HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: The future of General Practice, HC 892

Tuesday 15 March 2022

Ordered by the House of Commons to be published on 15 March 2022.

Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Rosie Cooper; Dr Luke Evans; Sarah Owen; Dean Russell.

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Witnesses

I: Dr Kate Fallon, GP Partner, Somerton House Surgery, Somerset; and Dr Andrew Green, retired GP.

II: Professor Martin Marshall, Chair, Royal College of General Practitioners; Dr Kieran Sharrock, General Practitioners Committee (England), BMA; and Dr Becks Fisher, Senior Policy Fellow, Health Foundation.

Examination of witnesses

Witnesses: Dr Fallon and Dr Green.

Chair: Good morning and welcome to the first session of the House of Commons Health and Social Care Committee's long-awaited inquiry into the future of general practice.

GPs are often considered the beating heart of the NHS, but in recent years the profession has been under enormous strain. Patients worry about getting appointments, even though GPs are delivering about 1.5 million more consultations than just two years ago. There are still more people leaving than entering the profession. Many worry that the vital role that GPs play in preventing the need for hospital treatment is being compromised.

We will look at all those issues as a Committee. This morning we are going to focus on the GP workforce, and why so many GPs are choosing to either go part time or retire early. We will be joined later by the Royal College of General Practitioners, the British Medical Association and the Health Foundation. First, we are going to hear from two GP partners on the frontline, who will talk to Dr Luke Evans, our resident GP Committee member, about their experiences in recent months and years.

I welcome Dr Kate Fallon, who is a GP partner at the Somerton House surgery in Somerset, and Dr Andrew Green, who retired as a GP partner in 2018 aged 57 but subsequently returned to practice during the Covid pandemic. Welcome to you both. Thank you very much for joining us. Over to you, Luke.

Q1 **Dr Evans:** Thank you, Chair. Good morning, both of you. If it's okay, I would like to get a bread-and-butter feel of explaining to the world what being a GP is like. Kate, could you start off by just explaining what your day looks like? Can you talk me through how you are set up? How many sessions do you do, and what do you deem a session to be?

Dr Fallon: I am a six-session partner. I work all day Monday, all day Tuesday, Wednesday morning and Friday morning or afternoon at the moment. I get in at about 7.30. The phones go at about 8 o'clock. I go through my morning surgery, which will be a combination of phone calls, face-to-face appointments and calling people in from the phone calls. Then we meet up at about midday, have a chat and do some supervision with our physician associate or our junior members of staff. I sign prescriptions, dish out the visits, if there are any, and then paperwork, paperwork, paperwork. Then more again in the afternoon. I am often in on my half-day at the moment because we are short.

Q2 **Dr Evans:** How many patient contacts would you have in, say, a morning and then in an afternoon? How many visits?

Dr Fallon: Visits are less now because an emergency home visiting service has been set up to support us across the PCN or the CCG. There might only be one or there might not be any as things stand at the

moment, which is a help. We have 16 booked contacts in each surgery, but of course there are many other contacts; we have to phone people because of other issues.

Q3 **Dr Evans:** You said, "paperwork, paperwork, paperwork." What kind of paperwork are you doing? What does it look like? Talk me through the day-to-day stuff that you are doing.

Dr Fallon: I have a list on my toolbar with all the blood results that have come in from all the patients, letters that have come in from consultants, discharge letters and anyone else who wants to write to us, which all has to be looked at and put into the patient record. There are other things like insurance reports, DVLA reports and that sort of thing.

Q4 **Dr Evans:** How many blood tests a day are you doing? How many prescriptions are you signing off? How many reports do you think you do? Give me a flavour.

Dr Fallon: Prescriptions? It is 60 to 100. Blood results? Again, 60 to 100. Letters? It is 20 to 30 a day. Maybe two or three reports a week.

Q5 **Dr Evans:** How many people are in your practice? You said you were a six-session GP.

Dr Fallon: At the moment, we are down to three partners. There is another six-session partner and a four-session partner. We have a salaried GP who does six sessions for us, but unfortunately we lost another salaried GP last July. Our retainer has also left us for pastures new. We have not been able to recruit. We have had ads out since last July. That is the major issue for us at the moment.

Q6 **Dr Evans:** You guys are doing six sessions. No one is doing eight or 10 sessions, but from the sound of what you are saying you are doing them as pick-up. You are doing extra to cover. Is that fair?

Dr Fallon: Yes. I would say that I do eight sessions because I do at least two sessions of paperwork a week, which is why a lot of people drop down to six sessions, so that they can actually—

Q7 **Dr Evans:** So they can cope.

Dr Fallon: And stay alive.

Q8 **Dr Evans:** I will come back to that one. Dr Andrew Green, talk me through your day when you are working.

Dr Green: I am not working now because I have retired. I am an expert in retiring, having done it four times. As regards the actual day, I cannot improve on what was said. It echoed very closely what my days were when I was a salaried GP and a partner.

When I went back, I was a Covid conscript. I retired, aged 58, but at age 59 I went back as a Covid conscript. To pick up on your last point, I was working then completely remotely from home for about five hours a day

dealing with the very administration tasks that we have heard described to us. This was a 30,000-patient practice by that stage. I was dealing with complex repeat prescription requests. I was dealing with some of the hospital letters that needed GP actioning. I was dealing with all of the lab results and setting out treatment plans for those patients. I worked in that way. When you consider that it was five hours a day solid doing that sort of work, it echoes the administrative burdens that are on the GPs.

I then retired from that post, but at 60 I went back as one of their vaccination lead GPs. I think that illustrates two things: first, the enormous variety of GP jobs; but also, focusing on retention, the fact that for GPs, probably more than for other professions, retirement is not an event. It is a process that can sometimes take several years. Once you have embarked on that process, the things that keep you in the workforce are often heart decisions rather than head decisions. There is a balance between the things that pull you back into the practice and the things that push you away from the practice.

It strikes me that if you are trying to retain people it is almost like managing someone with a terminal disease. If you concentrate just on preventing the death of someone who is terminally ill, they have a miserable time and they do not spend any longer on this earth. If you concentrate on making their life worth while, not only is their life worth while, but the final date of departure is often later than if you treat people aggressively. Please concentrate on—

Q9 **Dr Evans:** Let's explore this. I was not going to do down this route, but as you brought it up: what would have made a difference in terms of the flexible workforce? We hear a lot about that, both in the private groups we have heard and looking forward to the way we should design our workforce. As someone who has been through retirement, what do you think? Who do you think should be doing it? GPs are in quite an interesting place as to who you are responsible for. Is it individual practices? Is it the PCN? Should it be the CCG? What should be the offer about putting an arm around someone who is thinking of retiring?

Dr Green: I am a great believer in loyalty. The reason I went back during the Covid crisis was an absolute sense of loyalty to my practice and to my patients. I believe that loyalty is best engendered in a small group environment rather than a big organisation that has changed hands many, many times.

Each of my changes in career was precipitated by a different thing. When I became a salaried GP, I did so with a zero-hours contract. They are very unfashionable, but it suited me very well because it gave me the flexibility that I needed. Many doctors in their late 50s and early 60s have family responsibilities. We have grandchildren coming in at one end and we have parents often becoming frail at the other end. Flexibility at that stage is really important and valued. I got that through a salaried post.

Q10 **Dr Evans:** Thank you. Dr Kate, would you talk about the appropriateness

of the work you are doing? We often want doctors to be doing more of the work they are licensed to do and less of the work they should not be doing. First of all, how much admin was there, both from the interface with secondary care and from things that could be done by nurses or other allied health professionals? Can you give me a rough percentage of how much you see coming through that is either inappropriate or could be done by someone else?

Dr Fallon: It is quite a difficult question to answer because every piece of admin and every blood result you look at needs a clinical decision. Although we have a lot of extra clinicians helping us in practice at the moment—for example, pharmacists and physician associates—they are still not able to take full responsibility for the decisions.

With our admin, for example, one of our secretaries upstairs codes the letters for us. She puts useful information in the letters, but we still have to look at them ourselves, we feel, otherwise things get missed. It is a really difficult interface, I think.

Q11 **Dr Evans:** This is very interesting. We have heard a lot in this Committee about trying to get allied professionals in. From what you are saying, am I right to infer that the workload just becomes more complex and what you are left with are more complex decisions, or patients who are more complex because they have five or six comorbidities and are sat in front of you for 10 minutes? Is that a fair summation?

Dr Fallon: Absolutely. The population is older. Everybody has five or six different morbidities. They are all on a lot of medications that did not exist 30 years ago, when I started. That is the interesting part of the work in lots of ways, but it is very time-consuming.

We are bringing people in supposedly to help, and they do to a degree; our pharmacists are really helpful to us. For example, they have a 30-minute appointment to do a medication review, which they do extremely well, but then when the patient brings up further issues that they have in that consultation, we will still then get a Task to say, "What about this?" Then you have to take that on and deal with it yourself.

Q12 **Chair:** On the comorbidities point, Kate, thank you for that, but could you tell us what has happened to continuity of care given the increase in the GP workload? Are you still able to maintain personal relations? Do patients in your surgery have their own GP or has that become more difficult?

Dr Fallon: We have always worked to personal lists. Yes, they do, apart from the patients belonging to the two GPs who have now left us. We have not been able to recruit, so we have a pool of patients at the moment who we are all trying to look after as well as our own.

We believe very strongly in continuity of care. It is a much more efficient way of working. When patients are so complex, there is no way, if you have no idea about them, that you can deal with them appropriately in a

10-minute consultation. We are striving hard to keep it going because I think it is one of the great jewels in the crown of general practice, but it is becoming increasingly hard. If we cannot recruit, the quality of care will not be so good.

Q13 **Chair:** Andrew, could I bring you in on that point?

Dr Green: Continuity is really important. In our practice, we did not have personal lists. When I was working, it was a 10,000-patient practice. The acute on-the-day work was done by the duty doctor.

Patients are clever and sophisticated users. If they feel they have a problem for which continuity is useful, especially for the complex chronic diseases, they wait to see the doctor they want to see. That is why coming back from holiday is sometimes so difficult, because you see all the patients who could not possibly see anybody else.

Towards the end of my career, patients were completely different from the ones at the start. They were far more complex. I want to pick up on the 10-minute appointment. We need to accept that 10-minute appointments are not safe. The only way that you can run a 10-minute appointment surgery on time is by cutting corners. Experience helps in that process, but we are deluding ourselves if we think that we are always safe. One of the things that made me finally give up normal clinical work was the feeling at the end of the day that I was not happy with the work I had done, because I could not fit what the patients needed into 10-minute appointments.

It gets to mathematics. If you divide the number of minutes that a GP has per patient per year, it is just over an hour. At the moment, we are running roughly six 10-minute appointments. If we agree that that is untenable and we go to three 20-minute appointments, which is probably the time we need for very complex cases, with the GP as the expert medical generalist, and which I am sure is the way we need to go, we need to ask ourselves—this comes to the point about other workers—who is going to see those patients on the other three occasions? Where are they going to see those patients? What qualifications will people have so that they can deal with them rather than just pass the problems on, and who is going to make sure that the right patient gets to the right professional? Those are the challenges.

Q14 **Chair:** I will bring in my colleague Sarah, and I will come back to you, Luke. Can I ask you both one follow-up to that question? When you are not able to give the care you want, either because you are not able to give consistent care to the same patient because they are having to see different doctors in the surgery or because you only have 10 minutes and it really should be 20 minutes, what is the impact on you personally? How does that make you feel in terms of job satisfaction and even your own mental health?

Dr Green: It makes you leave because you get home at the end of the day worrying. When I look back on my career, I am actually very pleased that I was a GP. I loved the work. I loved seeing the patients. I am proud of what I did. The thought of spoiling that in the last year or so was just too much to bear for me.

The problem at the moment is that the career is a marathon, but doctors of all ages are being forced to run it at a sprint speed. If that happens, there are two consequences: either they collapse before the finishing line; or they get to the finishing line, but have done themselves or others damage in the last few laps. I was not going to let that happen to me. I do not think I am in any way unusual in thinking in that sort of way.

Q15 **Chair:** Kate?

Dr Fallon: I am still here, of course. You just put in the extra hours. At the moment I think that is probably what I do. You are absolutely right; none of us wants to go home at the end of the day worrying about patients. I make sure that I do not do that. Sometimes I do, but I just love the job. I think that is what is keeping me here at the moment. I seem to be able to manage it in some way.

It is feeling harder. As I have done my 24-hour retirement, I know that I just need to give my six-month notice at any stage, and I can go. That helps me keep going. I know there is a way out. It does not sound good, but that is the way it is at the moment.

Q16 **Sarah Owen:** I have a quick question related to the continuity of care point that both Kate and Andrew mentioned. The 111 services across the country are increasingly being used by CCGs almost as a booking service, particularly over the last two years during the pandemic. How sustainable do you think that is, Kate? What is it doing to continuity of care?

Dr Fallon: They can book us a couple of appointments a day, which the duty doctor picks up. That is not particularly good for continuity of care, although as I work in a small practice I think it helps because we all know a lot of the patients. We only have 6,500 patients. If we worked in a much bigger practice, which I have not had any experience of, it must be much more difficult for patients.

Chair: Thank you. Luke, do you want to finish? Then I'll bring in Dean and Lucy.

Q17 **Dr Evans:** Can you talk about the IT that you use? What is it like? How good is your IT and your computer, for the blood systems and joining things up?

Dr Fallon: We use SystmOne. It is busy, but it does the job.

Q18 **Dr Evans:** How much time do you spend in your day chasing letters and sorting out your IT? Can you give me a percentage of your time spent chasing hospitals, letters and IT stuff—scan results and things like that?

Dr Fallon: I do not chase. I get somebody else to chase.

Q19 **Dr Evans:** I mean patients coming to you and saying, "I've been to see the diabetes specialist in hospital and they put me on this medication. Can I have it?", and you say, "I haven't seen the letter." Is that relevant to you? Does that happen?

Dr Fallon: Yes, it happens quite a lot.

Q20 **Dr Evans:** How much of your time do you think is spent? Is it 5%, 25% or 1%? Can you give us a feel?

Dr Fallon: It is 5% of the total day.

Q21 **Dr Evans:** What about your experience of technology, Andrew, as a user in a GP practice?

Dr Green: I went from having no computer to being fully computerised, which was an interesting journey. It is fantastic for getting patients' care over time, particularly with numerical things. It is nowhere near as good for getting the soft information out.

The real problem with IT is on a Monday morning when you go in. You are already a bit stressed. You press the button and it says "Update in progress" or it just is not working. Honestly, it makes you want to cry because you know that you will never catch up. It is the fact that there are so many old computers. We live in a rural area, and the biggest problem was the N3 connection, which was just too slow.

Q22 **Dr Evans:** That is my experience. I was trying not to lead it too much. Absolutely. It was going in and waiting 15 minutes, with all six doctors standing in the corridor, while the update happened on a busy Tuesday morning. It was almost weekly. How often was it happening, Andrew?

Dr Green: It seemed more often than it was, but certainly once a month.

Q23 **Dr Evans:** That frequently?

Dr Green: Yes.

Q24 **Dr Evans:** Kate, I noticed in the press that you have been lauded as a leader in your local area. That is fantastic. Can you talk about how you are inspiring? You said you still have love for the job, which is great to hear. How are you inspiring the registrars and the medical students coming through? What is their perspective when they see you at work?

Dr Fallon: Sadly, I do not have medical students at the moment. We cannot teach any more because we do not have enough doctors to do it, which is so sad. It is a difficult one. It was my dear partners who put me forward, so you do not really know what you are doing.

It is really important to teach. You can give love of the work to the registrars and the medical students. You can take them through all of the interesting stories that you have and show them the importance of

continuity of care and the relationships you have with the patients. I think those are the key things.

Dr Evans: Thank you.

Q25 **Dean Russell:** If I may, I will come to you first, Dr Green. Building on the technology piece in the first instance, I was very fortunate a while ago to visit Bridgewater surgeries in my own constituency in Watford. I spent about four hours there. One of the things that was clear to me was how much goes on behind the scenes in terms of the organisation and management of patients, the follow-up and so on.

That seemed very reliant, understandably, on technology and seamlessness around that, but I hear from other GP surgeries that it is not always quite the same. I hear that there are inconsistencies. I hear that from a patient perspective there are often challenges in making sure that the GP surgery fits with what they have had at the hospital or other places. I want to get your take on whether that sounds like a correct analysis and where you think improvements could be made.

Dr Green: Getting information to everybody who needs it is an absolute challenge. The sharing of records between hospitals, GPs and, where appropriate, people like community pharmacies is absolutely essential. The problem is that you are very dependent on the quality of the information that is put in. Sometimes, when you see information that is put in by other providers, it can actually be far too much. You cannot then extract the information that you need from the reams and reams of notes. This can be a problem with SystmOne, from what I have seen of the SystmOne work.

IT is essential, but it takes time. I started with seven-and-a-half-minute appointments. When we went to 10 it seemed wonderful, but those two and a half minutes have now definitely been taken up by inputting data on the computer. The computer, if you are not careful, can be a real barrier between you and the patient. It is difficult to put the screen to one side and concentrate on the patient, but then where do you find the time to input the data that you need to keep your practice running?

Q26 **Dean Russell:** Do you find that can get in the way of the efficiency of the work you are doing? Obviously, your role and purpose in life as a GP is to look after the patient and to make sure they are okay, and not be a data entry person.

Dr Green: It depends how you define efficiency in general practice. You could talk about that all day.

Q27 **Dean Russell:** May I come to you, Dr Fallon, with the same question about technology, the role it plays in the surgery and where the improvements could come?

Dr Fallon: We have to make notes. We wrote notes before we had computers. It is really important not to make the computer a barrier. You still talk to your patient in the same way. It takes a lot of extra time, as

Dr Green has just said. But you can do searches; you can text your patients; you can do video calls; and you can get advice from consultants via an app. There are a lot of positives with IT as well. I don't know that there is a perfect system, particularly when it goes wrong, but there are benefits as well, I would say.

Q28 **Lucy Allan:** Thank you very much for coming this morning. I really appreciate you giving up your time.

Dr Fallon, you have spoken quite eloquently about the challenges of recruitment and retention, and the impact that has had on your surgery. Could you describe how that has been exacerbated through the whole Covid backlog and all of that? Has that been something that has made it more difficult to recruit and retain good people?

Dr Fallon: I don't know why there are not GPs out there, actually. It has never happened before. When I first went into medicine, it was competitive; we had 30-plus applicants per post. We have never ever put out an ad and had nobody even interested. To be fair, we had one interested in a partnership, but he was offered more where he was and stayed there.

It is really difficult to know what is going on out there. It is having a huge impact on the workload of the three partners who are left. I do not know why they are not there. I suspect that the more stress there is in general practice, the more people think, "Well, I don't want to go and work in that environment." It becomes a vicious circle.

Q29 **Lucy Allan:** Obviously, the Covid backlog has created difficulties for patients in accessing GPs. Do you find that your patients come to you frustrated and angry? Is that something that impacts on your morale?

Dr Fallon: I think that patients are very kind to us really. Obviously, some are cross but we would never refuse to speak to anybody or see anybody if they needed seeing. The bigger impact we are having is the delays in hospital care. We have a 63-week wait to see a gastroenterologist at the moment. What are all those patients doing? Well, we are holding them. We are taking the risk. We are trying to support them through that. That is causing us an awful lot more patient contact than if the service was more timely. It is not just gastroenterology, but that is the worst example.

Q30 **Lucy Allan:** If you could say one thing to Government that would make your life easier in treating your patients, what would you like to see the Government and the NHS do to help support GPs in the context of what you do?

Dr Fallon: What I need is more GPs. I know that you cannot produce a GP. It takes 10 years, but that is really what we need at the moment if we are to be able to provide the service that we want to provide.

Q31 **Lucy Allan:** Dr Green, what would you like to see happen going forward?

Clearly, as MPs, we get all the time—in fact even while I have been sitting here this morning—somebody saying, "I can't access my GP. I'm going to have to go to A&E." Then A&E say, "We're going to shut the doors because we're overwhelmed." What do you think Government need to be doing to try to address this, because it is going to deteriorate, isn't it?

Dr Green: I wish we would talk a little bit more about capacity rather than access. The problems with access are due to the lack of capacity. Picking up on the younger doctor issues, we started having foundation year doctors in our practice for three-month periods. We always used to debrief them afterwards. Quite a lot of them said, "I think what you do here is fantastic. I didn't realise you did all of this. The job is so interesting and varied, but I can't do it." It almost put people off, and they went into hospital medicine because they felt that a speciality with a defined area of knowledge would be easier for them personally. I do not know if that is true or not, but it is one of the impressions that they left us with.

It all comes down to workload. If you want to keep people in the system, you have to make it a job that is doable to a high standard for 30 years and that preserves doctors' self-esteem. One of the things Government could do, I am sure, is to back their GPs a little bit. The constant denigration of the profession which gets into some aspects of the media is one of the factors that pushes people away from the job, if they are in it, or from entering it if they are considering it.

The most obvious example recently was when GPs did a fantastic job going to a digital first model. After a few months, a section of the press turned against it. Instead of it being defended by people in government and within NHSE, they seemed to jump on the social media pile-on that was going on. Don't underestimate how distressing that is and how much it lowers GPs' self-esteem and how that would be a push factor for keeping people away from the profession. Please support us.

Lucy Allan: You make a powerful point. The rebuttal to that is that if you are an MP, and people are constantly saying to you, "I can't see my GP," they assume it is the GP's fault. They do not necessarily understand the capacity issues that you have articulated. It is how we try to address that. I take your point; thank you.

Q32 **Dr Evans:** I have a final question for you both. Dr Fallon, as you are practising, is there hope?

Dr Fallon: There is always hope, isn't there? I talked to a lot of my peers and PCN leads before I came here, and one chap said, "A bit more respect from people. It's not the money, but when we had seniority payments it helped to make you think you were a bit valued."

When we were driving to work in December, we heard on the radio that we were going to be dropping everything to give the Covid boosters. We

had not heard before the general population heard. It just makes you feel that maybe you are not quite as valued as you might be.

Q33 **Dr Evans:** Thank you. Dr Green?

Dr Green: There is hope. I had a fantastic career. I enjoyed it. I don't regret it. I am not a bitter retired GP. What I want is for my younger GP colleagues to have the pleasure from their work that I had. I loved seeing patients. I loved the work, but the job became impossible. There is hope if you can make the job possible. That might need some brave decisions.

I have mentioned this idea a few times. It has always gone down like a lead balloon, but I will try it once more. It might be that the expert medical generalist needs to be a doctor other healthcare professionals refer patients to when they feel it is needed. That would be a huge change in the profession. It would not be welcomed by many doctors. It would be a very brave politician who did that, but I see no other way of balancing the mathematics to give GPs the time they need with complex patients. That is really a problem for you and not for me.

Chair: Thank you, Dr Andrew Green and Dr Kate Fallon. We really appreciate your joining us this morning. It is very important evidence. Thank you both.

Examination of witnesses

Witnesses: Professor Marshall, Dr Sharrock and Dr Fisher.

Q34 **Chair:** We now move to our second panel this morning. I am very pleased to welcome back Professor Martin Marshall, who is chair of the Royal College of General Practitioners; Dr Kieran Sharrock, who is deputy chair of the General Practitioners Committee of the BMA; and Dr Rebecca Fisher, who is a practising GP and senior policy fellow at the Health Foundation. Welcome to you all.

Let me start, if I may, with Professor Marshall. Let's try to think, if we could, about the scale of the problem. The GMC recently found that nearly half of GPs are planning to reduce their contracted hours, and nearly a third are going to leave general practice altogether in the next year. Does that ring true with you? Is the profession in crisis?

Professor Marshall: Yes, it does ring true and, yes, the profession is in crisis. It is a massive concern. I have been a GP for just over 30 years. I have seen ups and downs over that time in the status of general practice and general practice's ability to do its job, but I have never seen things as low as they are now. It really is a major concern. If we are not able to provide the majority of care, as we do in the NHS—90% of patient contacts happen in general practice—if we are not able to serve our communities and if we are not able to do the job we do in general practice, which is to protect the rest of the NHS, especially services, so that they are used judiciously and when they are required, that is a really big crisis.

You are right. The GMC survey was very worrying in terms of the morale of general practice. Our own work in the college showed that 60% of GPs said that their mental health had suffered in the last year; 34% of GPs said that at least once a week they simply cannot do their job, not even providing safe care for their patients; and 34% of GPs said that they planned to retire in the next five years. That would mean 14,000 fewer GPs than we have at the moment. We are likely to be losing more GPs than we are recruiting at the moment, and that is a massive crisis.

Q35 **Chair:** Looking at early retirement and people going part time, we heard evidence from the two doctors in the first panel about the pressure of workload. Dr Andrew Green said that it was really pressure of workload that prompted him to retire early. You and I have talked many times about the need to have independent reviews of the number of GPs we should be training for the future, but that is a five to 10-year process before it really makes any difference. What are the short-term things that we could do to address the workload issue?

Professor Marshall: You are right that the crisis is one of workload. It is essentially the demand and the need for general practice services being greater than the supply of general practice services. I think there are three solutions to that. One of them is a larger workforce, as you say. We are making some progress on recruitment, but going backwards on retention.

The second solution is working differently. You started to touch on that with Dr Fallon and Dr Green, about the role of the GP alongside other members of the primary healthcare team. Perhaps we can come back to that later. The third solution is changing the nature of demand and helping patients to know when they need to access professionalised services and when they can self-care or go to a local community pharmacist, or other ways of accessing care.

There are three basic solutions. It is not on the basis of evidence, but I would guess that probably 85% of the answer is a larger workforce. There aren't any quick or easy answers to this crisis, and that is what worries me most.

Q36 **Chair:** One of the things we talked about in that panel was the question of continuity of care. Tell us about the findings of the *British Journal of General Practice* Norway study on the impact on patients of seeing the same GP over many years.

Professor Marshall: The study from Norway that was published in the *British Journal of General Practice* adds to a growing body of evidence conducted over 30 years or so in lots of different countries and lots of different health systems. The evidence in favour of continuity of care is really strong.

We know that if I see a patient I know and who trusts me, where we have built a trusting relationship, the patient is more likely to be satisfied

and to have a good experience. They are more likely to comply and agree with the advice that I give. They are more likely to get better health outcomes. They are less likely to use emergency departments and hospital services. We know that the overall cost is reduced. We know that my professional satisfaction is greater.

The evidence is really convincing. Indeed, I would say that the trusting relationship between the GP and their patient is probably one of the most effective interventions we have. It is more effective than many of the drugs and the surgical outpatient appointments that I make, yet because it is rather soft, policymakers do not seem to understand it. They put a lot of effort and energy into other interventions like drugs, for example, but there is insufficient understanding of the importance of relationships. That really needs to be delivered.

There are many different ways to deliver it. We have to accept that the old model of one GP and one patient for 40 years is not sustainable. That is not what society is like, but there are ways of delivering trusting relationships in a new society, and that is what we need to work on.

Q37 **Chair:** Do we need a modern version of the old GP lists? That is not to say that a patient saw the same person every single time, as might have happened in the olden days, but that there is always one GP who is accountable for every single patient. Sometimes, they direct that patient to the practice nurse or someone else in the surgery, but there is always one person accountable for a patient's care.

Professor Marshall: There is no doubt at all that the sense of responsibility that comes from having a patient on your list is a really important element of the effectiveness of general practice and its cost-effectiveness. Only about 8% of practices in the UK now have personal list systems. Dr Fallon is in a significant minority of practices. That is a real concern, because the nature of the workload challenge and the nature of many policy interventions over many years has made general practice an increasingly transactional activity, where the consultations that we have are a disconnected set of transactions rather than a journey that we are on with our patients. It is a major problem.

We could go back to a different model of relationship-based care, often, as you say, a team-based model; the old model might have been a GP and their practice nurse. We now see some practices developing micro teams of perhaps two GPs sharing a list and working with a nurse, a social prescriber or a pharmacist. That small, micro team is a way of delivering continuity of care at a time when so many of the social pressures stop you delivering the traditional model.

Q38 **Chair:** I am sure that my colleagues have more questions for you, but I want to bring in your fellow panellists. Dr Fisher, do you agree with the analysis that you have just heard from Professor Marshall from your work at the Health Foundation and as a practising GP? What is your take on the issues of burnout and workload that we have been hearing this

morning?

Dr Fisher: A lot of what has been mentioned is hugely familiar to me. I had a very late night in practice last night. I think probably almost all GPs you speak to would say that the workload feels as though it has been going up and up for years. It baffles us by going up and up still. I reflect that in my own practice it feels like the channels that we use have widened and there are more of them in the last couple of years.

You asked about Covid workload. There is clearly workload associated with Covid itself: the management of patients who are unwell and the vaccination programme. We are also using, for example, email far more than we were before. We are using Tasks far more than we were before. The different workstreams coming in to me on a given day feel like they have expanded enormously. I think that is a challenge because it inevitably leads to longer work days.

I agree with everything that Professor Marshall said about continuity of care. At the Health Foundation we have done a lot of work looking at how you can preserve and improve continuity of care. We know that, even in challenging circumstances, quality improvement approaches in particular can be used to maintain continuity of care and improve it.

Something I would really like to stress, though, is that these problems are not the same everywhere. General practice in this country in areas of high deprivation is underfunded and under-doctored relative to need. That is a persistent problem. It is not a new one. At points in time, particularly in the noughties, we were getting somewhere, particularly on workforce. Since then, under-doctoring has widened again. We are in a position now where, relative to need, general practice in areas of high deprivation has on average 7% less funding in practices, and a GP working in an area of high deprivation will be responsible for, on average, 10% more patients. To me, that is an enormous problem.

We talk a lot about how we can improve health inequalities. It seems to me very difficult to do that in a context where the provision of an essential service like general practice is not equitable. That plays into the workload problem and the retention problem as well. Although it is a problem everywhere—I certainly would not deny that—we are remiss not to remember that it is more of a problem in some areas than others.

Q39 **Chair:** Can you explain why there is that inequality in funding? As I understood it, the funding formula that the NHS uses takes account of deprivation as one of the factors it assesses. I thought there was a premium on more deprived areas getting additional funding. Is that not the case?

Dr Fisher: I think the funding formula you are perhaps thinking of is the funding formula for CCGs, where there is a top slice for deprivation. The vast majority of funding for general practice comes directly to practices through, mostly, the GMS contract. The majority of practices use that

contract type. About half of their practice funding will be determined by something called the global sum formula, which uses a formula colloquially known as Carr-Hill.

There has been underfunding in areas of high deprivation for a long time, but from the 1990s through to 2004 there were top-up payments called deprivation payments for practices in deprived areas. They did not solve the problem, but they went quite a significant way towards improving it. When the global sum formula was brought in, in 2004, it was in theory meant to account for the different needs experienced by different patient populations, but it did not include any adjustment for deprivation. For example, if you have a 10% increase in deprivation, according to the Carr-Hill formula you get 0.06% extra funding. That was research from colleagues at the University of Leicester. It does not account for all of the practice funding, but across almost all other income streams into general practice—for example, QOF, or locally enhanced services—practices in more deprived areas get less money. Wherever you look, the way the payments work skews towards practices in more affluent areas getting more money. That is how you end up with the 7% discrepancy.

Q40 **Chair:** Are you sure that it is practices in more affluent areas, or practices with more older people? Sometimes the two go together.

Dr Fisher: Our work is very clear that it is practices in more affluent areas. We do it by dividing the country into areas—

Q41 **Chair:** But what I am saying is that, if those areas also happen to have more older people, that would be a reason why they might require additional funding.

Dr Fisher: Carr-Hill weights very heavily for age and does not include any funding for deprivation. Inevitably, part of this is that we have such a large and increasing life expectancy gap that in areas of high deprivation our patients simply do not get to be "old" old, so fewer of our patients attract the extra funding that comes with the bigger adjustment for age, and we do not get any additional—

Q42 **Chair:** Health inequalities in that sense would be the cause of the problem of the underfunding of less affluent areas.

Dr Fisher: Yes. I would contend that the root cause, and probably the place to look were we to talk about challenging this, would be the funding formula for general practice, but certainly health inequalities themselves play into the underfunding.

Q43 **Chair:** I will quickly bring in Dr Sharrock. Do you have any comments on what you have heard so far? Could I also ask you about the pensions issue and whether the structures and the annual pensions pot are causing GPs to retire early?

Dr Sharrock: I concur with what my colleagues said about retention and recruitment of GPs. If a third of GPs are reporting psychological distress,

that is not going to encourage people to stay or join the profession. Most GPs report that they are overworked. In fact, a survey of GP trainees has shown that 61% stay longer than their contracted hours, and 41% say that they regularly go to work early to catch up from the day before. That is not a way to encourage them to come into the profession long term.

We know that, when people are having psychological distress, they are more likely to leave. Yes, they might go to what is termed "part time", but actually the work-life balance survey of 2019 showed that part time was 40 hours. In most professions, 37.5 hours is full time, so the average GP still works 40 hours a week. That might be over only six sessions, but if those sessions are six hours long, that is 36 hours. Saying "part time" is a little disingenuous. We need to focus on hours worked and not numbers of sessions done. If the sessions are long, it is a long time. I concur with my colleagues; we need to make the job more attractive and more sustainable to recruit people and sustain people.

On the pension issue, there is a situation whereby financial advisers go to GPs towards the end of their career and advise them to leave work. We know that, last year, 55% of doctors retiring were taking voluntary early retirement. That is because the pension taxation situation makes it as if they were paying to work. Financial advisers are advising GPs to retire early or reduce their work commitment. We need to uncouple the amount of work done from the taxation of the pension, in the same way that judges have had that done for them. There was a problem with recruiting and retaining judges that has been sorted by looking at their pension.

If I was working in a stressful job and someone said to me, "Well, actually, you might as well retire because you are paying to come to work," I would either retire or say, "Well, make my job less stressful and I might stay." I don't mind paying to work in a job I love, but if you have both things putting pressure on you to leave, you are going to leave.

Chair: Thank you.

Q44 **Dr Evans:** Professor Marshall, I would like to go into this idea of complexity and the changing nature of patients. What is the royal college's position on how complexity has come in and how allied professionals are helping out? Is that a good thing, a bad thing or somewhere in the middle?

Professor Marshall: In a whole range of ways what we do in general practice is more complex, beyond just the simple workload and the number of patients we are seeing. We know that the population is older. We know that they are more likely to have multiple medical conditions. We are more likely to see greater ethnic diversity in populations as well, particularly where I work in east London. All of those factors together mean that the kind of problems that we are seeing in general practice, as well as medical advances, are far more complex than they were when I first started my career.

A consequence of that is to make each consultation more stressful. We know that the average consultation length is 9.8 minutes. The average number of problems is about three. You have a complex problem and two or three minutes to deal with it in a consultation. It doesn't work. What it means is that you are constantly cutting corners and you are constantly making compromises. Those compromises are most likely to fall on your ability to provide personalised care, person-centred care and probably equity of care as well. Increasingly, they put pressure on the ability to provide safe care. A number of GPs I know are constantly worried that they are going to make a prescribing error or a diagnostic error. That adds to the stress, which is why—

Q45 **Dr Evans:** You have very complex patients repeated over and over again. We heard there were about 16 contacts in the morning and 16 in the afternoon as an average, to start with.

We have had a litigation investigation. There was a lot of talk about the fact that there is a changing nature, in that GPs are supported—it is an educational side—if they were to make a mistake. Do you believe that is borne out in the way that people practise? Can you talk to me about defensive medicine?

Professor Marshall: Yes, it is without doubt. One of the most important roles of general practice is to hold risk and to manage uncertainty. That means that every young child I see with a fever could have meningitis. The vast majority of them do not have meningitis. What I do is make a clinical assessment and live with the uncertainty that very occasionally I might have got it wrong. That is catastrophic when it happens. That is our job. If I were to refer every child with a fever to hospital, query meningitis, the hospital would collapse very quickly. Our ability to do that is under stress when we are under pressure. Increasingly, I think there is evidence that younger doctors find it more difficult to hold that uncertainty and risk, which is playing out in a larger number of referrals and investigations. It is basically overmedicalisation.

Q46 **Dr Evans:** They do not want to take the risk. You see it in A&E. You say, "This was never chest pain; it is atypical chest pain," but you are sat in a GP consultation going, "Well, it could be a heart attack." Am I right in saying that if you are a GP, why would you take the risk? If you are not sure, or it is 50/50, if you are right you have saved the person's life and if you are wrong you have wasted a bit of time. That seems a very sensible decision to make. Is that the way people are practising, with the sword of Damocles over their head that the law might come after them? Is that a fair assessment?

Professor Marshall: Yes, I think that is a fair assessment. The purpose of general practice training is to help us to manage and hold that risk; to manage uncertainty. When we are trained to operate in a reasonable environment, where the workload is reasonable, we do that job incredibly well. One of the great things about general practice is the fact that we do not investigate everything. We do not refer everything. We manage a lot

ourselves, but when the environment is not conducive, we refer more and we get more stress.

Q47 **Dr Evans:** We heard from Dr Fallon that pharmacists are useful, and nurses are useful, but they still come to her for the risk decision. Is that borne out across the system that you are seeing?

Professor Marshall: Yes, that's right. One of you asked Dr Fallon about the proportion of patients that had relatively straightforward and transactional problems. I agree with Dr Fallon that it is very difficult to determine that. The reality is that, when we do not have enough GPs, we need to focus on where we add the greatest value. That is, at one end of the spectrum, triage. GPs are very good at making quick decisions about risk. At the other end of the spectrum they are managing complex, what we call, biopsychosocial problems, taking into account the psychosocial elements. There is a whole series of work in the middle. That might be 20%, 30% or 40% of care that can be done as effectively or more effectively by other members of the primary care team, and that is where the multidisciplinary nature of primary care has become so important.

Chair: Thank you. I will come back to you, but I need to bring in Sarah Owen.

Q48 **Sarah Owen:** Thank you, Chair. I apologise but I have to leave shortly, so I am grateful to be able to come in now. Dr Fisher, I want to ask a few questions about regional variation. I represent one of the areas that you described. It has lower than average UK life expectancy, but within Luton a man can expect to live 10 years less in a deprived area of Luton compared with a more affluent area of Luton. Getting this right is key to ensuring that we tackle health inequalities.

What do you think could be done to really target support to general practice workforces in areas of high deprivation, where we also see that they are under-doctored? I am curious about the 2004 top-up payments. What were those payments used for and why were they effective?

Dr Fisher: Thank you very much for the question. We recently did a big piece of work at the Health Foundation looking back over 30 years of efforts to tackle the inverse care law in general practice and all the national policies that tried to tackle it, to try to answer the question of what we should do next.

I will come to your point on workforce first. Funding probably underpins it. Workforce is a difficult but not intractable problem. If we go back 30 years, there was under-doctoring in the most deprived areas, but significant policy efforts were made, particularly in the north-east, via a couple of different mechanisms. One was changing contract types to bring in salaried GPs. Another was something called equitable access to primary care, which built new GP premises in areas of high deprivation. Those things seemed to work, in combination with other, smaller incentive schemes to attract GPs to work in deprived areas, such that by 2008-09 we were starting to see more GPs in the most deprived areas.

That is what we would want to see if we are to deliver equitable general practice.

Those efforts were not continued in such a concerted manner in the decade we have just been through. By 2013-14, we started to see under-doctoring again, and now we are back to a situation where there is a linear correlation. The more deprived you go, the fewer GPs there are per adjusted head of population.

It is also worth saying that prior to 2002, but from 1948, there was something called the medical practitioners committee that effectively controlled GP entry into different areas. If you wanted to go and work somewhere, you applied to the MPC and they could say no if that area was already adequately doctored. I am not necessarily saying that we should bring that back. I certainly would not suggest that we should mandate doctors to go and work anywhere. I do not think that would solve our recruitment problems in general practice at all, but there is good evidence that you can improve workforce distribution in general practice.

Funding is key. With the independent contractor models, to a certain extent the amount of practice funding you have determines how much you can pay people, the terms you can offer them and the workload they are expected to undertake for you. While we continue to have this perverse underfunding of general practice in the areas of the highest need, I find it very difficult to see how we can really change the workforce picture.

Coming back to look at that, it was 2004 when Carr-Hill was brought in. We need a full review of funding for general practice of all the different streams of income and working out a better way to account for need associated not just with deprivation but with age, with comorbidity, and so on. How do we have a funding formula for general practice that looks in the round at the need of patients in a given area? I hope that if we did that piece of work we might get closer towards solving some of the other problems that I suggest stem in part from it.

Q49 **Sarah Owen:** I want to follow on from Luke's hopeful question. Luton is turning out a fantastic number of medical students. Lots of really bright young people want to go into medicine. What would you say to them to encourage them into general practice?

Dr Fisher: Oh my goodness. Come. It is the best career. I am 36. I absolutely love it. I never thought that I would be a GP. I thought that I would be an intensive care doctor or an A&E doctor. I continued to think that until several years after I had qualified. I am absolutely delighted that I made the decision.

To give you some evidence that is not just me, five years ago two colleagues—Nish Manek and Rammya Mathew—and I set up something called Next Generation GP. We had the privilege of being fellows to Sir

Bruce Keogh at the time. We wanted to try to share that to empower some of our colleagues. It has been a rip-roaring success, not really due to us. Over 2,500 GPs have been through our programme. There are 62 programmes across the country. We have been in all four nations of the UK. Nobody is paid to come. People are not, broadly, being paid to give up their time to run our programmes. They are young, early career GPs making an effort to invest in themselves for the future of the profession.

I have antibodies to the narrative that early career GPs do not feel as invested in the profession as senior GPs. We have a lot to learn from our senior colleagues. The ways we want to work may be slightly different, but we absolutely care about our patients, and we absolutely care about the future of the profession. I certainly think there is hope.

Q50 **Lucy Allan:** Thank you very much, Dr Fisher. I thought what you were saying about the variation across the country was incredibly interesting.

I wonder if I could ask about super-surgeries. In my area, which is a deprived area, we have a 60,000 patient list and one practice. In that context, do you feel that retention and recruitment are affected? Morale for a doctor working in a 60,000 patient practice list must be very different from working in something smaller, as we heard earlier from Dr Fallon.

Dr Fisher: It is interesting. There are lots of different models of larger practices or at-scale practices across the country at the moment. I suspect that the way they work is quite different from each other as well. Within some of those models there may well be attempts to preserve continuity. It may not be list based. It may be that, although you are working for a bigger organisation, you are actually working within a relatively small practice with colleagues you have continuity with. Continuity of care is, of course, not just about relational continuity with patients. It is about informational continuity across records. It is about managerial continuity with colleagues.

I cannot comment specifically on how we preserve continuity in those bigger models. I would say that a strength of general practice, as I see it, is the range of models we have. It means that, as a practitioner, you can work out what type of model you would like to work in and find somewhere that works in that way.

Q51 **Chair:** Professor Marshall wants to come in.

Professor Marshall: In answer to the question, I think there are advantages to large practices, the advantage being that you have the resources to develop an infrastructure to support HR, data, quality improvement and all of those things. There are advantages to smaller practices. They tend to be more personal. It is a design issue. You can have a large practice that designs itself in such a way that it delivers personalised care by designing itself into micro teams. It is possible. The mantra is get big to stay small. It is possible to have a larger organisation

and the infrastructure that goes with it, but still to have a small, personal local front end, which is what general practice is all about.

Q52 **Lucy Allan:** One of the concerns is that, in effect, it is a monopoly, so local people cannot choose to go somewhere else. They have only this super-surgery that they can go to, and if that is not delivering for them there is no other way of accessing the NHS. I think that has been a big struggle. In your experience, would you choose to work in a super-surgery?

Professor Marshall: I work in a large group practice. There are about 14 practices in the group that I work in across London, mostly serving deprived communities. We organise and manage ourselves in such a way that we have a fairly high level of autonomy in the small group where I work, serving the community that I serve. I think it is possible.

Going back to your first question, the British public are surprisingly un-consumerist about general practice. They do not want to exercise choice very much. What they want is a really good service in the practice that they happen to belong to and that is part of their community. That is what we have to aim for.

Q53 **Lucy Allan:** On the point about disadvantage, because you have experience of a disadvantaged area, would you echo the points that Dr Fisher made that service for people in a disadvantaged area will be less good than elsewhere?

Professor Marshall: Yes, without doubt. Becks is the expert in this area, but there is no doubt at all that the quality of care that is deliverable, and the resources available to deliver that quality of care, will be less good in more deprived areas. The solution is not to further spread out the current workforce, which is already too small in every area. I do not think there are many practices, even working in wealthy areas, who have enough of a workforce to be able to say, "Go and work next door instead." We need a larger workforce generally. As we expand that workforce, it needs to be distributed in a way that addresses the concerns.

Q54 **Lucy Allan:** A recognition that there is greater need and that patients will have poorer health outcomes generally, and therefore be coming to see you more often, with greater demand on A&E.

Professor Marshall: The evidence is very clear there.

Chair: Dr Sharrock wants to come in.

Q55 **Lucy Allan:** Please do, Dr Sharrock.

Dr Sharrock: One of our concerns is that the current new funding model for general practice, which is primary care networks, has actually worsened health inequalities. A primary care network gets funded to recruit clinicians through the additional roles reimbursement scheme. If the primary care network is able to recruit, it receives the funding.

In an affluent area, where it is easy to recruit already, they receive the funding for extra staff, so the people in that population get better care. In a less affluent area, which is less attractive, they cannot recruit so they do not get the funding. Again, the funding is increasing health inequalities. We need more flexibility around the additional roles reimbursement scheme, to allow primary care networks to invest in the workforce they feel they need for their population but, more to the point, that they can actually recruit. Instead of limiting them to one mental health worker, if they have four or five mental health workers they can recruit, let them have it. Instead of letting them have one social prescriber per 100,000, let them have five if they think that is necessary for their population. Allow them to recruit an extra doctor if they can, or an extra nurse. At the moment, the additional roles reimbursement scheme is very prescriptive and is not flexible. It is making health inequalities worse.

Lucy Allan: That is a really interesting point. Thank you.

Q56 **Dean Russell:** If I may, I will come to you first, Professor Marshall. I want to explore some of the mental health impact on GPs. I have met a few times with Doctors in Distress. Clare Gerada has given evidence here before. I was speaking to them just yesterday and she is very involved in that.

It seems that a lot of the pressures and burnout of course are going to have a mental health impact. I know that suicide is, sadly, a risk for doctors in general, including GPs. What more do you think should be done to create respite for GPs, so that they are not at the brink and then do not just want to leave but potentially are forced to leave because they are suffering or in distress?

Professor Marshall: I agree that the mental health of the doctor workforce, and indeed the whole of the clinical workforce in primary care, has deteriorated significantly. We cited some of the evidence earlier.

There need to be services like the practitioner health programme to support people who are struggling and who have mental health problems. The practitioner health programme and other services like that—mentorship programmes, for example, and coaching programmes—are doing a great job, but they come in too late. We ought to be preventing it from happening in the first place. To have a workforce who are so stressed that they are unable to do the job that they are trained to do, and unable to provide the quality of care that we know our patients want and need, is simply not acceptable. We know from the GMC survey that 32% of GPs said that they were in crisis. That is more than any other medical specialty, and twice as much as the average across medicine. There is no part of the health service that is not struggling, but general practice is feeling it more than any.

In part, that is about the extent to which we feel responsible for local communities and for patients, and the nature of general practice and how

it runs. If I were an orthopaedic surgeon and there was a two-year waiting list to see me, I would not be held personally responsible by the patient for that two-year waiting list; it is the system's problem and the NHS's problem. In general practice we are closer to our communities. We are closer to our patients. We are held, and feel, more responsible for it. That adds to the mental health crisis that we have.

Q57 **Dean Russell:** Thank you. May I ask Dr Fisher a similar thing? It is related to your Next Generation GP programme, which sounds like it is going really well. In terms of that, what are you seeing for the next generation coming through? Are they facing the same issues as GPs who have been working in this space for decades, or are they facing different types of mental health issues?

Dr Fisher: I do not think I can comment specifically on the differences in mental health issues between generations, but it would be reasonable to suggest that the pressures that are being experienced in general practice are likely to be universal. It is worth saying that I think it is a particularly difficult environment to come into at the moment.

A lot of this has already been discussed, but to add a bit more evidence, at the Health Foundation we partner with the Commonwealth Fund to do an international survey of GPs. We last published evidence from that in 2019. Two things stand out. One is that UK GPs, compared with international counterparts, are the least satisfied with their workload. The second is that we are an enormous outlier on the length of appointments. We need to start to move to a point where we say, "What can we do to make things better in general practice?" We have to look at ways that we can manage our workload. We have to look at ways that we can boundary it.

There are probably two other things that would help. Dr Green has already spoken of one, which is that the wider public discourse about general practice does not make us feel good to be GPs. It is hard when you go home at the end of a 13, 14 or 15-hour day and the media discourse is negative, and that appears to be supported at some points by senior politicians. That feels personally very disappointing.

The second thing is a conversation with the public about what it is feasible for general practice to be able to deliver at this time. I know that is a difficult conversation, but when we do polling for the Health Foundation with Ipsos, what we see is that the public really want fast access to general practice appointments. The evidence is much less clear on whether people want face-to-face or remote appointments. But while there is a prevailing narrative that is fast access, it is very difficult for us to meet that because the priority of GPs is sometimes to deliver the best possible care to the patients who need it the most. That is not always the same as the patients who want it fastest.

Q58 **Dean Russell:** May I build on that with you, Dr Sharrock? A few months ago, I raised in Parliament the concerns I had about GPs not doing face-

to-face appointments. I also balanced that with the fact that I have fantastic GPs in my area who, during Covid, were open throughout and worked incredibly hard, as they all do. The narrative in the media off the back of that was more on the negative than the positive. I think most of my question was positive. I totally get the narrative of that.

I mentioned the Bridgewater GP surgery in a question earlier. I visited them and was there for four hours. I saw the work that they were doing. They had been open and were accessible throughout Covid. But there are still GP surgeries that have not opened their doors. I speak to constituents, as mentioned by Lucy earlier, where in our inbox they are saying, "Look, I need to get an appointment." You speak to people and there is concern that they cannot see a doctor face to face.

How do we break that cycle, where you have GPs that have been doing face to face throughout and then some that still are not? This is not me bashing GPs. I know it is an incredibly difficult job to do. I just wondered if you had any thoughts on how we deal with that in the current times.

Dr Sharrock: The evidence is that actually GPs, throughout the pandemic and currently, are doing more appointments than we have ever done before. That is with fewer in the workforce. In 2015, the average GP was supposed to be caring for about 1,900 patients, and now they are caring for 2,200 patients. The average GP is having to deal with more patients. We are doing more appointments in general practice, and 70% of those are face to face.[1]

We have to square that, and work out how we can identify people who really need to be seen face to face today, tomorrow or next week. The best way to do that is by using technology, telephones, video consultation and online consultation. It may not be what people want, but it is what the system needs. It may identify patients with clinical need initially to have a telephone or video consultation, whatever, and then when they physically need to be seen that can be arranged.

I can tell you from my personal experience that someone may well book an appointment to come and see me about a problem that is completely inappropriate for me to deal with. I am not a diabetic expert. My nurse, Carly, in the room next door has three or four degrees in diabetes. Rather than insisting on seeing me, the GP, it would be better to go through and speak to a care navigator, who can say, "Well, Carly will deal with that problem better," and get them seen by Carly.

One in five GPs has been the butt of abuse as a result of the recent campaign against general practice. Dialling down the rhetoric against general practice is really important if you want to retain and recruit GPs. We have to have a campaign that sets out exactly what general practice can deliver and not what it should be delivering. Clearly, a 10 or 20-year

[1] The British Medical Association has written to correct that the proportion of appointments in general practice delivered face to face is 60.3% (based on January 2022 data).

plan is needed for that, including a workforce plan. At the moment, we cannot deliver what we want to be able to deliver. We need a campaign to the public to say, "This is what can be delivered by the service at the moment." That would be really helpful and might actually make the profession feel supported.

I have a care navigator in my practice who burst into tears after having abuse from a patient. We have to have zero tolerance of that. The reason that patient was abusive to the care navigator was that he had been told that he could get an appointment when he wanted it, not when he needed it. He should have been told, "You will be assessed to see whether it is needed, and then if you need an appointment we'll get someone to deal with it and it will be the most appropriate person for your problem." Dialling down the rhetoric would really help.

Q59 **Dean Russell:** On that point, to explore further, I agree wholeheartedly. There is no excuse for abuse. My understanding is that quite often it is the people who are doing the call centre bit. I was quite surprised to see a team of people working in an office with their screens flashing all the time and taking phone calls and so on. They are working as quickly and as hard as they can, so it is not even just the GPs but the back office staff. It is the receptionist. It is the support teams.

On that point, though, in terms of looking forward, you mentioned technology. If there was a magic wand you could wave and say, "Look, we would put in right now one new bit of technology that would help"—I appreciate it would not transform everything but it could make a difference—what would that be in your mind?

Dr Sharrock: Electronic prescribing for hospitals. At the moment, a patient in hospital, either in out-patients or being discharged because they have been in hospital, goes out and the medication does not follow them, for whatever reason.

They come to the practice and request the medication. We do not know what they have been on in hospital. We do not know why it has been changed. It creates a huge bureaucratic burden for us to try to find out. It would be much easier for the hospital to be able to say, "Well, actually, this is what you are on. We will send the prescription to the pharmacist in your local area so that you do not have to travel 30 miles back to the hospital." EPS for hospitals would make a huge difference.

Dean Russell: That is very helpful. Thank you.

Q60 **Chair:** I think Martin wants to come in.

Professor Marshall: I want to add some data on the access problem. I understand that MPs' postbags are full of letters from dissatisfied patients. In many ways, MPs and GPs are in the same place. We are at the front end of patient concerns.

The national data does not support the argument that access is a massive problem in general practice. The latest national patient survey suggests that 85% of patients rated their last appointment as either good or excellent; and 80% said that they were very satisfied with the mode of access that they were given. Only 16% of patients had to wait for longer than a week and a third of patients were seen on the same day that they asked for appointments.

Given the pressures that general practices are under, the data is actually remarkable. The reason is that GPs are prioritising access over everything else. It feels to me that in policy terms we need to get out of the access space for a while and start focusing on quality of care, on safety, on equity and on personalised care. That is where we need to be putting our effort.

Dean Russell: Can I make a quick comment on that?

Chair: Briefly.

Q61 **Dean Russell:** I think what you will find with MPs is that there might be a particular surgery or a particular ward, as it were, where there is an issue. We will then get a lot in our postbag around that, which then means that when we talk about it, if I came in here and mentioned a particular ward or a particular surgery, first, it would be unfair on them, and, secondly, it would be harder to have that conversation. I think that sometimes with the narrative from politicians, our postbag may be full, and we also get the anger. I am not trying to say it is like for like but, quite often, when walking down the street someone might come up to us angrily and say, "Why aren't you sorting this out? Why aren't I able to see my GP?" I completely get it, but there is no excuse for abuse on any level.

Dr Sharrock: I can offer you a solution to that point.

Chair: Please do. We like solutions.

Dr Sharrock: The royal college, the Health Foundation and the BMA would all say that we do not support bad practice or bad access. If there is a particular surgery that causes you an issue, the people to take that up with are your local medical committee. They have a good relationship with practices. They will be able to go in and have a quiet word. The practice will not feel like they are being collared if the LMC is spoken to.

I encourage you, as MPs, to develop a relationship with your LMCs. Then you can say, "I have an issue with this practice," or, "Can you tell me what the issue is there?" The LMC has the soft intelligence about why a practice is struggling, or they can say, "Well, actually, they shouldn't be struggling so we will go and have a word with them, and try to change things and work with them." If you speak to a CCG or the CQC it will feel much more like a hammer to crack a nut. LMCs are the friends of practices, and they can be the go-between.

Dean Russell: I should clarify that Watford is a very great place. We have great GPs.

Q62 **Chair:** We heard that. Thanks. Becks?

Dr Fisher: Thanks, Chair. I have a quick point. Thinking about the future of general practice, it strikes me that, where there are issues with practices, in recent years CCGs would often have been the bodies that would intervene. They have not always worked in the ways that they should have worked or achieved what people hoped they would achieve, but they have done a huge amount of behind-the-scenes organisational support for general practice and support of practices that are struggling, monitoring some of the metrics that come out of general practice.

CCGs are going and I want to raise this question for future consideration—I am sure the Committee will come to it: who will hold those functions and how are they going to be held in the new infrastructure of the NHS? What do the requirements of ICBs need to be, for example, to make sure that the vital infrastructure that supports general practice, which is there in different ways in the acute sector but really does not exist for us, is maintained in the new structures that will emerge? How do we deal in the meantime with my concern that support is somewhat missing in action at the moment as we go through the wider transition of NHS reform at precisely the point at which we may need it most?

Q63 **Chair:** Becks, would you write to us on that issue? It would be a very helpful part of our evidence gathering.

Dr Fisher: Of course.

Q64 **Chair:** I have one final question and we will wrap up at 11.30. I will give the rest of the time to Luke Evans.

My question is about QOF and whether it is time to scrap QOF. Perhaps we could continue to collect all the data we collect in QOF so that we understand whether quality and safety standards are being met for diabetes patients or whoever it is. It is the business of linking payment to very specific outcomes in QOF. I was thinking about what Becks said earlier about a more capitation-based model where you could factor in age and deprivation, saying that if someone is over 80 they get £500 a year and if it is in a deprived area there is an extra £50 a year, or whatever the calculations were. They have scrapped QOF in Scotland. Should we do the same here? Let me ask you first, Martin.

Professor Marshall: Yes. From a college perspective I think we should. When QOF was introduced in 2004, it served some really important functions. It systemised care. It produced a more team-based approach towards long-term condition care. That was good, but now we see the downsides, particularly the bureaucratic and low-trust approach to managing professional behaviour. The inflexible approach far outweighs any benefits. Our view is, yes, it is fundamentally important to have a different kind of contract which is higher trust and less about box-ticking

and more about professionals being able to make the right decisions for their local community and their local patients.

To give you a practical example, according to QOF, I have to give the same attention to an asthmatic who is well managed, and maybe not even taking regular medication, as I do to an asthmatic who is poorly controlled. The incentives to deliver the same care to both of them make no sense whatsoever. That is why we need to be able to use our professional judgment to prioritise those with the greatest clinical need.

Q65 **Chair:** Thank you. Becks?

Dr Fisher: Whether or not QOF should be abolished is not something that the Health Foundation would hold a particular position on, but I think it is clear that QOF has not necessarily achieved all it was hoping to. As it is at the moment, it is certainly one of the contributors to inequity in funding of general practice, albeit a fairly minor contributor. It accounts for about 10% of the income of most practices.

Were QOF to be retained, something that I would certainly want to see is a much greater regard for the implications of practising in different areas. The impact of deprivation on your ability to achieve highly on QOF is significant and is unaccounted for. We could be a lot cleverer in our approach to what we incentivise, if indeed we incentivise anything.

Q66 **Chair:** Thank you. You negotiate all the bits of QOF with the Health Secretary every year, Kieran, as I know from past experience. In a way, you are in a prime position to tell us whether you think the whole thing should be scrapped or not.

Dr Sharrock: I do not believe it should be scrapped, but I certainly think it needs to be simplified, and it certainly needs to build in measures that look at deprivation. Again, if you cannot recruit, you cannot provide good care, and that then worsens the health inequalities because you are not being funded through QOF for giving good care. You need to find some way of incentivising the parts of QOF that can be delivered, making it more flexible and simpler so that it is not so bureaucratic.

Chair: Thank you. I am going to give the last five minutes to my colleague, Dr Luke Evans.

Q67 **Dr Evans:** We have talked a lot about workforce, but we all admit that it is at least five years off. I do not know a single GP, friend, family or anyone who wants to take on more work. My question to each of the panel is, what solution or idea do you have that could make a difference and encourage us to be able to get more people to take on more work? Is it a matter of working to contract so that is entirely all you do? Is it a matter of offering educational opportunities in a particular area so that you are more likely to set down roots there with your family? Is it simply giving people protected headspace to think about how to improve their system?

These are all things that we have heard on this panel before, but I would be interested to go down the line, maybe starting with you, Kieran, if that is possible, and for you to say something you think we could take away. We get to make recommendations, and I am really keen to know what would make a difference for the short to medium term particularly. We all understand the long term.

Dr Sharrock: One of the biggest issues to face is the inappropriate workload transfer from secondary care to primary care. One of the ways to deal with that is to make it so that everyone who works as a doctor, a nurse or any other health professional in secondary care settings has spent a good portion of time working in general practice, so that they understand the importance of that interface.

At the moment, people who want to work in general practice work in general practice, and people who want to work in hospital work in hospital. To become a GP, you also have to do some training in hospitals. All nurses and all physiotherapists work in hospitals as part of their training, but very few people come and train in general practice.

I suggest that all health professionals have to spend at least a year working in general practice so that they understand it. The other advantage of that is that you suddenly get a workforce that is coming to work for you for a year. That would be a way of improving the secondary to primary care interface.

Q68 **Dr Evans:** Thank you. Becks?

Dr Fisher: Inevitably, there are many things that will contribute. I think Dr Hayward, who gave evidence to a session on workforce, suggested that general practice is on the receiving end of rather a lot of system failures. I certainly think that addressing them is a part of this.

As to who is changing the discourse about general practice, it cannot just be people like me saying it is hopeful and I want to continue to work in this profession for many years. There have to be tangible improvements to our working lives. Part of that is being honest with the public about what we can and cannot provide. Part of it is also changing the narrative, as my colleague said earlier, about things like less than full-time working. Technically, I work four sessions two days a week in general practice. That is 16 hours and 20 minutes contractually, but I am often there for 36 hours a week and 24 on a regular basis. We have to be better at understanding the true workload of general practice. We have to train people for the jobs we do now and will do in 10 to 20 years, not train people for general practice 10 years ago. I think that probably means an extension to GP training, but I am sure that Professor Marshall will have thoughts on that.

My final point is back to equity, which for me is central. If we want healthcare to improve and if we want inequalities in health to reduce, we surely have to deliver general practice that is in proportion with patient

need. All of these interventions must consider equity and how things will play out through an equity lens. I worry about things like the additional roles reimbursement scheme, where there are absolutely no mechanisms to ensure that the new workforce in general practice is equitably distributed. That is likely to increase inequity. I really hope that we embed things that ensure that that does not continue.

Q69 **Chair:** The last word to the Royal College of General Practitioners.

Professor Marshall: You asked in the previous session whether there was hope for general practice. I agree entirely with what others have said. There has to be hope for general practice, otherwise there is no hope for the NHS. Is there an easy, shorter-term answer to the crisis we are in? There are a few things we can do, but I think that as policymakers we need to be focusing on the longer-term answer. We need to give a sense of hope to younger GPs that things will be better in five years' time.

In the meantime, there are a number of things that can be done. We have talked about reducing bureaucracy and better working at the interface. I agree with Kieran that that is really important. There need to be better communications with the public about what is possible, and maybe what is not possible, hard as that is for politicians to do. Those are the things that need to be done in the short term. We need to be honest with ourselves and say that we have reached a state in this crisis where we need to be working really hard on long-term solutions.

Chair: Thank you. That brings the session to a close. Thank you, Dr Sharrock for stepping in for Dr Farah Jameel, who is not well. We wish her a very speedy recovery. Thank you for stepping in at short notice.

Thank you very much, Becks, and Martin, Professor Marshall, for coming this morning. It has been a very important first session. We have taken away some short-term solutions. We have also heard loud and clear that unless we have a long-term plan to give hope that the capacity of the system starts to match the demand on GPs' time, in the end we are not going to give credible optimism for the future to the new generation of GPs. That is certainly something we want to think about as a Committee. Thank you all very much for joining us.