HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: The future of general practice, HC 113

Tuesday 28 June 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Rosie Cooper; Luke Evans; Marco Longhi and Laura Trott.

Questions 182 - 226

Witnesses

I: Matthew Taylor, Chief Executive, NHS Confederation; Saffron Cordery, Interim Chief Executive, NHS Providers; and Sarah Sweeney, Head of Policy, National Voices.

II: Dr Claire Fuller, GP, Chief Executive-designate, Surrey Heartlands Integrated Care System; and Dr Hugh Porter, GP, Clinical Director, Nottingham City Integrated Care Partnership.

Examination of witnesses

Witnesses: Matthew Taylor, Saffron Cordery and Sarah Sweeney.

Q182 **Chair:** In our inquiry into the future of general practice today we are particularly focusing on the interface between general practice and the rest of the NHS, whether that is hospital care, community care or social care. We have a stellar cast list. Matthew Taylor is the chief executive of the NHS Confederation. Sarah Sweeney is the head of policy at National Voices. Thank you both for joining us. We will also have Saffron Cordery online in a moment. *[Interruption.]* Hi, Saffron, can you hear us?

Saffron Cordery: I can hear you. Hi. Nice to see you all.

Chair: How are you feeling?

Saffron Cordery: Not too bad, thank you. I had a little bout of the terrible covid and it is still lingering.

Q183 **Chair:** Well, thank you very much for braving it and joining us remotely; it is really appreciated.

Let us start with some general points. Matthew, first of all, congratulations on your new role and the impact you are having. At the NHS ConfedExpo, which you helped to organise, the Secretary of State said he did not think the current model of primary care was working and there needed to be a plan for change. Do you agree with that, and what would be top of your list in terms of the overall things that need to change? Our focus is on general practice, but obviously that is part of a bigger picture.

Matthew Taylor: I do not think it is particularly useful to generalise in the sense of saying primary care is broken. We need to recognise that, for example, we are now seeing more consultations than before covid—11% more consultations, with 5% fewer staff, than five years ago—so actually there have been productivity increases in primary care. If we only had productivity increases at that scale in the rest of the economy, we would be thriving. Most patients are satisfied with their experience of engagement with primary care, although levels of satisfaction are declining, so there are really big issues, but let us also recognise that this is still a system that is working for most people.

In terms of where we are, I have thought a lot about this, and I hope you do not mind if I use a metaphor for understanding where we are. Sometimes I think there is a false dichotomy between those who say the issue is demand and capacity, and who seem therefore not interested in reform, and those who say the answer is reform and seem not to be realistic about demand and capacity. My metaphor would be that, until I recently moved, I would spend a lot of time in the morning rush hour waiting to get on an underground train at Clapham South station, and I could not get on. I could not get on for fundamental reasons of demand and capacity: there were too many people and not enough trains, and if

you did not recognise that, you were not recognising the truth. However, there are ways in which you can design trains to enable more people to get on them. The new Elizabeth Line trains, for example, are a single carriage—they have fewer seats. So you can do things that can help with the capacity issue.

Thirdly, the way the public behaves does matter. If people take off their rucksacks, if they are polite to each other, if they stand next to each other, we can also get more people on. Fourthly, the relationship of the underground to the rest of the transport system is also important: are there cycle routes, are there buses, do employers stagger people's start times? That is the way I would understand primary care: as a fundamental issue of demand and capacity, but there are important things we could do with design, with public expectations and with the wider system that could improve things.

Q184 **Chair:** Let us just focus, if we may, on the reform bit of that false dichotomy. You will not necessarily know this, but we have spent a lot of time as a Committee talking about the capacity side and the need to recruit and retain more GPs. Putting all that to one side, what are the big reforms that could make a difference?

Matthew Taylor: I would identify two. The first is enabling and incentivising primary care to operate at scale. That is the big idea behind primary care networks. We at the confederation represent all parts of the system, so we represent primary care networks and primary care federations. But we also represent the rest of the system, so we think a lot about how primary care interacts with that system. Primary care operating at scale has real advantages in terms of efficiencies and in terms of the capacity for learning and for innovation. We have created primary care networks; I do not think we have invested in the right way in terms of management capacity, organisational development and the space for primary care networks to innovate, but I still think it is the right idea. The idea at the heart of Claire Fuller's work, and Claire is on after us, around primary care networks coming together to work at a locality basis, is also powerful.

The second thing I would say is improving the way in which we triage at scale. If we look at the 111 service as an example, we could find ways to better direct people to the service they need when they need it and, even better, enhance that with the capacity to actually understand where demand is in the rest of the system. If I could give you a vision of the future, it would be trained people working in 111 centres within localities who not only have the record of the patient who is ringing them up and a good set of skills to understand what their needs might be, but a dashboard that tells them how many people are waiting in A&E or other services, so they are able to direct that person to the service they need. That could make a big difference.

Q185 **Chair:** Let me ask you a follow-up on that and then one final question before I bring in your fellow panellists. Other witnesses have said that the

system is just way too confusing for patients. Most people know that if it is an emergency, it is 999—get to an A&E—but if it is not at that scale, if you have something that is minor and not an emergency, do you use the out-of-hours service or 111, or do you call your GP surgery? It is very bewildering to know what to do. Do you think we need to make it much clearer for people to know what they should do in certain situations?

Matthew Taylor: I think so. The best service would be one where you knew where you had to go and where the person responding to your challenge understood you and your needs, as well as the capacity in the system, and was therefore, in the best possible world, able to give you choices and to say, "Well, you could go to A&E, but you might be waiting several hours, or you could wait three days and see a GP, or you could see a physiotherapist tomorrow because you are complaining about musculoskeletal issues." If we can improve the signposting and even give patients a capacity for choice that empowers people, that would be a big step forward.

Q186 **Chair:** I will bring in my colleagues shortly, but I just want to ask you about two specific reforms, and then I am going to ask Saffron and Sarah to comment on these two reforms as well. We have discussed them in earlier sessions, and we would be very interested in your insights.

One of these reforms is that we have heard from the Secretary of State a possible intention to scrap the partnership model. He wrote the foreword to a think-tank paper that suggested that the partnership model might be over by 2030 and that we should move to salaried GPs being employed by hospitals, as happens in some parts of the country already. We had a lot of evidence from GPs concerned about that, saying that the partnership model allowed independence and innovation, and that although there was an issue with the partnership model over premises, and the property risks were killing some partnerships in some places, we should try and solve that problem. So we would be interested in your view on that one.

The second one was on continuity of care. We are going to find out how much Claire Fuller agrees with this or not when we talk to her later, but there seems to be a view in the system that continuity of care—seeing the same GP, or with the same GP responsible for your care over a long period of time—is the right thing for complex patients, but that normally fit adults just want to see a doctor as quickly as possible. We had a lot of people saying that was rubbish and that it is incredibly important with normally fit and healthy people that they too see a GP or have a GP who is responsible for their care, in order to stop them becoming a chronic patient or in order to spot that cancer. Not only that, but GPs who see the same patients regularly are much happier and it is much less stressful than seeing 30 or 40 brand-new people every day. Those are a couple of thoughts there that we have heard. Matthew, first of all, what do you feel about both those areas?

Matthew Taylor: On the partnership model, partnership brings many benefits, particularly in terms of the kind of commitment that general practitioners make to that model. I do not think the partnership model is in any way in tension with primary care networks or federations operating at scale. There does seem to be a trend away from the partnership model. I do not think that the major reforms we need to achieve are unachievable with the partnership model, so why would you want to take on something that a lot of people care about , that matters to them and that motivates them? The challenges are hard enough without having a battle we do not need to have. That would be my view.

In relation to continuity of care, we need to distinguish between different types of continuity. One of the bits of continuity failure that most annoys people is around continuity of information. It is not so much seeing the same person; it is having to repeat the same details again and again. There is continuity of information, there is continuity of care, and there is continuity of relationships, and these are different kinds of things.

I agree fundamentally, and, indeed, I will take a story from Charlotte, from National Voices. She gives an eloquent story of her own experience. She does not have multiple conditions or long-term conditions, but there is a history there, having lost her husband to cancer and having had mental health challenges in terms of members of her family. The idea of having to explain that history, which is quite a painful history, all over again to somebody is not nice.

So, yes, there are people for whom continuity of care matters who are not people who have long-term, multiple conditions. Therefore the principle should be signposts, not no entry signs. If patients say continuity matters to them, we should trust them that it does and try to enable them to have it.

Q187 **Chair:** Thank you. Saffron, are you getting continuity of care for your covid?

Saffron Cordery: Well, fortunately, I have not yet had to access a healthcare professional for it, so let us hope it stays that way.

In terms of the questions you ask here on partnership and continuity of care, the partnership one is really interesting. We have a number of our members who are, as trusts—not just hospital trusts, but mental health trusts and community trusts—actually working with GP practices and running GP practices in some of their areas. It is not the only solution, and we should be really clear that we should not be jumping to a single solution to solve a big challenge here, because I do not think the partnership model is what is creating the challenges that exist in primary care and GP practices. It is actually a broader issue that we know runs across a whole host of the challenges we face across the NHS, and there is just as much that unites secondary care and primary care in those challenges. It is about the availability of workforce. It is about the levels

of demand going up. It is about the availability of social care. And, to an extent, it is also about funding.

This is not a silver bullet, if you like, to solve the problem, but we have seen that it is working in some places. There is no evidence that simply being employed by another organisation will resolve the workforce challenges, for example, that we have across the NHS. We also know that there are not actually that many trusts at the moment who are running GP practices. There is no empirical evidence on that, but we think it is probably around a dozen or so, so it is not a widespread model at the moment.

On that basis, we should think really carefully before jumping to a solution that says all GPs should be salaried and that the partnership model is dead. It is about working out what local circumstances need, and working out within systems, and with trusts within systems, the best way to take these things forward. It is fundamentally about building that capacity. It is about having a supply of workforce. It is about a proper workforce plan for GPs. It is not about the model of running a particular service in this instance.

Q188 **Chair:** What about continuity of care?

Saffron Cordery: That is a really interesting one, and certainly what I take from reading the Fuller report, for example, and my own conversations with Claire and others is that we should start to think much more seriously about the functions of what we are trying to achieve with both primary care and secondary care, rather than about where that care takes place and how it is delivered, because that is the fundamental element. Are people able to access the type of care they need and want in the way that they need and want to? Sometimes that will be about having access to the same GPs, but at other times it will be about overcoming some of the real challenges that we see—certainly in the interface between secondary and primary care—which are about flows of information. It is about chasing up referrals. It is about getting the right digital data interface in place, which we know is one of the big challenges facing primary care. Often, it is about sorting out those—I was going to say hygiene factors, but they are way more than hygiene factors—fundamental infrastructure issues that would then create the space for GPs and other primary care professionals. We get very fixated on GPs, but it also goes beyond that.

Q189 **Chair:** Thank you. We will come back to you. Sarah, your thoughts on those two potential reforms?

Sarah Sweeney: It is quite difficult to comment on the partnership model in a way, because it is not that we speak to patients and they give us feedback on the types of models or what happens behind the scenes. From our perspective, the reality for people who either have long-term conditions or are occasionally or sporadically accessing health and care services, is that there is not necessarily an understanding of the

difference between general practice, primary care, community care and all the different parts of the system. Each time we enter the system, we need to have effective signposting and then communication to understand what is happening. So it is not something where there would necessarily be a particular kind of patient—

Q190 Chair**:** They probably do have views on whether they get to see the same person.

Sarah Sweeney: Yes. For continuity of care, I think this is really important and this is part of the reason why we are seeing low polling and low satisfaction with GP practices over a longer period of time. What we heard during the pandemic was that access had worsened, which a lot of people here will be aware of, but of course, notwithstanding the fact that there are more appointments than there have ever been, we see long telephone waits and websites that are hard to navigate. One of the things we hear from people is they feel they do not have a choice about the way they access care or when they access care.

There is, of course, a very obvious argument for why people with long-term conditions should be accessing health and care in a way that enables that continuity of care. There are lots of different reasons why people might want that; they might not want that as well. In a workshop that I took part in last week, I heard of a man who specifically picked his GP because he is from the same country and can speak the same language, so there are lots of different reasons why people might want continuity of care and to see a similar face. Also one of the things we have learned around health inequalities throughout the pandemic has been that there is also a large role within health and care in terms of winning back the trust of communities that have experienced inequalities and exclusion from health and care services. Sometimes a person who you recognise, who you know and who you trust acting as the front door to the whole of the health and care system can make a really big difference within that. It is not just for people with long-term conditions and mental health, although that is important, but there are lots of other reasons why that might be part of the mix. So it comes back to choice, from our perspective.

Q191 **Laura Trott:** Sarah, can I ask you first off whether you think that accountability mechanisms for GPs are adequate at the moment in terms of the service they provide and also the access?

Sarah Sweeney: That is a very good question. We are part of lots of conversations at the national level where we work with Confed, providers and other organisations, so you have a really good sense of how it feels to work in a GP practice. Broadly, the thing we hear there is around bureaucracy, red tape and wanting to remove that and wanting to give people as much time with patients as possible.

At the same time we hear about some really concerning issues on the ground, especially around access. One of our member organisations,

Friends, Families and Travellers, for example, did a mystery shop of 100 GPs last year to see whether a nomadic patient could access registration through the services. Of those 100 GP practices across the country, 74 refused to register the mystery shopper because they were unable to provide proof of identity or proof of address or to register online.

To me, this speaks to a really basic thing that should be an expectation across health and care and indeed is part of NHS England guidance: that we should all be able to access general practice. This is also experienced by people experiencing homelessness, asylum seekers and refugees. For these issues, that fundamentally make a difference in terms of being able to access health and care in a country where everyone should be able to, of course there should be accountability within that.

But we also need to look at the full width and breadth of the support that is needed for GPs. I find it very difficult sometimes. We know that people are working incredibly hard, working really long hours and really want to serve the communities around them. Being human, lots of people get it wrong. To what degree you use carrot and stick is always going to be a very difficult thing. Broadly across the country, I see that people are keen to support and work with communities, but that mix is not always perfectly correct and that could be improved.

Around the access issue, that is a serious thing. It is unhelpfully played out in dialogues where you hear people say no one is getting access except through digital, which is not true. We have lots of people who either prefer to access health and care through digital means, but also lots of people who are given that choice. It is a really mixed bag, and we all need to look at the kind of full width and breadth of tools available to make sure we can all access health and care.

Q192 **Laura Trott:** Where you have identified the problems that you talked about here, do you feel there has been follow-up to address those?

Sarah Sweeney: With the access to registration for GPs for example?

Laura Trott: Yes.

Sarah Sweeney: Most people, when they hear that at every level of the system, are slightly horrified that that might be the case. There is not one of us that sits here and thinks this is acceptable, or even that it is happening, in lots of cases. I think there is a disempowerment within general practice of the reception team. Actually, the reception team are such a focal point for ensuring really good continuity of care for patients; they are the point of contact for all communications and for that kind of triage function, which involves a lot of the trust people have in health and care. It would be really good to see, as part of future reforms for general practice, a serious investment in the reception team. If people had more time to spend with people and explain why they were being triaged to a specific part of general practice or the wider health and care system, that

would make a lot more sense to people and it would help to rebuild some of that trust.

There is also that investing in the website models for GPs. We know that during the pandemic lots of people very quickly responded to the fact that we could not all be together in a room and that it was not safe for a period of time by creating websites. We also hear from patients and other people that their experiences of accessing those was not good because, even with a long-term condition, they were having to repeat themselves constantly and fill out extensive forms, or just feeling that it is not possible to fill out a form either because of confidence using digital or lots of other things. Yes, it is a real mixed picture.

Q193 **Laura Trott:** Matthew, can I ask you the same original question? Do you think the accountability structures for GPs are adequate at the moment?

Matthew Taylor: Anybody who is publicly funded and providing an essential service to the public needs to be accountable. As Sarah said, the experience that GPs and primary care more broadly have is of a highly regulated environment. However, I would say, and this is a general issue for the health service actually, that accountability is too upwards. That is to say, accountability is around responding to the regulations sent down from the centre. What we need to see is stronger accountability laterally. Saffron talked about community, social care and mental health, so actually what we want to do is strengthen the accountability of primary care to the other organisations working within systems, and that is one of the strengths of Claire Fuller's idea of locality-based working. You can bring together those people, who are often working a lot of the time for very similar people—the client group that you dedicate resource to in terms domiciliary social care, community services and primary care is very, very similar. So, we should have more accountability outwards and more accountability downwards into the community.

I do not wish to steal all Claire's thunder, because she is coming on next, but one idea in terms of freeing primary care up to do more population health management—getting out into the community, doing more preventive work—is that it means a model of primary care that is much more responsive to its local community and its needs. Let us try and get accountability better balanced, is what I would say.

The other thing is that, yes, performance does matter. One of the reasons why I think we want to see primary care at scale is that it means that smaller and more isolated practices get the opportunity to see how others are doing and to recognise that some of their practice may not be great. If you look at some of the best practices in federations, for example, they have that scale so that you can learn from colleagues. It becomes more difficult if you are not doing the right thing and people down the road are doing the right thing.

Q194 **Laura Trott:** You talked earlier about 111 and your idea for a better use of data, do you think that is also true in terms of looking at the

performance of GPs across the board—for their assessment within the primary care network, but also for them to compare themselves to other GPs nationwide?

Matthew Taylor: I am in favour of transparency to the public, but I do think we have to understand that if you were to compare the performance of primary care, you would have to say, "Well, hold on. Some parts of the country are very under-served in terms of GP numbers." For example, some parts of the country deal with much more challenging populations. As Sarah said, some primary care groups will happily take on homeless people or other people. Should they be penalised for the fact that, in doing that, their performance in other areas may not be as strong? Yes, accountability and, yes, data, but let us not have a system that creates perverse incentives to, for example, not take on the most challenging patients.

Q195 **Laura Trott:** Saffron, can I ask you the same question, please, in terms of whether you think the accountability structure for GPs is adequate at the moment?

Saffron Cordery: Yes, thanks for asking. I put my hand up to come in, so that is great. We have to think about what we are looking at in terms of accountability. On a very micro level there is, of course, the accountability for individual performance. Being a GP is a highly regulated role and profession, and we should reflect and remember that that is in place in terms of the functioning of that individual role.

Where it gets more interesting, as Matthew said, is when we think about the overall role, function and impact of GP practices and primary care more generally. We should remember that prior to ICSs, and as ICSs have come into development, it is not that primary care, for example, was entirely without any kind of accountability or regulation. We have had things like health and wellbeing boards in place for a long time, which are run by local authorities and bring together hosts of local partner organisations to hold to account, and to input into, the level of service and the efficacy of that service. We have the overview and scrutiny committee and local authorities that are carrying out some of that role on behalf of communities, holding public services to account. I would see the ICS role here is as pulling together and creating more coherence around that sense of accountability.

At a higher level, we then need to look at whether primary care and its contribution, and GPs within that, actually meet the needs of the population as a whole. That would be the broad sense of whether the ICS itself is meeting its strategic function. Of course, NHS trusts play a key role within that. We already have some accountability structures in place. Should they be strengthened within a system context? Yes, but appropriately so. What we do not want to do is tie up the hands and feet of every GP practice in the land with a lot of red tape. What we want to do is make sure that outcomes and needs are being met.

Q196 **Laura Trott:** The point you just made there, Saffron, about outcomes is very important because, as Matthew said, there is a lot of regulation—arguably too much—for GPs. But in terms of monitoring of actual outcomes for patients—whether they are missing a lot of cancer diagnosis, for example—that may be something where we could look at ICSs taking on a bigger role. Would that be something that you think is fair?

Saffron Cordery: I think we need to look at the role of ICS in terms of how they are meeting the overall population health needs of the patch they are there to serve. We will get into very difficult territory if we are starting to look at this on an individual condition-by-condition basis. We know that there are big chunks of conditions that do need particular scrutiny, but I do think that that will get us into quite challenging territory. We know different parts of the health system are already held very closely to account for cancer outcomes, and GPs will have a contribution to make to that, but whether we should be holding GPs, individually, severally, to account for whether or not they are missing cancer diagnoses, for example, would require further investigation before we went down that route. That would be my view.

Q197 **Luke Evans:** My question is to Matthew and Saffron. We have spent a lot of time hearing you say "we" need to sort this, "we" need to change design. Matthew, if I start with you, who is "we"—who is in charge of making these changes?

Matthew Taylor: We have a new architecture, of course, in terms of the health service, and again, to reiterate a point I made earlier, one of the strengths of primary care at scale and primary care networks, localities, federations, is that that gives primary care the scale to be able to engage with systems and with places. Generally, most problems that the health service have are systemic problems. If you take—I don't know—the issue of why ambulances are waiting at the front door of a hospital, that is in part to do with issues about the number of people who are in the community who have not been diagnosed during covid, but it is partly to do with whether people can get out of the back of the hospital, depending on whether or not there is social care provision or community provision. Given that most of the issues are systemic, you need to bring the system together. The voice of primary care has not been sufficiently heard because it does not have the scale to be able to engage in that conversation.

Claire's suggestion around strengthening it at a neighbourhood level, the place level, really gives primary care an opportunity to act in concert with others in order to be able to achieve change. That would be my locus for that because otherwise what you end up with is a rather kind of brittle situation in which you have the national infrastructure seeking to determine the behaviour of thousands—

Q198 **Luke Evans:** That is why I am really keen. If we go through NHS trusts, mental health trusts, NHS England, you had the CCGs, now on to the

ICSs. We have not even got into the care sector that goes in with that, and the ambulance service as well. We can clearly see that all the joins in the NHS are the most difficult, and Saffron was talking about primary/secondary care interface.

Sitting here having crossed from being a GP into the politics side of things, my question is, who is responsible for making these changes? Because a dictate coming down from the centre gets that response immediately saying, "You can't tell us what to do." Yet, we hear from the bottom end, "We don't have enough power to make that change." Which organisations is it that are doing this, and is it fundamentally one of the problems that we have that everyone is looking at each other, talking to each other, saying, "We know those are the problems. We can identify streams and flows and things like that, but how do we actually sort it out?"

Matthew Taylor: Yes, and that is why it is an incredibly positive thing that Claire, when she published her report, got every ICS to sign up to that report. That is really important. In my ConfedExpo speech, I advocated that as the Fuller principle, which we should apply in future: if we want to achieve major change in the health service, let us make sure those people who actually have to undertake the change are signed up to it.

So, yes, this is a responsibility of systems, but I also think, without wanting to go off on a tangent, that we have talked a lot about ICSs. What are ICSs there to do? A critical issue here is that ICSs should not see themselves as layers in the health service, where you have NHSE and then regions and then ICSs and then places and then localities. They should fundamentally see themselves as enablers. They are there to bring together the different parts of the system, to identify the problems that need to be solved and to get the system as a whole to work more effectively.

If you take something like the urgent and emergency pathway, again, to say what I said earlier, that is a systemic challenge. ICSs are there to bring the partners together at a system level, or sometimes at a place level, and to enable them to find solutions. The trick here is ICSs are responsible—not responsible in the kind of old-fashioned sense, but in a much more enabling, almost ecological, sense of bringing the system together to function more effectively.

Q199 **Luke Evans:** You have really helped outline the issue because, effectively, I see the ICSs as a way of focusing on the joins in the health service to make sure it runs more smoothly, because it has been too far siloed.

Saffron, if I can bring that to you, and more so given that you represent the ICSs in pulling that together, do you think the practical sides come through? The classic one is secondary care effectively dumping on to primary care their requests for tests and vice versa, and inappropriate

referrals going from primary care into secondary care. These are the bread and butter things that slow the system down. That, in turn, for patients, means they do not know why they are going for a test. They get bounced because the referral is rejected. They get lost over the communication pathways. We have identified now that there is a system at the top level to work out where these systems are, but how do we actually change that in practice? Is there enough emphasis on the managers to be able to make those decisions and be held accountable for the good that happens and also the bad that may happen?

Saffron Cordery: There is lots in there, isn't there?

Luke Evans: There is.

Saffron Cordery: Just to pick our way through that, NHS Providers represents trust of all types, whether that is hospital, community, mental health or ambulance, and we are really focused on the role of trusts within systems. You are right that the interface between secondary and primary care can often be the bit that people experience as pretty bumpy. I would say there are a number of elements there.

To go back to your original question, which is around who is actually responsible for making change here, within the current situation that we have, we see lots of primary care practices, GP practices and secondary care—so hospital trusts and others—using their autonomy and their agency as far as they can to overcome these challenges at a local level within systems. Northumbria, for example, is doing quite a lot to overcome that issue around GPs needing access to consultants for advice and guidance. They are making their consultants available for that advice and guidance and following up and ensuring that unnecessary referrals are not made. That is one really practical, tangible step, and that is happening.

However, what is sitting around that we have to remember—and this is more the responsibility of Government than it is of the local organisations— is the factors that influence the ability of organisations to do that. Do we have the workforce in place? No, we do not have the workforce in place. There are a number of reasons for that and we have spent the last year or so lobbying on a Bill to try and get a solution in place. We do not have that yet, but we are getting close to it.

Fundamentally, we need a long-term, funded and costed workforce plan for the NHS that includes things like GP numbers and supply of GPs; that would help immeasurably. That workforce supply issue would also help on the other side of the coin, which is with trusts and the supply of workforce there, because time constraints are often due to workforce constraints.

Another factor, and just one more factor that I will throw in—

Chair: Briefly, if possible, Saffron.

Saffron Cordery: Another infrastructure issue that we have is around things like digital investment and whether we have the right digital interface; that is a Treasury issue because we need capital investment. We do not have that capital investment, so we need things done with the CDEL limit, which would help us with greater capital investment. Sometimes the solutions do actually sit with Government, but organisations locally, and systems, do their best within the parameters that are there.

Chair: Thank you. Our next panel is due to start at 12. I will bring Marco and Rosie in on the next panel, unless they have a burning question for this panel. If not, I will just bring in Lucy now, because I am sure you have some questions.

Q200 **Lucy Allan:** Thank you, yes. Just following up, Saffron, on what you were saying in your role as NHS Providers, do you ever get frustrated that the difficulty that patients have in accessing GPs puts intense pressure on A&E and other aspects of hospital trusts, when you really should be seeing those patients in primary care? Is that something that you find frustrating—that people are being directed by 111 or not being able to access their GPs and are then turning up at the front door of the trust?

Saffron Cordery: This is a really interesting question. Frustration exists, but it is frustration on behalf of the patient; it is not frustration with primary care. It is worth saying that there is actually no evidence that A&E is overrun because people cannot get a GP appointment. There is evidence that that A&E departments are suffering extreme demands because patients are turning up who are more unwell than they previously were, and that is the same for the level of acuity we see for primary care as well. We have to be really careful here about attributing a cause and effect, because we are not clear that that actually is the case.

What we do know is we have to find some satisfactory answers for how people access different services. If we talk about primary care as the front door of the NHS, it is not about whether that front door sits in A&E or that front door sits with the GP practice receptionist; it is about making sure that people can access that care when they need it.

We have some false distinctions going on at the moment that are really important to overcome. Acuity is incredibly high. People are sicker than they were before. People are not caught early. There are whole hosts of reasons, and I do not think we should lay blame—blame is the wrong word—at the door of primary care. It sits at the door of a whole host of issues, including lack of social engagement and not having the right community infrastructure in place, which typically picks people up when they have issues and suggests that they access care. All of that infrastructure has gradually faded away, not only during covid, but also before that, with the diminution in funding for local authorities.

There are a whole host of issues there. It is pressure across the whole system, it is increased acuity and it is a lack of time to focus on that anticipatory activity and that preventive care, rather than not being able to access a GP appointment.

Chair: Thank you. Rosie, Marco, did you have one?

Q201 **Rosie Cooper:** My question is, how do you practically make this work for patients? We have talked at a very high level, and I am sure everybody who is listening to this thinks, "The words are all great, but when I can't see a GP, and I have to phone 111, it takes forever. I put the person in the car and go to A&E." In my constituency, an old gentleman was in the road for five or six hours. It was going dark and eventually we got a GP to come and get him and he was taken to hospital by car. Really, how does all of this make a difference for patients? A real difference—not talk, not a lot of words. How does it make a difference? Because people will not be hearing that today. I am not hearing it, and that is my big problem.

Matthew Taylor: You are going to hear from Claire next, and I think Claire's vision for primary care is a vision that will have a remarkable degree of support, actually. The question is, as we were discussing last week at ConfedExpo, how do we get from where we are to where we want to be? I really do not think there is an enormous disagreement about how we need to change primary care for the future. I would say we represent primary care and we represent the wider system, and there would be a consensus about that. Chair, you have discouraged us from focusing on the resources issue, and I understand that because it can drown out everything else, but as Saffron eloquently described, and she is absolutely right, there is a fundamental capacity gap, and that, at the moment, is standing in the way of us giving patients the care they want.

Saffron is also absolutely right about the acuity which seems to exist out there in the community. What we have is a consensus about where we want to get to and a real challenge about where we are now. The question we therefore need to answer is, how do we manage getting from here to the kind of vision that you are going to hear from Claire in a moment? That is a very practical question and we cannot dodge it. As I said at the very beginning, let us not make a recognition of the capacity problem the enemy of the need for reform. They must both go together.

Rosie Cooper: I think you are absolutely right. The problem is, everybody has heard that same sentence every five years, or every 10 years, as every change comes along. It is all magic, but it never actually—

Matthew Taylor: Sorry, Chair, but I should just say that things do improve. Outcomes do improve. GPs are seeing more people. Digital consultations were, unfortunately, subject to a, I thought, rather thoughtless attack a few months ago. Many, many patients are happy with digital consultations. They are happy with what they can get online.

As the quote has it, "The future is out there, but it is unevenly distributed." Let us not forget the examples of good practice Saffron has given. There is a lot of good stuff out there but generally, in primary care right now, overwhelmed with demand.

The private sector suggests that on the whole you need about 20% of free time to really be able to innovate. Ask any GP in this country whether they have 20% of free time to think about doing things better.

Sarah Sweeney: Could I come in there?

Chair: Make this a final comment, but, yes, please do.

Sarah Sweeney: There is something that could make a big difference. Any system of this size—any organisation—prides itself on listening to user experience and customer experience, but actually I think there has not been enough listening or power attributed to how people and communities feel—people and communities, and their diversity. For me it would look like primary care becoming more democratic and people having more of a right and an opportunity to input about what would actually make a difference to them. We spend a lot of time at the national level and in a lot of different meetings that we hold, talking about structures and systems, but actually it comes back to whether people feel listened to and whether what they say is acted upon—whether they feel supported to self-manage.

Also, we should look at the fact that only 20% of our health outcomes and conditions are influenced by what happens within the health and care system. It is about the wider communities in which people exist and the wider support. For me, that looks like a shift towards people and communities and their voices being more clearly heard in the decisions. We would have a very different health and care system if it was people living with ill health and disadvantage who were constantly making the decisions about how services are delivered.

There is also a huge role for the voluntary sector in holding prevention in the community and managing relationships and the trust that is needed as well. It is about a big shift towards people, communities and the voluntary sector, and learning from the kind of asset-based approach to community development that lots of voluntary sector organisations hold, because I think that has a lot to contribute to general practice. That would be my final say.

Chair: Thank you. It has been a very interesting session. It actually has been a bit sort of system-y this morning, Rosie—absolutely right. It has touched on a very important issue, which we will probably want to come back to as a Committee. We talked about the accountability of GPs. There is a much bigger question with the new structures, about the accountability of ICSs and how we make sure they are also accountable, downwards and laterally as well as upwards. We may well want to return to that and ask all of you back. So—to be continued.

Thank you very much indeed for your time this morning. Much appreciated. And thank you, Saffron, for dialling in as well, given your condition. Good luck with your recovery.

Examination of witnesses

Witnesses: Dr Claire Fuller and Dr Hugh Porter.

Q202 **Chair:** Like Banquo at the feast, Dr Claire Fuller has been listening to all of that. She is the architect of the NHS England report, which, as we have heard, has been signed up to by all the ICSs. She is also the chief executive-designate of Surrey Heartlands ICS which, in the interests of transparency, I should say covers my constituency. I know Claire very well and will be extremely careful not to get on the wrong side of her during this morning's session. Thank you for joining us, Claire.

Dr Hugh Porter, thank you for joining us. Hugh is the clinical director of Nottingham City ICP, so he is going to be right in the middle of these new structures.

I want to cut to the chase. I will let you weave in any general comments that you want to make. Could I start with you, Claire? I just want to ask you very directly the question that Matthew Taylor was talking about, which is how we make sure that there is accountability downwards to patients with our primary care structures and not just accountability upwards to NHS England. Is that actually possible without dismantling the millions of targets that are imposed by NHS England, whether directly in terms of national waiting time targets, or indirectly through things like the QOF system that GPs have to follow like a straitjacket if they are going to get paid for their services? Is there a risk that your vision of strengthening bonds at a local level is just pie in the sky unless we get rid of all those national targets?

Dr Fuller: At the same time as doing the stocktake, we also commissioned a review by the King's Fund, which was a global literature search looking at how you bring about change within primary care. What it showed, which will not surprise any GPs that are here, was that, actually, in England more than anywhere else in the world we have relied upon centralist financial incentives to drive change, and there is very little evidence that it actually drives change. It does drive an increase in activity but does not necessarily drive change in outcomes.

I think we sometimes use primary care as being synonymous with general practice, which it is not, so we need to be careful, and most of the time we have been talking about general practice here. Actually, the way to drive change—and I am going to say in primary care because it is in primary care—is to create teams, give them a clear remit, create the environment for them to succeed and leave them alone. It is to actually enable teams to work in high-trust environments. That would be my comment on the top-down accountability.

Q203 **Chair:** I think that is a nice way of saying we do need to get rid of some

of these national financial targets and financial incentives. I appreciate you want to be diplomatic about how you say that, but I think we understand where you are coming from. Can I just ask you some very specific things? The partnership model: the Secretary of State is reputed to want to scrap it by 2030. Do you or do you not agree?

Dr Fuller: You will remember from the scope of the stocktake that the things that were out of scope were the partnership model, funding and contracting. I cannot talk from having done a national review looking at it, but if you want to ask me as somebody who has been a partner, and from a local point of view, the partnership model works very well where I currently work, and I am very much of the view that, if something is working, do not mess with it, but there are a lot of areas around the country where it is not working. We have talked about the inverse care law already this morning, and it is those areas where I think we need to look at doing something differently, because it is our most vulnerable people that are not served well by the current model.

Q204 **Chair:** Another quick one: in terms of the complexity of access for patients—should you go for out-of-hours service or 111, call your GP surgery or go to a walk-in centre—is that something you think needs to be simplified?

Dr Fuller: It should not be up to people to work out the severity of the condition they have. It should be up to us, and that "us" would be me as an ICS chief executive and us more globally as leaders of the health and care system. We need to actually make it as simple as possible, and that will actually be about co-ordination of points of access. For people, it should be whatever works for you; we should create a system that works for that individual. That is one of the other ways that you provide continuity. So it is continuity of a relationship, continuity of data and continuity of access. Those three things matter to people.

Q205 **Chair:** The third thing I wanted to just ask you about was on this issue of continuity of care. Your report is very carefully worded, I would say, in order to please everyone. I just want to quote what you say: "Some people—often, but certainly not always, patients with more chronic long-term conditions—need or want continuity of care, while others are happy to be seen by any appropriate clinician, as long as they can be seen quickly".

I do not think anyone could disagree with a word of that, but I want to understand really where you stand on continuity of care, because we heard a lot of evidence from people who felt very strongly, and in fact you heard it this morning, that it is really dangerous to say that continuity of care only matters for people with complex needs. If you have the context, for example, of someone who has a family member who was killed themselves but does not themselves have complex needs, understanding that family context can be very, very helpful in giving someone the support they need. If you are trying to spot a cancer and you know someone's background, or if you are trying to develop a

relationship where you can persuade someone to quit smoking, all those are cases where the patient may not have complex needs but having a GP who is responsible for that patient's care can be very, very important.

We heard from Dr Jacob Lee in Bristol, who spoke very powerfully about the fact that, for GPs themselves, his surgery has a system where about two thirds of the patients they see are their regular patients. He said it was massively less stressful to look at a list and say, "I know most of these people." So I just really want to understand where you are at on continuity of care.

Dr Fuller: I became a GP to deliver cradle to grave care within a community in which I lived. That is how I started. I have been a GP 27 years, which is longer than I have not been a GP. When I started, we did not have mobile phones, we did not have computers and I had a list size of about 1,500 people who I did absolutely everything for. In my career I also did a spell of single-handed practice in rural Northumberland, so I absolutely understand the importance of continuity of care**.** But it is not possible to deliver that everywhere at the moment because of, as Matthew was saying earlier, the demand and capacity that goes on.

One of the things that has been misrepresented from the stocktake is that the two things are binary. They are not. When we talk about the neighbourhood teams, the neighbourhood teams are there to wrap around the practices. There are the urgent transactional interactions where people genuinely do not mind. My children do not care who they see; they just want to be seen quickly. If you have a rash and you just want to know if it is infectious, or if you have a baby with a really high temperature, you just want to be seen. We then talk about the really complex people who require continuity, but that continuity may be required through a team because of the specialism that is required. We ask neighbourhood teams to identify the most complex, which will probably be—

Chair: Can I just, sorry to—

Dr Fuller: Sorry. So the continuity bit is the rest of the patients that do not actually fit, that we are wrapping around to enable practices to then have shorter waiting times to deliver continuity. It is somebody who wants to investigate infertility—you do not want to keep going to somebody different. It is the unexplained weight loss. It is the ongoing investigations of things that may not be urgent. We have to make sure that people do not have to wait months to get those appointments, which is why we need to increase capacity.

Q206 **Chair:** I completely understand. The model we heard from Dr Lee, which is what I wanted to ask you about, was one where basically, when you call up for your appointment, they say, "You can see your regular doctor, Dr Lee, but that will not be until Tuesday week. If you want to see someone tomorrow, Dr Smith is available." That way, what happens is most people end up opting to wait a bit longer and see their regular GP,

and about 60% of consultations are patients seeing their regular GPs. The point is, they say you can do that now; you do not have to wait. We all know there need to be more GPs, but you do not have to wait for more GPs. You can introduce that model now and start to get the benefits of the Norway study, where there were 30% fewer hospital appointments because of people seeing regular GPs. Is there anything to stop us changing the incentives now so that GPs—

Dr Fuller: I do not even think you need to change incentives. The stocktake is littered with case studies of people that are delivering care like that. It is giving people the choice of being seen on the day if they do not mind who they see and they are prepared to travel more, versus wait to see their GP. That is at the essence of the model of the neighbourhood team. It is making sure we protect practices to deliver the lion's share and allow that continuity of practices, but also create around the case management of our most complex a team, because actually those needs are more complex than you would be able to look after in a single practice through a single GP.

Q207 **Chair:** This is the last one from me on this one. Less than 10% of practices have kept individual lists. Is it not, at the heart of this, about the need to go back to everyone being on a GP's individual list? That does not mean the GP will always deliver their care, but the GP would always be responsible for the care of the patients on their list. Sometimes they might ask someone else in the team to look after them, and that is what they have at this practice in Bristol. Is that not the only way that we are really going to get back to proper continuity of care?

Dr Fuller: We do not have enough GPs to work in that way. I think they are clearly in a very fortunate position there.

Q208 **Chair:** You do not agree with what the people in Bristol say—"Even with the capacity we have, we can manage individual lists and it is better for GPs." You do not agree with that?

Dr Fuller: No, I do agree with the importance of continuity of care. I do not agree that everybody can do that everywhere. In other parts of the country I think we need to put more support in place and, again, my job as an ICS chief exec is to support practices to do the transformation that they need to improve the patient experience.

Q209 **Chair:** Thank you. Let me just ask one question to Dr Porter and then I will bring in my colleagues.

Dr Porter, a general comment from you: you are going to be right in the middle of these new structures of ICPs, so do you think you are going to have enough autonomy to do your job and actually focus your energies on patients if we do not get rid of all the national targets and the micromanagement that the NHS in England is world-famous for?

Dr Porter: That is an interesting question, isn't it? The move to ICSs, with this system working and population health management, is actually welcomed by most places involved and by general practice. General

practice has been in a holistic, PHM sort of world throughout, and that is the way it has always operated, so the system is moving closer to how general practice thinks, and there are real opportunities.

We talked about the accountability downwards and there are some really interesting opportunities for us to work with our communities, particularly when we think about the wider determinants. Generally, ICSs are keen to be enabling, as we have heard before—very much so. They want to try and co-produce with us rather than down to us, so, again, there are some real opportunities there, but you have to be realistic. We talked about accountabilities in the earlier sessions; it is a very highly managed environment that I work in, and I certainly think it would be grown up of us to think about where some of those are adding value and where some of them are not adding value.

Q210 **Rosie Cooper:** This is initially to Dr Fuller. The broadbrush question is what you see as the main challenges that general practice faces in implementing the vision your report sets out. I am going to take this from this very high level, right down to the bottom. One of the first things your report says is, "streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it". My question to you is, what does that mean? What actual changes or difference would I see?

You talked before about the more complex patients and where it is perhaps too difficult for one practice to handle, so a multidisciplinary team would look at it. Who is making all these decisions? I am the poor patient and I am thrown in here, but I actually want to deal with the GP. So, in the first case, what do those changes mean and, in the second case, who is making the decisions that I should be going here, hither or thither? Who is going to join up to make decisions with me or for me? How does it look on the ground?

Dr Fuller: From a patient point of view, it should make it easier. That is what we are looking at. At the moment it is incredibly complicated, and the piece about being able to access care in different ways is about making sure that, whichever route people choose to say, "I need help"—whether that is through an e-consultation, a phone call or walking in— we can direct them to the people that are available to provide that care. It is not up to the patient to get it right; it is up to us as professionals working together in teams to make better use of community pharmacy, better use of the optometrists, better use of the dentists, better use of sexual health. So there are lots of other services out there that actually will provide better care for people, and we need to make it easier for them.

In terms of deciding who is the most complex and how you do that, places that have already implemented this have done so through counting the number of long-term conditions people have—it is the Frimley anticipatory care, and they have done it in Kent—there are many

examples. They have done it through people that have multiple long-term conditions that currently are going to multiple out-patient appointments in a silo. What they have done is bring the professionals to the patient instead to reduce the number of appointments and, actually, if you have those experts in the room at the same time, you can improve the outcomes for the individuals. Sometimes it might be, "Well, my heart failure's going off", "Okay, we need to increase your diuretic, but that is going to throw out your renal function."

Q211 **Rosie Cooper:** That is fantastic. I know that, in Liverpool, something like 5% of patients are probably responsible for 50% of the output in community services. I get all that, but you often cannot get the consultant and the right person in the right place at the right time, so how are you going to get all these people actually talking to each other in the right place at the right time and delivering?

It is not that I do not share your vision—I love your vision—but it is how it translates and works. For example, you just spoke about a patient presenting at the wrong place; let me test that. I have presented at A&E and I really should be at an urgent clinic because I have a cut or something that is not that serious. Would it be a case that we signpost you to where you need to go, or do we make the appointment for you? Do we take all that nonsense out of it?

Dr Fuller: Yes.

Rosie Cooper: Because unless you do, this is just more fluff.

Dr Fuller: I agree. Many emergency departments actually have the urgent treatment centre placed in front of them, so actually it is a, turn left, don't turn right. So, actually, you are not in the wrong place; you are just in the wrong bit of the right place, aren't you? This has to be about us as professionals making it easy for people to access care when they need it.

In the stocktake, the recommendations were really clear about ensuring that all professionals are part of those teams. We talk about it being part of job plans for secondary care consultants, and we talk about e-rostering to make sure district nurses are part of those teams, to make it really concrete, so this is not relying on goodwill—this is relying on changing the way we actually deliver care for people. It is not that it will be difficult to co-ordinate; people's jobs will be designed to co-ordinate around more complex patients.

Q212 **Rosie Cooper:** The final bit for me really is, what support do ICSs need from Government and NHS England to make those changes? From the last panel and this panel, we know we have workforce and finance issues. When we met a group of hospital workers, from consultants to healthcare assistants, Luke asked them, "Would you rather have the computer systems fixed or a pay rise?" Well, the answer from consultants was, "Yes, we will get the IT systems fixed." The people at the bottom of the

scale wanted their pay rise. So how do you do all that?

Dr Fuller: Again I come back to the fact I got all 42 ICS chief execs to sign up to this. As part of that, all 42 committed to the actions, there is a framework for implementation at the back, and in that there are actions that we have agreed as ICS chief execs, but there are also the bits that we have asked for help with from NHSE, DHSC and Health Education England. They are around estates, workforce and data. It is around the data sharing and the liability about data sharing that has got in the way of some of those bits.

With regard to estates, every GP will have a story about when they have done a consultation in a cupboard. I have worked in a room that was affectionately known as the cupboard, which did not have a couch in it and I had to go and find another room that was empty if I needed to examine someone. After 12 years our local practice has now moved to new premises, but previously the disabled access was via the bins at the back. Primary care estate and general practice estate has been neglected for too long, which is why we are asking, again, ICSs to develop estate strategies that work within where people live and start from the bottom. The bit that is important about this is that we have asked for those plans to come up through the integrated care partnership rather than the integrated care board. ICSs have two boards; one is more the NHS plus social care, and the other is very much the partnership board, but to ensure these estate strategies are built not just on NHS estate but on local authority estate and using better use of commercial assets, we are asking for that strategy to come up through the other arm of the ICS.

To come back to your question, the thing that we need from Government and from national bodies has to be more support over estates. Saffron spoke about the issues around the CDEL limit, which gets in the way enormously. The workforce issue is that there are just not enough people, and actually the conditions of employment are different in general practice than they are in the rest of the NHS. It was Sarah that spoke about receptionists in particular, who have more patient contacts than anybody in the NHS, and they are probably the most lowly paid bits of the NHS and indeed not recognised by the NHS people plan. We need to do something in terms of attracting people in to work within our practices and actually create a career infrastructure and career development so that people want to stay and want to become part of the NHS.

The data then comes back to the fact that we need to be able to share data not just across the NHS but across more organisations. Locally we are looking at identifying our most at-risk children for our CAMHS services—children and adolescent mental health services. Once you start to bring together the data from schools, which includes school avoidance as well as information from police, plus the fact that there may be an ongoing mental health issue, the prioritisation increases and it brings a greater understanding of risk. It is that ability to share data for direct patient care that is needed.

Q213 **Rosie Cooper:** How soon do you think you will be able to say, "I can see some green shoots and things are really improving"?

Dr Fuller: There are green shoots. That is the point. It is really important for us to speak well of so much work that is going on around the country. Of all the case studies that are in the stocktake, there were as many that we did not include and actually, Matthew and Confed are going to run a series of webinars looking in detail at the case studies that we have picked so that people can then understand how and why those places have succeeded. It is really important we acknowledge the amount of good work and the number of green shoots that are already out there.

Chair: Marco Longhi, welcome to the Committee. This is your first evidence session, and the floor is yours.

Marco Longhi: Thank you very much, Chairman. May I apologise to you and the Committee for not being able to attend previous Committees since I was appointed and for my delayed arrival today?

Chair: No problem at all; we are happy to see you.

Q214 **Marco Longhi:** I have two sets of questions, if I may, and the first is around integration. As someone who has a local government background over 20-odd years, and as a former chairman over several years of a health and wellbeing board, the word "integration" is very attractive to me, but of course it can be an umbrella term that can mean several different things to different people. I would like to try and understand a little bit better what we actually mean by integration. Will we in some way also be addressing that long-standing issue we have with, "This is health. This is social care. These are two different budgets. That is education"? Our people, our patients, our customers often get bounced around, with poor outcomes from that. That is a question around integration. How does your vision seek to address that particular point?

My second question was addressed a little bit by the previous panel, in a sense, but I am very interested in how the commissioning side of things is going to be discharged, particularly if we are going to be looking at integrated outcomes. Is there going to be an integrated commissioning side of things, and would there be a divorcing of accountability and commissioning, or is accountability going to follow commissioning as a function as well?

Dr Fuller: Integration means seven things to three people. The stocktake I led nationally was looking at integration of primary care within systems, so those interfaces between where it works. The areas we looked at were health and social care integration, primary and secondary care integration and physical and mental health integration.

When I started doing it, I think I was expecting to find the biggest gap between health and social care and actually, that is probably where the integration around the country is working best. Not a single ICS chief

executive could not speak of really good examples of health and social care integration that is happening.

The biggest divide, and we have heard this here today, was actually between primary and secondary care, and that is why it is really important to get primary and secondary care clinicians in the room together, talking about patients and creating better solutions for patients.

On the integration point, to ensure we had local government input into the stocktake, we had Joanna Killian, who is the chief exec of Surrey County Council. We took a population health approach looking at the model of care: start well, live well, age well. Joanna Killian led the start well work stream for us, and we had local authority representatives in each one of our work streams. We then asked the LGA to actually look at the report at the end to make sure we had covered it off. In terms of integration with social care, there is really good understanding and really good examples of how that is working well.

To move away from the national picture and talk from a local point of view, in Surrey we have a number of joint roles. The director of adult social care sits within my team as the ICS chief exec and sits within the local authority executive as well. She has accountability for mental health, continuing healthcare, learning disabilities like autism, and carers, with aligned joint budgets. That is how we are making joint decisions locally that are right for people, rather than working in that siloed way.

The second point was around the commissioning. We are moving from clinical commissioning groups into integrated care systems. One of the things we are trying to do that worked really well in covid is actually allow people more freedom to work in a way that delivers the care that is right for people. There are things about autonomy of decision making, moving away from bean counting—£1.17 for this and £3.24 for that—and looking more broadly at the outcomes that are right for the population. We ask for each of the neighbourhoods to identify the most important health inequalities, and they will be held to account for improvement of those, but by working with communities to make sure that care is delivered in a way that works with and for the community.

Q215 **Marco Longhi:** I see. What about accountability for outcomes?

Dr Fuller: Well, I think that is my job. I am accountable for the outcomes across Surrey Heartlands. In Surrey we have a different chair for our integrated care board and a different chair for our integrated care partnership. Tim Oliver, the leader of our council, is actually the chair of our integrated care partnership, which is important to put in that democratic accountability for improvement in outcomes for the population.

Q216 **Marco Longhi:** Thank you. Dr Porter, would like to add anything?

Dr Porter: Just two little bits really. Building on from Claire, we must not confuse structural integration, which is what we are talking about, with

that cultural piece. We have had a generation of commissioner/provider splits and various bits of competition in the system. Actually, many of our staff have grown up and worked their whole lives in that environment where there has been a competition edge. We are moving into a much more positive place, but we have to do some work and we are doing it. There are some really good green shoots of that cultural piece, and we need to make sure we support that and give time and room for it to grow. It takes time, but that is what will really deliver the success.

On the commissioning front, again, like Claire I was chair of a CCG for a long time. We are trying to move into a new world where commissioners are not these separate things sitting above the system dictating, but actually trying to co-produce with our providers and our communities that triumvirate of better outcomes. Certainly, we in the Nottingham ICS are not viewing it as different layers; we view it as a family. We all have different things to bring as a family within our ICS. That split by commissioning is almost like old language that we are trying to remove, because it has a whole lot of connotations for a lot of people in our system, which is not very helpful when we are trying to put the citizen right at the centre.

Q217 **Marco Longhi:** To what extent do you believe geographical challenges might hamper deliverability of what you are seeking to achieve and how might those be addressed?

Dr Porter: I will let you go first, Claire.

Dr Fuller: One of the joys of having led this piece of work is actually having spoken to every ICS chief exec around the country, so I now have a much better understanding of the challenges my peers go through. The way people deliver care is about geography, topography and demography—it is those three 'ographies that influence the model of care.

In Lincolnshire, we have one long road that goes right the way down through the middle. It is all very flat and everything is spread out. That means the way services are delivered is very different than it is in Surrey, where we have a very complex road system, with four hospitals spread around the county.

One of things that surprised me was the similarities of deprivation across coastal towns; there were more similarities in Blackpool and Hastings and bits of Essex than I think I would have predicted. It comes from the real deprivation and shortage of workforce that exists within those communities, which have been made much worse by the pandemic over the last couple of years. It is not just geography; it is the demography and the topography.

Dr Porter: Working in the 11th most deprived area in England you would say it is really, really important. Nottingham is a fantastic city, but it is hugely diverse and hugely deprived, and that creates massive challenges

across the board, both for primary care, for social care and for secondary care services. On the health inequalities and the wider inequalities, we have to make this real. Covid has shown us that, and I am particularly thinking about some of my BAME communities, who have suffered so much in this that it is beholden of us.

One of the things we are debating, very importantly, in our ICS is the issue of equity that actually, for some communities and some areas, it requires more investment. We have to be brave and make sure that our system and all the system players understand that and buy into the equity principle because that could be really important going forward.

Q218 **Lucy Allan:** Dr Porter, I am very grateful to you for making that important point about health inequality, because we are sitting here talking about continuity of care and all the rest of it, but in some areas, actually accessing care at all is a challenge. We have to recognise these differentials across the country, and I am grateful that you have done that.

I really welcome your vision and all the recommendations, and I am delighted that the ICSs have all signed up to that. The key, No. 1 recommendation here is, "Ensuring care is always available in the community when they need it." Right now, coming out of covid, with the backlogs, the fact that orthopaedic surgery cannot be done, so people are suffering more and having to go to their GP and so on, you are facing massive challenges to make access to care when people need it a reality. How are you going to overcome that huge challenge so that people do not just think it is another wonderful report with some lovely outcomes, but it is so far away from the mark that it is not something that can be implemented?

Dr Fuller: The more I think about it, it is access in its broadest definition that is the most important issue that is facing us at the moment. Waiting times are about access to operations. It is about access to care when you need it.

Lucy Allan: I have known services that do not pick up. Call centres are just awful.

Dr Fuller: But it comes back down to demand and capacity, and the demand at the moment is beyond anything I have seen over my career and people are leaving.

Q219 **Lucy Allan:** Is that effectively covid backlog—people have not had the opportunity, a condition has got worse and they have not had their surgery?

Dr Fuller: That is absolutely an element. Saffron spoke articulately about the acuity and the rising backlog of the routine work that did not happen over the last two years—the number of smears, the sort of routine maintenance—which means that other people are presenting and they are more sick when they present. But also there is more work to do to

catch up on the work that we were not able to do because people were busy dealing with the pandemic.

There is that demand, and there is also a change in public behaviour. We have seen the British social attitudes survey that shows that now, for the first time, the public is less satisfied with the NHS than it is satisfied, and that has never happened in the history of the survey.

People are understandably worried. People are worried about their health and they want to be seen, and that is driving some of the increase in demand. You will have seen we have put on digital appointments, so not only have we got an increase in digital appointments, but we also then still have all the other appointments. So there is more activity happening, but people are still feeling that it is not working for them.

It is really important that we measure people's experience of access rather than just counting the number of appointments, because the number and types of appointments will differ depending on who you are and where you are. If you are in a university town with more young people, they will choose to access care differently and that electronic access will matter more to them than if you live in a rural part of Cornwall, where you may want care in a different way. That is why we must not fall into the trap of looking at the number of appointments by when. But we should measure patient experiences of access and make sure that that continues to improve. Sorry, that was slightly roundabout, but it is the experience that is important rather than the counting of the numbers.

Q220 **Lucy Allan:** I am so glad to hear you say that because, as an MP, the most frequent issue raised is people's inability to access their GP. I do not mean to see a GP—I mean actually to get someone to answer the phone, and that is on a daily basis, so I am really glad that you picked that one up.

The ICS chief execs, effectively, are responsible for implementing these recommendations. Is that right?

Dr Fuller: We have all committed that we will prioritise the recommendations, but not all the recommendations are for the ICSs. It is important to remember that some of the recommendations are for DHSC, NHS England and Health Education England as well, so it is a mix. The letter was a commitment to take the report through boards, and it is not just the ICS boards that are taking the report through—many systems, all of the trusts, are taking the report through because there are implications.

The report is not just about general practice and primary care, but also about how you organise your system and how all bits of the system then interact. To properly deliver the teams, it is not just about general practice working differently; it will be about the community trust, the voluntary sector and the acute trusts orientating their work differently as

well. As ICS chief execs we have all committed to the work and the recommendations, but there is also the ask back that we talked about.

Q221 **Lucy Allan:** Do those multiple partners believe that your fantastic vision and recommendations are deliverable?

Dr Fuller: The multiple partners were involved in the review and each of the work streams. We worked really closely with NHS Providers, where Saffron is the chief exec currently, and involved trusts and other bits of the sector, such as Patient Voices. If you look, there are extraordinary numbers on engagement: 11,000 individual people came on to the website to leave views, there were 1.5 million people on Twitter, and we had more than 1,000 people that we involved in the work streams in one size or the other.

There is real commitment, but there is still an understanding that there are some things we need to put right, which is around the workforce, around the estates and around the data. We need to put those in place, and ICSs need to create the right environment and to focus on delivering care in this team-based way rather than in the siloed way. We can do it because so many places already are doing it.

Q222 **Lucy Allan:** Do those responsible for implementation believe it is deliverable, yes or no?

Dr Fuller: With the right conditions. That is what we say. It is really clear that we believe this is deliverable if the conditions are correct, and we list what those conditions are.

Q223 **Rosie Cooper:** Right conditions—all I can hear and see in my head are enzymes busy at it to make these transactions work well.

Dr Porter, unfortunately, all the questions are directed to the ICSs, so you are getting a lucky escape, but we might come back to you. ICSs are commissioned across the system and we hear about autonomy, earned autonomy—all those nice words—and yet, when you actually read the *HSJ* or anything else, you see a lot of stuff about the strong central hand directing what is going on. In terms of Lucy's questions, I just wondered how ICSs will be able to manage the huge pressure to get waiting lists down. You made reference many times to the extra things that were not done during covid, so you have your backlog. You also have the things you did not do that you are now desperately trying to make sure you have not missed—for example, cancer patients or long-term conditions. So how can you make the right decision in the face of what may be quite strong pressure from the centre, and the public, to get waiting lists down when, for example, you might want to invest a lot of money in acute services as opposed to community services, which are easier to hit and not as visible, or, move community into acute trusts? That is a battle that is coming. How do you actually do the right thing?

Dr Fuller: It is the thing that always gets in the way, isn't it—the being overrun by operational pressures that stop the changes? But what is

really powerful, and I will come back to it, is that all 42 have signed up for it. The NHS England board have signed up to the stocktake. I went to the NHS England board and spoke with Richard Meddings, the chair, and Amanda Pritchard, who are both really supportive. At leadership events and at Confed there has been more focus on primary care, general practice and system working than I have ever seen in my career, and I believe the backing for the centre for working as systems is genuine.

Rosie Cooper: I believe the intention, and I absolutely, genuinely do believe that is a real intention, but when it comes to it—when it comes to winter—what are you going to do? I just think that will start to crumble.

Dr Fuller: That is why we must start now, and people have started now.

Q224 **Rosie Cooper:** They have started now, but come the real pressures like the Government, the Department of Health—however you want to disguise all that political pressure—and the public demanding to get their orthopaedic operations, or whatever, you are going to have hospitals rammed. You are going to be trying to do that. I know the theory, but how do you resist that pressure to make decisions based on those outside influences, not necessarily the programme you want?

Dr Fuller: If we do not, it will never get better. We will never have enough money. We will never have enough people to work. It is the whole slightly cheesy analogy, isn't it, that the tap is on, the bath is running over and we are constantly mopping the floor. Until we can actually turn the tap off or turn it down, we are never going to get ahead. Political pressure will be enormous, but we have to start to look after our population in a different way, and the removing of the duplication, the working as teams, has to be the right thing, because it is patient centred. It is relentlessly patient centred and about patient care.

Q225 **Rosie Cooper:** Again, I absolutely agree. Patient-centred treatment, a patient-centred NHS, is exactly where we want to be. You will not have seen, because there is no need for you to have seen, but I asked a parliamentary question at Health questions, which was about whether we actually still have an NHS or if we have ICS kingdoms. How does it work when, for example, today I am reading a report which says Amanda Pritchard is moving patients who require operations across the country to other places to get those operations done, to get two year waits down, and yet I have a constituent who I asked the Christie, which is 30 or 40 miles away, to help out, and because it is across an ICS's border, they said, "Out of area."

Dr Porter: If I can just come in. It has always been the way of the NHS—central targets versus doing. This is not new. I have been a partner even longer than you, Claire, and it is something we have always had to live with. If you think about health systems, most of our spend is not discretionary; it is going to go to our patients or operations, but there is always a bit of discretion—5%, 10%. We have to, as an ICS, as a system,

agree to say we are going to use the discretionary spend we have in this upstream way in terms of where we want to go—

Q226 **Rosie Cooper:** Hang on. So has choice disappeared? Have you abandoned choice?

Dr Porter: No.

Rosie Cooper: What has happened to it? Why can I not choose? Come on.

Dr Fuller: Choose to do what?

Chair: Rosie, just to remind you this is an inquiry into general practice. Can we gently return to the topic?

Rosie Cooper: My apologies.

Chair: We may well come on to ICSs.

Rosie Cooper: Absolutely.

Dr Fuller: I think you can help us. As part of this Committee, as politicians, by speaking well of what we are trying to do through the reforms and through the changes, you can give us enormous support in bringing about longer-term change rather than focusing on the here and now.

Chair: We are drawing to a close. Rosie, did you have any more?

Rosie Cooper: No, we agree with the vision, I just have problems with how we are going to get there. Thank you.

Chair: I will let you have the last word on this occasion. We have had a very good discussion. It has been really helpful. I think we recognise, as a Committee, that there has been broad support for your report. It has been widely welcomed, and we would like to thank you for the enormous effort you put not just into writing it, but also into securing a consensus behind it. I am sure you will understand if there are areas where we would like you to go further and faster—that is the nature of our job in terms of the scrutiny that we provide, but we are very grateful to you for all your work and also for your time this morning. We are also grateful to Dr Porter. We wish you well in your new ICP role. Thank you very much indeed.