland commission. We have been leading the push to expand and enhance the skills of the workforce in primary care, and we are not protectionist. We are saying we need this range of skills, we need GPs—we need as many GPs as we can get—and we need other colleagues to work so that they have the right workforce with the skills that 21st century patients need in the community. We are not protectionist—far from it.

**Lord Warner:** You have said you want 10,000 more GPs by 2020; Sam has said they will not get them in London so we are going to change the skills mix. I am not sure what message the Committee is supposed to take away from this. Is there really a shortage or is there poor organisation?

**Professor Maureen Baker:** Yes, there is a shortage of GPs. Some 10,000 GPs across the UK is one per practice. That is not an explosion in the number of GPs. When you look at why people are working part-time and why the job is so difficult, it is a hugely intense, pressurised job. Having more GPs with the skills is absolutely an aspiration, but it is not just about GPs, which is where I come back to what I was saying about nurses and others. I am sorry; I cannot listen to three people at the one time. It is not a mixed message. The difficulties of recruitment need to be

addressed and we need to think about how we make the job sufficiently attractive. We need to think about how we increase our recruits; we need to think about how we get people committing to staying in general practice to the end of their careers.

**The Chairman:** The message you are trying to give is if we are looking at 2030 and a future model beyond that, yes, I understand that we need to start thinking now and training people for that now, but if you are looking at a model of primary care and community care for 2030, then we need a model that describes the workforce needs not just of doctors but nurses who work there, the physiotherapists who work there—

**Professor Maureen Baker:** Absolutely. That is what the Roland commission has done.

**The Chairman:** All we need is a consensus that that is the model we should have.

**Professor Maureen Baker:** That is what the Roland commission has done, and we supported the Roland commission. We fed into that and then we supported the findings. We have been working ever since to expand the roles we have put into the general practice setting and the primary care setting; increasingly we want patients to access the skills they need in the community or at home.

**The Chairman:** We need the workforce. I am going to move on. Lord Lipsey.

Q189 **Lord Lipsey:** The Government keep telling us that recent reforms have swept away bureaucracy from GP practices, but when I meet a GP they do not, on the whole, say, "Life is so wonderful since the bureaucracy has been swept away". Has it increased and what can be done to diminish it?

**Dr Clare Gerada:** Do you mean the latest reforms, as in the Lansley Act?

**Lord Lipsey:** The Lansley Act and subsequent CQC claims to have changed all its methods so it is now a perfect figure.

**Dr Clare Gerada:** We live in a bureaucratic jungle. It is terrible. Every single day is full of box-ticking and reporting. Even I do not now know what I am meant to do. I discovered the other day that I have not done my heavy lifting training, which will make me non-CQC-compliant. I have to go and do it. It is dreadful in there. It certainly has not released us from the bureaucratic nightmare.

**Professor Maureen Baker:** Bureaucracy has increased and the King's Fund report in May of this year specifically drew attention to that. It has increased, not decreased.

**Sir Sam Everington:** I want to give some solutions to multiple regulators and a system where you cannot get an answer from somebody. That is the problem. Even if you have a fabulous idea, you go

round a whole raft of regulators and performance managers to get a solution. HEE is the classic example. By the way, come and meet our practice nurse, who is a full profit-sharing partner of the practice, or some of our social prescribing team, and you will have a sense of a completely wider team, which includes patients, by the way.

**The Chairman:** Stick to the original point.

**Sir Sam Everington:** HEE needs to change. The second thing is estates. Just to give you an example, we had to get one of your fellow Lords to intervene in an issue about tens of thousands of pounds only to have a meeting on an estates issue in Tower Hamlets. Basically, because there are so many people involved in making the decision, you cannot get anything done. The final thing I would say is that the consequence of this regulation—and, I think, a loss of compact with patients because it has a very strong focus on rights rather than responsibilities—is that if you are a GP and you walk across the border to Scotland, you will pay a third of the cost of indemnity charges. Look at the consequences of what regulation has done in changing what I would argue is the compact that our society has with the NHS.

Q190 **The Chairman:** We come to the last question. I have a feeling I know what you are going to say but I will ask it anyway. If there was one recommendation that you would like to see this committee make on the long-term sustainability of the NHS and social care, not just focusing on general practice, what would that be? Clare.

**Dr Clare Gerada:** Fair funding for health and social care. Once you have done that, we can start looking at creating the accountable care organisations with a sensible geographical size, co-located with local authorities. There has to be fair funding; we are drowning at the moment.

**Sir Sam Everington:** A forward view for consultants, nurses and all the other stuff that you talk about. A vision about what these people will be in the future. Secondly, social prescribing should be the norm in any practice around the country. After all, we see 90% of patients in a year. Tesco would die for that as a footfall. Do not worry too much about the weight in the NHS; look at it as an opportunity. Finally, a chief medical officer for the Department for Education. For the five to 18 year-old it is all about school. Health and well-being should be a compulsory part of the curriculum, ahead of maths and English, because it is the thing that is delaying, most of all, the educational achievements of kids in my area.

**Professor Maureen Baker:** I would repeat those points, and I would expand a little on Clare's. On fair funding and transparency of funding, it has become clear to us over the past few years, when we have been looking at funding streams, that to meet the ever-increasing demands of the acute sector, different areas that are outwith the acute sector suffer. We have heard recently about money intended for child and adolescent mental health services not going where it is meant to. We have seen this, year after year, in the funding of general practice and primary care;

money is held back to address acute trust deficits. I know that is a “now” issue but if we keep going on like this we will not be able to grow our NHS as we need to. Just to finish on the same area and come back to real-time data, if we are able to see our funding streams—where they going and how they are being used, et cetera—that is a hugely powerful weapon. It is transparent, and it gives power to people.

**The Chairman:** Thank you all very much. If you have any other evidence you want to send in following our questions, please do so. We have quite a volume so it has to be pertinent. Thank you for today. This was the 19th session and you have succeeded in exciting the Committee more than the last 18 sessions. Maureen, I did not put you off going into general practice as a specialist. Thank you very much.