

Public Accounts Committee

Oral evidence: Out-of-hours GP services

Monday 1st September 2014

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Members present: Margaret Hodge (Chair); Mr Richard Bacon; Guto Bebb; Austin Mitchell; John Pugh

Sir Amyas Morse, Comptroller and Auditor General, Laura Brackwell, Director, National Audit Office, Sue Higgins, Executive Leader, Local Services, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Witnesses: Dame Barbara Hakin, National Director of Commissioning Operations, NHS England, Una O'Brien, Permanent Secretary, Department of Health, Simon Stevens, Chief Executive, NHS England, and Professor Keith Willett, Director for Acute Care, NHS England, gave evidence.

Chair: Welcome to your first hearing, Mr Stevens. Having looked through the programme this morning, I think we have three before Christmas, so we look forward to seeing you as and when. You have the quality today, if not the quantity. September is always odd and there is an important statement in the House.

Reading through this report, I thought it was rather gentle on this service, actually, although perhaps Barking and Dagenham has a particularly bad quality of service. There is very low awareness of these out-of-hours services: one in four had not heard about the service and nearly half do not know how to contact their out-of-hours services. The number of cases has fallen by a third, although not the contract values. We constantly hear and worry about an increased pressure on A and E. There is a link between all of that, which suggests to my mind that things are not going well with this bit of the jigsaw—offering emergency services to patients and citizens.

Simon Stevens: The first point is that if you ask patients about the service, on balance they say that they get good out-of-hours services, but there are clearly big differences between different parts of the country. On awareness, as we have been moving to a system where most people are now accessing their GP out of hours through the 111 system, that is going to be the main thing that most people need to know about for urgent but non-emergency access to the NHS. I think the figure in the NAO Report is that 19% of people did not know about that so I assume that the extrapolation is that 81% of people do know about 111.

Q1 Chair: I think the figure was less optimistic than that. It was 19% who did not know but there was another figure next to it, which was that they did not know how to get it or something.

Simon Stevens: It was 11% who were unsure about what it did, so we have work to do.

Q2 Chair: It is a third. That's not very good.

Simon Stevens: 111 is a new service. To have perhaps two thirds or three quarters of people aware of it is a good start but clearly more effort is required.

Q3 Chair: We will come to 111. I think if one had seen a reduction in expenditure because people were using alternatives, I would feel a bit better about it but we are not really seeing that. I know the Report says that it has not gone up with inflation but that is on the margins, bluntly. It strikes me that lack of awareness, lack of usage, but no lack of expenditure and great pressure on A and E when people should be going to their GPs or their out-of-hours services is not good news. Are you not worried about that?

Simon Stevens: There clearly are very substantial pressures in the emergency care system, including in A and E departments and we absolutely want to change that to the greatest extent we can.

Q4 Chair: You are not worried about the way out-of-hours services are currently being used by the public?

Simon Stevens: I think that the picture that emerges for all of the emergency services is one of too much fragmentation. We have out-of-hours services that have historically been separate from the walk-in centres, some of the urgent care centres, A and E departments and 999. The real game has to be to make it a much simpler front door for the NHS and to join up all the pieces. That is something that, over the next 18 to 30 months, we are making major strides in doing on the back of the urgent and emergency care strategy.

Q5 Chair: So are we going to see further reform? One thing that has impacted on my constituency is the £50 million to get GPs to open their surgeries for longer. If they are keeping their surgeries open for longer, for which you are paying them more, out-of-hours services ought to be used less because, I hope, people can access that rather than going to an out-of-hours service. It is another bit of fragmentation that you are in the middle of piloting just as you are here telling us that there is too much fragmentation. Why are you piloting and are you talking about yet more reform to get us away from what, I think, is unacceptable fragmentation?

Simon Stevens: We are piloting to learn and to get it right. I spent Friday evening in the out-of-hours and 111 services serving people in your area and I had a chance to hear about the kind of interactions that people were calling in with. I think a mix of things is going on. A number of calls that I was a party to would welcome easier access to GP services on evenings and weekends, even for non-urgent services. That is what the £5.6 million for the Prime Minister's challenge fund that is coming to Barking will do. I do not think we need make any apology for testing new models but we

know that a lot needs to be done to redesign out-of-hours and emergency care services in the round.

Q6 Chair: So we are going to see more reform?

Simon Stevens: We are getting changes in the way services are configured to make them easier for people to understand, more efficient for people to use and more joined-up from the patient's point of view.

Q7 Chair: Are we going to see more reform?

Simon Stevens: Of out-of-hours and emergency and urgent care services? Certainly, for the very reasons that you say—because we know the system is not working optimally as it should right now.

Q8 Chair: Something else which really niggles at me is that, certainly from looking at those in my own patch, GPs have their contract and can now moonlight and spend time in A and E in the evenings to pick up extra money. That helps them but it doesn't help us when NHS budgets are under pressure. The Department of Health has very kindly given an extra £5 million-plus, but much of that will go into GPs' pockets. It seems that there are more ways for them to earn money without the service necessarily being better for members of the public in my constituency and elsewhere in the country. It feels like they're moonlighting here and getting an extra bit of dosh there but the NHS budgets are under pressure.

Simon Stevens: NHS budgets are under pressure and we do want GPs to be able to provide services, in some cases in A and E departments or urgent care centres next to them. It is therefore quite reasonable to fund those new services where we put them in place. In general, GPs are working very hard and GP services are under some pressure.

Q9 Chair: But they can earn extra money.

Simon Stevens: They can certainly work overtime.

Q10 Chair: They earn extra money by going into A and E and if they keep their surgeries open longer.

Simon Stevens: Yes, and that has always been the case.

Q11 Chair: They also earn extra money in out-of-hours services.

Simon Stevens: That has been the case since 1996, when the first major change was made to enable GPs to deputise their services to co-ops of GPs, where they would work shifts and were given extra sums of money in 1996 to do that. There were further changes in 2004, by which time 95% of

GPs were already using co-operatives or deputising services to do that. Of course, if you're working those extra shifts, you get paid extra.

Q12 Chair: Why do you think that clinical commissioning groups haven't reduced the value of contracts with the emergence of this other bit of fragmentation, the new 111?

Simon Stevens: They have, in that the real-terms cost of the out-of-hours service has been going down year by year since the mid-2000s.

Q13 Chair: Have they? According to the Report, some have but most have not.

Simon Stevens: I think the Report finds that they have been flat at about £400 million in cash terms since the mid-2000s. That is a real-terms cut.

Q14 Chair: Yes, but that is across the NHS. You brought in 111, which is supposed to take the pressure off. You are hoping GPs extend their surgeries, yet these contracts are all let by CCGs—your GPs—to GPs. It is a very cosy little coterie of GPs managing this, but they should have reduced the value of those contracts.

Simon Stevens: No extra cash has gone into the system for 111, so in the round, the services are being delivered for the same envelope or less, given inflation, as they were previously. It is worth putting this in context: if the average cost of the GP out-of-hours service for each of us is £7.50 every year, and the average cost of the 111 service for each of us is £2.22, each of us in England is getting access to out-of-hours urgent care services every day of the year for less than the cost of one cinema ticket. I think that is good value.

Q15 Chair: But you don't know where the 111 directs you to. What is that measuring?

Simon Stevens: That is measuring the cost of providing access to 111 through the year.

Q16 Chair: How many people move on from 111 to an urgent care service or an A and E department? That is a bit of a silly figure.

Simon Stevens: We have those data. The average cost of a 111 call is £10.

Sir Amyas Morse: Despite having sent out a favourable Report, it is not clear to me—given all that is in motion and all that you are trying to test—why you do not have better information about what is going on nationally. It seems odd. Given the difficulties of judging what is happening and the fact that there are always complex factors at work, why are you not monitoring what is happening more at a national level? I don't understand that. It is odd given what you are trying to do. Yes, we are trying to nudge you in that direction because I don't really understand why you are not doing it already.

Simon Stevens: Traditionally, out-of-hours services, as you know, Sir Amyas, have been arranged locally by primary care trusts or by their health authority predecessors so it is a pretty recent development to think there would be national oversight, assurance and publication of data, which we are moving to do this year. That is combined with the fact that for the first time the Care Quality Commission, under its new inspection regime, is inspecting all out-of-hours services and publishing those results as well. So we are going to have more information on out-of-hours services by the end of this year than there has ever been at any point since 1948.

Sir Amyas Morse: Forgive me, Chair, may I just say that if I look at the comments in this agreed Report, in figures 16 and 17, where we are asking about NHS England being able to assure itself at a national level as to the quality and reasons for variations in care, are you saying that you will have enough information to do that by the end of this year?

Simon Stevens: The NAO said that the “assurance appears reasonable given what we have found” and “In general, clinical commissioning groups have adequate resources to manage their contracts for out-of-hours GP services” so I think we agree with your conclusions on both points.

Sir Amyas Morse: You are saying that you are gathering information nationally. I am just trying to determine whether that information will be adequate for you to come to some conclusions nationally—yes or no?

Simon Stevens: Yes. Take a step back; there is no doubt that during the course of 2013-14, as your thoughtful and useful Report correctly identifies, there were many things on the plates of CCGs and, indeed, NHS England. Given that the underlying performance of out-of-hours services was generally thought to be reasonable, it was not top of the pile. Are we intensifying the scrutiny and the assurance that goes with out-of-hours and 111 in the context of the broader changes to emergency and urgent care? Yes, we most certainly are.

Q17 Chair: Can I ask one final thing on what you are looking at because the financial incentives are currently wrong, aren't they? If you go to A and E department you get extra money; if you go to out-of-hours services you don't because it is a block contract. Are you tackling that?

Simon Stevens: Yes, they are absolutely wrong. We, NHS England, have just published a consultation document with Monitor during August, looking at reforms to the way that hospitals, GPs, out-of-hours services and ambulances are paid for urgent and emergency care. We proposed several different models and have asked for responses from the NHS. We have also asked for different parts of the country to work with us to test those new models during the course of next year, with a view to rolling out broader payment reform, to deal with exactly the incentive issues that you are talking about, the year after.

Q18 Chair: How will that fit in with longer opening hours of GPs? The Cambridge Centre for Health Services Research did an interesting survey—you must know this is the Institute of Public Health—and found that patients could not get through to their GP or book routine appointments so they went to out-of-hours services. It calculated, having looked at half a million patients, that over 4,000 out-of-hours appointments could have been prevented with better in-hours services.

Simon Stevens: Yes. That sounds plausible. In general, we have a system out of balance—

Chair: Are you looking at the financial incentives there? You have got to look in the round because if it is in the GP's interest to earn extra money by running an out-of-hours service, they will do that. I do not know what you have got out of Barking and Dagenham, but I know from my constituents that they try to ring their GP, are told to ring the following morning at 8.30 am, they want an urgent appointment and ring at 8.30 in the morning and, of course, it is busy—if it is not an 0800 number, which it still is for too many of them—and they end up somewhere in the emergency care system where they should never be.

Simon Stevens: Yes. That is an entirely accurate description of the fact that we have got pressure building from social care and pressure on GPs for in-hours services. All of that spills over into out-of-hours services and emergency care services and that is what we have got to change.

Q19 Chair: So you are looking at the financial incentives involved in GPs extending their hours and ensuring that that tallies with not encouraging GPs to let patients go to out-of-hours emergency services?

Simon Stevens: Yes. I do not think there is evidence that there is an incentive problem with access to GP appointments in-hours; it is just that GPs are under an awful lot of pressure because the consultation rate has been going up. There are other things we can do—Professor Willett may want to speak to that—in terms of supporting self-care and making information more readily available to patients so they know what their options are. But, fundamentally, we have got to strengthen the quality and availability of in-hours primary care, and that is part of what the various initiatives that you described are trying to do.

Professor Willett: From the point of view of the urgent emergency care review, we have been going round the country building this in public and talking to the patients and clinicians, and one of the things they tell us, as you said, is that the payment system currently does not tell the patient's story, and as such it is very difficult. Even when the parties—out-of-hours, 111, general practice and secondary care hospitals—come together and agree a way forward that is right for the service, we find that GPs are currently funded on a capitation-based payment; out-of-hours is on a block contract; the ambulance service is on an activity-based, national currency, local price model; the hospital is on a PBR tariff base; and community care is on a block contract. Even when they come together to try to resolve those problems, as they are now doing well in our urgent care working groups around the country, they find that, although they can agree, it is difficult for a hospital to give up activity and for a community to take on activity when it has already been allocated its block resource.

We are looking at having a much more uniform system of funding that recognises there is a core payment element that is always open, because it has got to be there irrespective of the amount of work, and arranges for the volume components—the activity components—so we can move patients through the system in a way that does exactly what we want to do. It will be different from locality to locality. In a rural area out-of-hours provision locally may be an absolute priority because there is a long way to travel, and in an urban area there may be a different priority. We are trying to suggest—we are putting out for a consultation at the moment—a payment system that tells the patient's clinical story, so people will be able to adapt locally to make flow changes and make the offer more attractive to patients in the right setting.

Q20 Mr Bacon: Do you think it would have been better if the payment issues and incentives had been sorted out before clinical commissioning groups were introduced?

Professor Willett: This is a result of everybody coming together following that, so it is difficult. Going back over time, as Simon Stevens said, the system was fragmented, and that happened for a variety of reasons. As we are all now working together—local authorities, primary care and secondary care—to design a system that makes a better offer for the patient, it has become obvious that some of those barriers and boundaries have to come down. The strongest message that we have had back from the system is that to do that, they want payment reform now. That is what we are looking at.

Q21 Chair: Say that again.

Professor Willett: They want to reform the payment system. Again, we are doing that with them; it is not something we can impose. We must not constrain them locally, because local service planning is needed. But, on the other hand, they want some national steering.

Q22 Mr Bacon: You make it sound as if you have built a car with an engine you know doesn't work well, which makes horrible noises in all the wrong places and whose gears grind and crash, but only by driving the car can you hear where the noises are. Are you seriously suggesting that you could not, through good architecture, have come up with something? I know it wasn't your responsibility to design it, but are you seriously suggesting that only by running it could you see how badly it worked? That is what it sounds like.

Professor Willett: If you want to use the car analogy, we have a car that we all recognise is running very hot and is close to failing the next MOT, and we recognise that we have got to do more than just change the gear box or the clutch; we have got to look at the whole car to ensure we get it running properly. That is only going to happen when the patients, the clinicians and everybody else designs the system together. We are at that point now, and I think everybody recognises that.

Q23 John Pugh: I am interested in the question of whether we have a more efficient service here. On the face of it, you could say that we do, because we are spending no more than we used to five or six years ago—presumably, demands on the health service have increased during that time. The previous Report of 2008 suggested that the service could quite happily save £134 million if everybody worked at the optimum level. Certainly, some element of that figure can be saved—maybe not £134 million, but quite a bit. If we take into account that there are still significant variations in the system, in terms of different commissioning bodies and how effective they appear to be, and if we take into account the imponderable effect of the 111 service—the effect that that has had—are you convinced you actually have a more efficient service now than you had when this was last up for review by the Public Accounts Committee?

Simon Stevens: The problem with some of the numbers being referred to is that we are not necessarily comparing like for like, for all the reasons that you say. The first is that in different parts of the country we have different types of patient being served by out-of-hours services. So the number of thousands of pounds a month that are being spent in your constituency on LanguageLine for the out-of-hours—as I heard, the Bulgarian person needing the Bulgarian translator in real time

on Friday night—are not necessarily the kind of costs that are being incurred in different parts of the country.

We know that age, as well as deprivation and mix of population, explains some of the difference. We know that the type of services that the different out-of-hours services are being contracted to provide ranges in scope, so some are also including urgent care centres and some are just doing the phone handling with the clinical support. From the data it is pretty hard to draw the conclusion that we have a significant underlying difference.

Q24 John Pugh: I accept that there are variations—’twas ever thus, really—but broadly speaking we want to know whether this service is making progress. In 2008 it was doing a very similar job to what it is doing now. I am simply asking, on the basis of the data available to you and to us, do you think the service can be said now to be more efficient?

Simon Stevens: For the reasons you say, I am not sure we completely know the answer to that question.

Q25 John Pugh: You are not sure. Okay. One of the big drivers of cost in the service is the cost of hiring GPs or doctors to form the service. Back in 2008, the cost of a doctor in out-of-hours ranged between £50 and £70 an hour. What is it now?

Simon Stevens: I do not know off the top of my head. Do you know, Barbara?

Dame Barbara Hakin: I don’t.

Q26 Chair: We know that one of the companies, Harmoni, is spending some ghastly amount—a huge amount—£1,350 on a shift. Is that true—£1,350 for a shift if you are a doctor working with Harmoni?

Dame Barbara Hakin: I would imagine that if that is a very long shift, that could be the right number. I do not know for a fact whether it is true or not.

Chair: It is much more than £50 an hour.

Dame Barbara Hakin: It is, yes.

Q27 John Pugh: Is that a feature of the market—is it actually getting harder to recruit doctors for this particular form of work?

Simon Stevens: On the one hand, for the reasons we have talked about, GPs are under pressure and there are other ways GPs can spend their extra working time, but when you look at the extent to which out-of-hours services are having to rely on locums versus local GPs who are willing to take shifts, actually the evidence appears to be that out-of-hours services are doing reasonably well at finding local GPs who are willing to do those shifts.

Q28 John Pugh: So you have an analysis of how the work force serving out-of-hours breaks down in terms of percentage of locums or of local GPs?

Simon Stevens: I will not steal their thunder, but as you will have seen from the individual inspection reports, the Care Quality Commission have produced their first tranche of inspections of out-of-hours, and one of the things they looked at was that question. I think some reasonably positive signals emerged, but it is obviously for them to make their case when they publish their report.

Q29 John Pugh: Right. But you cannot give the stats to the Committee now?

Simon Stevens: The evidence that we have seen and that appears to be confirmed by the Care Quality Commission is that the concerns about locums filling shifts have abated somewhat rather than increased since 2008.

Q30 Chair: Do we know the percentage of agency staff working in out-of-hours services? What percentage of staff working in out-of-hours services are agency?

Dame Barbara Hakin: I am not necessarily sure an out-of-hours service would use that term, because they will hire GPs to do sessions. Some of those GPs will be local principals—they will be the partners or assistants of the local practice. Some will be locums. So are you asking what percentage—

Q31 Chair: People will either be on contract to provide a service or they will be brought in because there isn't anybody. How many people are brought in because there isn't anybody—what proportion of GPs working out-of-hours services come in because they are brought in because there is nobody there?

Simon Stevens: I don't think that there is a national requirement for there to be—

Q32 Chair: You don't have data on anything.

Laura Brackwell: We asked that question in our survey.

Chair: And?

Laura Brackwell: Our data was that a high percentage—92%—were employed or directly contracted and that 6% were agency.

Simon Stevens: So that is a pretty low proportion—

Chair: You should know it. With the greatest respect, you should know it.

Simon Stevens: Should we? I don't know. Should we require staff—

Q33 Mr Bacon: Do you mean that you don't know whether you should know or not?

Simon Stevens: It was perhaps a rhetorical question. If we actually had central, mandated collections of the staffing returns of every hour of every GP shift being worked, the burdensome red tape that that would impose on front-line services if we were to do this across the board would be quite substantial.

Q34 Chair: You are creating an absurdity. You ought to have the basic data, rather than just giving examples, to be able to say to us whether you are happy with the quality.

May I ask another rather provocative question? Is there an English test now so that everybody has to speak English if they work in an out-of-hours service?

Simon Stevens: Yes.

Dame Barbara Hakin: Yes. There is.

Sorry; I am slightly deaf, so I am struggling to hear.

Chair: So am I. Join the club.

Dame Barbara Hakin: In fact, I am very deaf.

Una O'Brien: Perhaps I could help on this issue. The terrible case of Mr Gray—you will remember the Dr Ubani situation in 2008, which was in fact an issue to do with gross negligence rather than language per se, although language played a part—exposed a loophole between the language testing of non-EEA-qualified doctors and EEA-qualified doctors. We have worked very hard indeed with the help of Mr Gray's sons to address this. Starting this summer, the GMC instituted a new system whereby they have to satisfy themselves that an EEA-registered doctor fulfils language competence. If they have concerns about an EEA doctor, they can refuse to give them a licence. We have therefore worked extremely hard to close down that loophole, albeit that the European-wide regulations have not yet been changed.

Q35 Mr Bacon: Can I just clarify what you are saying? Do you mean that if you are a doctor who comes from an EEA country, the GMC has this particular test?

Una O'Brien: Yes.

Q36 Mr Bacon: What if you are a doctor from a Commonwealth country, for example, that is not an EEA country, does the same stipulation apply, because not all Commonwealth—

Una O'Brien: There has always been a stipulation, as I understand it, for non-EEA doctors and languages—Barbara can correct me if I am wrong. Where the loophole existed was in relation to doctors from European or EEA countries. If you remember, that was the big issue that was exposed by that particular case and others. Because we are unable to achieve a European-wide agreement, we have found a route whereby we can stiffen the capability of our own medical regulator to ensure

that the language capability of EEA doctors is taken into account before they get the registration to work here.

Dame Barbara Hakin: One of the really important things is that to deliver primary medical services to patients, whether you are a GP in a day-to-day practice or are working in an out-of-hours service, you have to be on a thing called the performers list. They were at one stage held by the 152 different PCTs, so we had 152 separate performers lists. In the case of Dr Ubani, there is evidence that there was a slip between two different areas holding the performers lists, because there had been problems with him in a different area. That is why I was a little reticent about the differentiation between a GP who is a principal and people who only work for out-of-hours services, because you could be on a contract and only work for out-of-hours services. Some people on contract will be GPs, but they will have a contract for regular sessions. Some will be locums, who may be retired GPs who come in and do extra shifts. There is a range of different types of GPs who undertake such services, but they are all on the performers list. That is the basic test or assurance that we get that these individuals are safe to deliver general practice services whether in-hours or out-of-hours. The performers list is now held by NHS England, so there is one list for the whole of England.

I will not pretend for one moment that everything we have done is perfect. I am afraid that we are on a journey and there were a lot of changes with the reforms. We are now having to ensure that all our area teams, who have taken over from PCTs regarding the list, are being absolutely consistent in the standards that they use for people to get on the performers list and that we have a really great exchange of information, so that we cannot have a situation as we had in those days where someone who was really not up to standard somewhere was missed elsewhere.

Q37 Mr Bacon: You are talking about two entirely separate things. You may say that you were reticent because of the performance issue, but the Chair's question was actually about cost, not quality. The question was "What percentage are this and what percentage are that?" in order to elicit what the cost might be. It turned out that not only did you guys not know the percentage of this and that, although the NAO fortunately did, but that you also did not know the average cost of one of these GPs. It was very striking to me, Mr Stevens, that you know that the cost of a phone call to 111 is £10, but when Mr Pugh asked the cost of one of these GPs—it was £50 to £70, but what is it now?—you did not know.

Simon Stevens: It is £68.

Mr Bacon: Okay. You did not know before, but you do know now.

Simon Stevens: The question is now posed so forensically that I get your meaning, and the answer is £68.

Q38 Mr Bacon: Is that the average cost?

Simon Stevens: For a call to an out-of-hours service, yes.

Q39 Mr Bacon: Sorry, but that was not my question, and nor was it Mr Pugh's question. The question—correct me if I am wrong, Mr Pugh—was about the cost of a GP per hour. That was the question, and you are not saying that the cost of a GP per hour is £68.

Simon Stevens: No. The cost varies hugely across the country.

Q40 Mr Bacon: That was the question to which we were looking for an answer, and it was striking that you do not know that answer, although you do know the cost of a phone call. I would have thought that it is not that bureaucratically burdensome to find out your costs. To run any organisation not merely successfully but to improve, as you acknowledge that you need to do, you need to understand your cost base, and I do not think you do.

Simon Stevens: We need to understand the cost of providing the service. We do not necessarily need to understand the cost of every component that makes up the service. That is what the bids are—

Q41 Mr Bacon: If you do not understand how the service is composed, you cannot understand why costs are going up or down. You sound like one of those people who were handing out PFI contracts: "We don't care how you provide a service, just provide it and let us know when you have done so." The provider then turns around and tells you that the bill is much higher than you thought, and when you look under the bonnet you find that they charged £190 to change a light bulb and £900 to change a socket, which is why the costs have been so high. You have to understand the underlying structure of your cost base, and you do not.

Simon Stevens: The cost has not been high in that it has been flat at £400 million, or thereabouts, since the mid-2000s, so the cost has actually been going down in real terms, as we said.

Q42 Chair: But you do not know whether it is value for money because you do not understand your cost base. Let me give you an example. It is not a cost example, but one of the reasons why we are doing this study today is that we had a whistleblower in a previous inquiry who came to us about the out-of-hours services in Cornwall. In that hearing, which was before you were here, it emerged that the data being provided had been falsified. There was no monitoring through the system that enabled that to emerge; it came to light only through a very persistent whistleblower, supported by national media. We are keen on whistleblowers, and we are keen on the information that they give us, but it is not the way to run a system.

Simon Stevens: Absolutely.

Mr Bacon: Not only was false information provided, but the contractor had a plethora of confidentiality clauses to ensure that it was very difficult to expose that fact. They were protecting malpractice legally.

Q43 John Pugh: May I ask a question about integration? That is a great way in which we help to save a lot of money across the health service. Looking at figure 15 on page 45 of the Report, I am a little concerned that the figure is surprisingly low for an urgent care service.

When out-of-hours are called out, figure 15 appears to show—I assume I am reading this correctly—that only some 7% of people go to accident and emergency after being seen by out-of-hours, and an ambulance is called in only 2% of cases. Elsewhere, the Report says that 111 is fairly risk averse, and a previous Report stated that there is a lack of robustness to protocols on emergency.

Do we have percentages for cases where the GP or the doctor is called? What does that 7% represent in terms of face-to-face callouts? I get complaints from care homes where, basically, the only job that out-of-hours do is turn up, look at the patient and put them in an ambulance. Have you drilled down into the figures to find out the percentage of occasions a physician is called out to see a patient in an emergency and the result is that they just call an ambulance and off they go to A and E?

Simon Stevens: Yes. I will ask Keith Willett to comment on that in a moment. In terms of the figures in the round, there were 5.8 million calls last year to out-of-hours services, of which 3.3 million gave rise to a contact with a GP, 800,000 of which were home visits. Those are the kinds of ratios—

Q44 John Pugh: I am trying to figure out what actually happens during the home visit. It is obviously not a good service if all the doctor does is what the person might do in the first place were the doctor not there—go to the local hospital. Can you clarify?

Professor Willett: If we take the figures from the Report, some are composite and some are broken down. In essence, from the out-of-hours service, which represents about 2% of all the GP contacts that go on a year—this is a very small group—as Simon Stevens said, 3.3 million go to face-to-face, of which 800,000 occur as a home visit rather than the patient going to an urgent care centre. Overall, less than 2.4% of patients who contact out-of-hours end up in A and E.

Q45 John Pugh: Yes, I understand that, but when the doctor actually calls, what percentage end up in A and E simply because the case is unclear or the doctor is risk averse or whatever?

Professor Willett: Overall, 7% get sent to hospital. We do not have a breakdown. We do not know about the individual consultations and the ratios that come out of them.

Q46 John Pugh: I am surprised at that, because that is a key factor to know in terms of the integration of services. If the out-of-hours person is turning up and sending the person to hospital and not actually intervening in any other way in, say, 90% of the cases, then in effect there is an extra layer in the process.

Professor Willett: Those data will be better understood locally; that is where they should be understood.

Q47 John Pugh: But you don't understand them.

Professor Willett: We would not have them for every single clinical commissioning group or every single urgent care working group.

Q48 John Pugh: Do you have a general picture of it?

Professor Willett: The general picture is the overview that we have given. We do not have a breakdown. There will be a variation from locality to locality.

Q49 John Pugh: But a variation is of concern. If a local out-of-hours service is essentially acting as a postbox for patients—just turning up and sending people off to A and E—that is not integration. You would hope that in at least 30% or 40% of the cases, the doctor would actually do something that would alleviate the need to call the ambulance and send people off to hospital. That is the point I'm making.

Professor Willett: That is where we have to get to, but this is part of the totality of the response. The problem we have had for a long time is the individual scrutiny of each of the fragments of the system and not seeing it as a total system. The review is all about moving to a system whereby we see all of the fragments in the same way and we start to measure all the fragments in the same way, and we look across the system at how it is performing, rather than at each individual component and how they connect. That is very much the focus of the review. It is the out-of-hospital that is the most fragmented, but it is almost certainly, as you said, where integration will have the greatest likelihood of improving the performance.

Q50 John Pugh: I am trying to understand NHS England's role in this. It did have a role at one stage in supervising GPs who could not supervise themselves, where the GPs were essentially providing an out-of-hours service. You have extracted yourself from that direct role and given it back to the CCGs. You now have a strategic role basically looking at the picture across the nation. I wonder what you are doing in that direction at the moment.

Can I ask you specifically about the software being used in all these various enterprises? I understand the provider has historically been Adastra for the out-of-hours service.

Simon Stevens: For NHS pathways, yes.

Q51 John Pugh: Is it still?

Simon Stevens: Yes.

Q52 John Pugh: Are you giving any advice to the various CCGs as to their IT provision?

Simon Stevens: Just to clarify my answer, Adastra, as I understand it, is the software supplied for the algorithm for NHS pathways and is used inside 111. Where 111 and out-of-hours are combined, they often use the same package. Where individual out-of-hours services are legacy packages, they may be different from the Adastra system. Perhaps Mr Bacon knows the answer better than I do; he is the expert on this topic.

Q53 Austin Mitchell: Since we are so interested in out-of-hours care—as someone who works an out-of-hours job, I think we need to be—why is the health service closing down the Darzi walk-in centres? Ten years ago, in the good old days gone by, they were all the rage and all the trusts had to have one, but now, in my experience, most of them have been closed down. In Grimsby, the one I used has been closed down: it was stopped from financing its weekend and out-of-hours service. Why is that?

Professor Willett: I think the concern with walk-in centres is that, as we have moved to a greater understanding of the flows—I accept that we do not have a full understanding—we have recognised the concern about doubly providing. You had potential for the out-of-hours phone number, which existed in isolation, to be taking a certain number of calls and inquiries and of the ambulance service 999 calls, 25% turned out to be category C, which is a very similar sort of activity. Then you had the walk-in centres and urgent care centres as well as the out-of-hours provision. So this is part of looking at the provision and saying, “We should not be double paying for something.”

Q54 Austin Mitchell: But in Grimsby there will now be fewer walk-in services delivered. Why is that? Are you worried about the costs?

Professor Willett: As we go forward, the local health economy, working with the public, will need to decide how they want to provide and offer the services and what the best arrangement is for that. Certainly, we want to make sure that patients get the right care close to home, but also clearly we have to look at the financial costs, and that was part of it.

The scrutiny that you are raising this afternoon about double paying or overpaying was one of the issues with walk-in centres, because you had an out-of-hours service paid for and you might have had NHS Direct and a walk-in centre. That was clearly inappropriate in some places. Also, the walk-in centres across the country were remarkably different in where they were located, what they did and who they were supported by. So not only—

Q55 Austin Mitchell: Is that the reason for closing them all down? In Calderdale the centre closed and now we are all sent to accident and emergency.

Professor Willett: So, part of the review we are doing is about taking what patients want, looking at the flows of the sort of care that is needed and the offer that we need to make and then recommending that a much more uniform system is put in place that, first of all, the public can understand and so that we are providing only the right level of service in the right place. And importantly, as Simon Stevens said, we need a system whereby, whichever portal is used, the offer is similar across the NHS.

We cannot expect patients to understand what they want. They do not know whether they need the all-singing, all-dancing hospital or something like an out-of-hours service. So, whichever portal the patient approaches the NHS by, we need to ensure that it is very clear what they get and where they get it, in as few steps and as close to home as possible.

Q56 Austin Mitchell: The offer is the same for all the services because there is no offer. That is a silly answer.

Professor Willett: As we see 111 going forward, the service specification for 111 in the new contracts which start next year will say that you will be able to speak to a clinician—they will be able to take over your call—so you will have direct access to clinical advice in many areas. They will also be able to book you into the urgent care centre, if that is the appropriate place for you to be seen. They could even line you up to go to A and E or book you in for a call-back from your general practitioner the following morning. We need to move to a system that gives the patients a much better offer than now.

Q57 Chair: Am I hearing this right: you are going back to having the phone answered by a clinician?

Professor Willett: For the proportion of cases for which that is useful. We do not know the exact figure for that, but at the moment 21% receive clinical advice: 12% get that immediately and 9% get a call-back within a short time. So we already do that, and that has been part of 111. What we are doing is looking at how we increase the cover.

Through talking to the public and looking at the analysis, we understand the sort of calls that are arriving where the patient is left in some way dissatisfied because they have not got the definitive decision that they wanted: they did not get booked into the place they wanted. So we are looking to the nurses, general practitioners, pharmacists, community mental health nurses and dental nurses for support, because those are the calls that, very often, people are left dissatisfied with and otherwise default to a high acuity settings such as A and E, which is unnecessary and inconvenient for the patients and expensive for the system.

Q58 Chair: Whose job is it to tell the patient where to go?

Professor Willett: We cannot tell the patient where to go.

Q59 Chair: Well, you need to tell them what is available.

Professor Willett: We know that public education is very, very poor at changing patient behaviour and public behaviour. You can have a short, transient effect over something like a flu vaccination, but if you are trying to do something as wide as the access to urgent care, particularly when the patient is in an anxious state or, more usually, there is a concerned family member, they are not going to work like that.

The way people change their behaviour in public around urgent care—the evidence supports this—is through experiential learning, so if somebody uses a system and it gives them what they want, very promptly and conveniently, they will use it again, but also they will tell their family and friends.

Chair: Whose job is it to inform—

Q60 Austin Mitchell: Just let me say that in Grimsby they were using the system; they are using the system. The walk-in centre has done a survey of patient satisfaction, and it has come back—I have seen it—showing glowing support for the service, which is now to be closed, so I don't get this story about—

Professor Willett: I cannot comment on—

Simon Stevens: On that one, Mr Mitchell, that decision will have been made by your local clinical commissioning group.

Q61 Austin Mitchell: It was, but it's wrong.

Simon Stevens: That is the local GPs controlling the CCGs, working out what they think is best for the patients in your area. You may well take that view, but that is not something that is being imposed by Professor Willett on Grimsby.

Q62 Austin Mitchell: It was done to save money. The letter said they could no longer afford to maintain the service. It was as simple as that. I don't think it was done because of patient satisfaction or any desire to serve the people of Grimsby. But let me move on. It says in the Report—this is paragraph 15—that “NHS England has very limited oversight of out-of-hours services where GP practices have retained responsibility”, so why don't you monitor the GP provision of out-of-hours services?

Simon Stevens: We have clarified that CCGs will do that for the small proportion of practices that have maintained that responsibility, but I think the important point here is that, frankly, this is a distinction without a difference.

When you look at the 10% of GPs who have opted in or retained responsibility, it is not that they themselves are directly doing these services. They are, in almost all cases, using the same out-of-hours providers that are being inspected by the Care Quality Commission and overseen through the other assurances processes that exist. Take the doctors just across the river—south-east London. They have opted in, in Lambeth, Southwark and Lewisham, but they are using SELDOC, the co-op, just the same as the opted-out doctors are. This, I think, is, as I said, a distinction without a difference.

Q63 Austin Mitchell: But you can't say that patients are receiving an acceptable service unless you do the survey.

Simon Stevens: You can, because the Care Quality Commission is inspecting SELDOC in just the same way as it is inspecting other out-of-hours providers, and the out-of-hours providers being used by opted-in GPs are the same as the out-of-hours providers being used by the opted-out GPs.

A very small number—fewer than a handful—of practices across England are doing their own, the Isles of Scilly being one example. There, for good reason, given the geography of the Scilly Isles, they do it themselves. But what appeared on paper at the time that the Report, for perfectly understandable reasons, was written—that somehow there was a big distinction between opted-in and opted-out in terms of who was actually providing care—is, on closer scrutiny, not the case.

Q64 Austin Mitchell: But why don't more practices do it? I am sure the level of satisfaction is okay with the after-hours service, on this survey. It might be even higher if the out-of-hours service came from people's own practice, which knows them, which has their records and which they are accustomed to dealing with. It used to be the case that even single-doctor practices would provide an after-hours service. Now, we have big group practices, which could surely work in proper shifts, so why can't the doctors do it?

Simon Stevens: That was before the mid-'90s, but, as I said, by 2004 95% of GPs, prior to the arrival of the new contract, had already opted out of doing their own out-of-hours in their own practice, because it made more sense to have a bigger rota so that individual GPs were not working one night in two, one night in three or one night in four and as a result were tired and stressed when seeing their patients in the surgery later that week.

Laura Brackwell: At the time of our Report, we reported, and you agreed, that you did not have information centrally on the extent to which opted-in GPs were subcontracting. Have you now collected that information?

Simon Stevens: We have. We have a complete inventory of the whole country. We can tell you exactly what the position is.

Sir Amyas Morse: That is really great. So you are collecting more information. All we are trying to push you towards is ensuring that the information is sufficiently coherent and that you know whether the out-of-hours service is value for money or not. We are not telling you to collect all the information that could possibly be asked for everywhere in the world or things that are burdensome; we are just asking you to take a logical approach to put something together that allows you to make good judgments at the centre. Is that fair?

Simon Stevens: We agree with that.

Q65 Chair: Can I ask you a question that arises out of one of the case studies used by the NAO—that is, Barnet CCG? Its service provider is Barndoc. Going through that, eight members of Barnet CCG are shareholders in Barndoc Ltd. One of the members of Barnet CCG, Jonathan Lubin, is the chair of Barndoc Ltd. Another is employed by Barndoc to provide the out-of-hours services.

That contract also covers Enfield and Haringey. Four members of Enfield CCG are shareholders in Barndoc Ltd, and one of them is the medical director. In Haringey, one member of the CCG and her husband hold shares in Barndoc Ltd. We have a theoretical separation between the commissioner and the provider and actually an incredibly incestuous relationship—yet another—between them. That may be an extreme example, I don't know; it is the one I looked at. With those really dangerous conflicts of interests, how can they be managed in the interests of the taxpayer or the patient?

Simon Stevens: Well, they have clearly got to be. The NAO looked at that question in the round and concluded on conflict of interest that, "Clinical commissioning groups understood these risks and were acting to manage them." Across the board, that is what the NAO found. It is in paragraph 3.19.

Q66 Chair: Did you find that?

Laura Brackwell: We said that they understood the risk. That system is generally reliant on people self-reporting, excusing themselves from discussions and that kind of provision.

Q67 Chair: I don't think that is good enough.

Laura Brackwell: What we did not audit was how that was working. Our audit was a brief question about whether they understood the arrangements and what they were, not whether the arrangements in practice were actually being applied.

Q68 Chair: Where you have got a commissioner who, in this instance, is actually chair of the provider organisation, it is just too close. You wouldn't do it; I wouldn't do it. It feels wrong.

Simon Stevens: I agree. Historically, where out-of-hours services have come from is that the funds to do out of hours have been embedded as part of the income that GPs got. They were included in the global sum and the assumption is it is about 6% of GP earnings. That is how the whole thing began in the mid-1990s. Going forward, we have obviously got to get to a position where, not just for the fragmentation reasons that Keith was talking about, not just out of hours, but also out of hours, 111, urgent care centres, that those are periodically properly tested in a transparent process, competed where that makes sense, and there are tests that need to be applied, precisely to deal with the question that you raised.

Q69 Chair: Okay. Let's go to two things. It is not just tested; they also need to be monitored. That is why monitoring is so important. In the examples that the NAO looked at, I think it is five out of eight of the contracts that were re-let, were re-let without a competitive process—maybe for very good reasons, I have no idea. You are saying, okay, we will rely on competition to ensure that this does not happen. They don't competitively test the validity of the contract and nobody is out there monitoring to ensure that conflicts of interest are properly manageable.

Simon Stevens: We are absolutely going to be doing that. I don't think that a close reading of the NAO Report said that they had actually looked at the question of whether this was reasonable or not, so they did not have a finding on that point. What has happened in a number of these cases is that the reason why contracts have been extended is that people could see that 111 contracts also began to become available as well as urgent care, and rather than do it in a fragmented way, it made sense to procure in combination. That is what is happening in north-east London. That is what is happening in your own area.

Q70 Chair: That may be the rationale for not going out to contract. All I am saying is that where you have a very unhealthy relationship between the commissioner and the provider and for the best of reasons you do not do testing in your procurement, you are not in my view managing the potential conflict of interest effectively.

Simon Stevens: Going forward, for exactly that reason, that needs to change, but would it have been sensible to let a whole load of three-year or five-year out-of-hours contracts a year before a bunch of 111 contracts came up for renewal, so that you would then have had two parallel,

independent, fragmented systems, perhaps with different providers and no point of connection between them? That would have been daft from the patient's point of view.

Q71 Chair: Going forward, what will change?

Simon Stevens: Going forward, what we want to see is joined-up procurement with clear testing of potential bidders and utter clarity about the conflicts point that you described.

Q72 Chair: What does that mean?

Simon Stevens: As part of the assurance process we have for CCGs, there are a set of requirements that people involved in bidding exempt themselves from any involvement in the procurement process. We will be assessing and ensuring that that is what is happening.

Q73 Chair: I have to say to you that with the Barndoc example, they are all in there. Eight members of the CCG shareholders—that is the Barnet lot—and four in Enfield CCG, one of them the medical director, and a husband and wife team in Haringey. It is too big; it is not the odd person. If you have an odd person on it, they can leave the room when the contract is being discussed. This is just too endemic.

Simon Stevens: I agree. That is certainly how it sounds. There is a dilemma here, which is that if we do not want a bunch of out-of-area locums staffing up out-of-hours services, then by definition it is going to be GPs in the local area who will be involved in actually providing those out-of-hours services. Nevertheless, we have got to put clear daylight between the decision processes as to who is doing it and the people who are subsequently providing it and earning off the back of it.

Q74 Mr Bacon: It might have been better value for money, might it not, to have said, "Right, it's mostly going to be GPs within area, so let's get a GP contract that pays GPs to do all of the job that is required, rather than some of the job that is required", and you could have done away with all this extra incubus of structure.

Simon Stevens: That is the position, of course, that existed prior to 2004, and with the opt-in GPs that is how they are resourced, through part of the global sum. But the decision was made in 2004, with the clear disinclination of GPs collectively to carry on with that arrangement.

Q75 Chair: But it sounds like GP fundholding. I am old enough to remember it and that is where it went wrong there; in the end, it was seen that they were both the commissioners and the providers, and it fell into disrepute. This sounds like it is going just in the same direction.

Dame Barbara Hakin: Two things on that. Conflict of interest for GPs under these circumstances is an issue; it is not just out-of-hours.

Chair: I agree.

Dame Barbara Hakin: However, with the whole issue that you raised earlier about the totality of the resource and the emergency doctor who just sends the patient into hospital, the GPs and the CCG—the body of GPs—of course are then responsible for paying for that care, so they are able to look at both budgets and identify where they have an out-of-hours provider who is not doing the right job—too many patients turning up at A and E, or being admitted—and they can deal with it.

There are two things we have asked our area teams to do specifically, which again we probably should have done earlier but getting the CCGs up and running for their £60 billion worth of services was our primary requirement. We have put extra assurance in, so that our area teams will be asking every single CCG this year to demonstrate when they do their September assurance—they do a quarterly assurance—that they are managing conflicts of interest, and how they are managing conflicts of interest, and for the areas that are much more local to assure themselves that this is being dealt with.

Again, in the early guidance what we said to CCGs was that there will be times potentially where conflict of interest is not just a couple of members who can excuse themselves, as you pointed out, but there are so many people around the table who have a conflict of interest that you have to have an alternative arrangement, whether it be your area team in NHS England awarding that contract or another CCG making those decisions and overseeing them for you. In the initial guidance, we were very clear to CCGs what they had to do if they had lots of members round the table so that the conflict of interest could not be resolved by just one or two—

Q76 Chair: Do you know how often this Barnet-Haringey situation happens? That just happened to be the example that—

Dame Barbara Hakin: On that particular issue, as part of this year's assurance process the area team will specifically ask that CCG how they manage conflicts of interest—

Q77 Chair: Do you know at the moment? Do you know how often? It is more systemic than individual. It is a systemic—

Dame Barbara Hakin: I don't know how many CCGs will have some. It will be a range, from some who have virtually none to some who have very high numbers.

Simon Stevens: But your point is you will know that this month.

Dame Barbara Hakin: Yes, we will know how they are dealing with conflicts of interest if they have them—and also triangulating the other pieces of information that they will have, such as patient satisfaction and what is happening with the national quality requirements, to make sure that however the contract is awarded, the patients are getting good service and the quality is high.

Sir Amyas Morse: Chair, just a point of information. We are just starting up an investigation into conflicts of interest in the CCGs.

Chair: Are you?

Sir Amyas Morse: Yes. So that is starting now. We have started work on it. It arose from correspondence I had with David Nicholson last year.

Q78 Mr Bacon: It's obvious that it was going to happen. It is a design problem basically, isn't it?

Dame Barbara Hakin: It is a design issue that we have to mitigate, but, of course, Parliament decided that there were significant advantages to the commissioning of local services being with local commissioners.

Sir Amyas Morse: Indeed, and the fact that we are doing an investigation does not necessarily mean there is anything wrong with there being conflicts of interest, but what is interesting is how effectively and objectively that is being managed and whether there is evidence that it is being managed properly or to the contrary. That is something we wanted to examine.

Q79 Chair: The other thing I am interested in is looking across the piece at out-of-hours contracts. What proportion are held by Care UK?

Simon Stevens: We have the list. In the round, about half—49%, I think, was your finding—are held by social enterprises, about a third by commercial organisations, and about a fifth by NHS bodies, such as ambulance trusts.

Q80 Chair: How many by Care UK?

Simon Stevens: We will send you a note on that.

Q81 Chair: How many by Harmoni?

Simon Stevens: We can give you the breakdown.

Q82 Chair: Again, something we are finding across the piece across public services—when you look at the provision of public services through private providers—is the emergence of these monopoly-style providers, with the challenges that that brings to both accountability and value for money. I would just be interested to know whether that is an issue in this particular area.

Simon Stevens: Two thirds of out-of-hours services are not provided by commercial organisations, so I do not think one could infer that we are at monopoly status.

Q83 Chair: The other interesting thing—Harmoni seems to be one that keeps coming up—is the north central London/west London consortium, where in the end, the contract was allocated on price, not quality. I just wondered, as the difference here was that on quality, the local consortium scored over 42 points against Harmoni's 35 points, but on price, Harmoni scored much better—30

points against the consortium's 15 points—so price was the determining factor. Have you a view on that? Do you provide advice on that? In the context of what the data tell us, which is that patient satisfaction is declining, not increasing—it is on the margin, but it is declining—should you have a view?

Simon Stevens: We are going to be issuing guidance to commissioners on procurement, both of 111 and out-of-hours services, within the next month or so, and that will be one of the points that we will refer to in that guidance.

Q84 Chair: I don't know what that means. To me, that is a non-answer to my question.

Simon Stevens: It's describing action we will be taking.

Q85 Chair: So you will have a view.

Simon Stevens: There may well be trade-offs, but one of the issues that I think has sometimes been rather short sighted in the way out-of-hours services have been thought about is that they have just been thought about in terms of cost minimising for the out-of-hours component itself, without really thinking through what the consequences are and what happens to patients once they have been through the out-of-hours service. That relates to Mr Bacon's previous questions about what proportion of patients, when they have been seen by an out-of-hours GP, still end up going to the A and E department or are admitted to hospital and so on. That is the reason why we want this end-to-end perspective, with data right through the system, so we can say what is happening at these different gateway points and understand the total resource consequence as a result.

Q86 Chair: If poor quality leads to extra costs in the long run.

Simon Stevens: Yes.

Q87 John Pugh: Can I just go back to what drives efficiency? It strikes me that in terms of the clientele for out-of-hours, there are going to be different categories of people, aren't there? There are going to be those people who have a genuine medical emergency and there will be those people who think they might have a medical emergency, but possibly do not. There are those people who just need medical treatment and they want it when they want it, and there are those people who are managing chronic disease of one kind or another and probably could find another route to whatever treatment they want without necessarily using the urgent care services. Obviously, the costs of the process are very much a product of the fact that sometimes people are accessing expensive services when there are cheaper alternatives.

During the course of the discussion today, you have touched on three alternatives that would drive that out of the system. You suggested at one stage providing the right incentives to the providers of the services, and therefore doing something about what Mr Bacon called the architecture. We touched briefly on educating the public, and I think it is fair to say, Professor Willett, that you are fairly despairing about that.

The third alternative that you came up with, which we have been talking about in the last few minutes, is getting local groups to sort it out for themselves in some way or another by sufficient peer group information being circulated and, as it were, handing the problem to them. How do you see your role in this? Are you going to be the people who are going to drive efficiency forward by lobbying Government for change in the incentives so that the incentives look right—so that the architecture is right—or is your role to put downward pressure on the CCGs to try to sort out a problem that may not directly be of their making?

Simon Stevens: I think the answer, from an NHS England point of view, is all three. We have a responsibility in all three zones.

Q88 John Pugh: Including educating the public?

Simon Stevens: Yes, and notwithstanding Keith's point, the fact is that as a parent, if you have a concern about one of your children and it is Sunday evening, it is pretty darn confusing to work out what is "the responsible thing to do". Making it less confusing and less complex, even if Keith thinks that that by itself will not be the answer, is a responsibility that we have in the NHS.

That is, frankly, one of the reasons for having 111 as the gateway into the urgent care part of the system—short, memorable, with the right clinical transfer connections to GPs and out-of-hours services where required, and increasingly the ability to call an ambulance direct when required, so that this really is the decision hub for the urgent care and is easily understood. It is not just calls but also digital. At the moment, we do not have proper connections between 111 voice and 111 online, so we have got work to do there.

Secondly, in terms of structuring incentives, we do not need to lobby Government. We ourselves would monitor and set those incentives and so we have got the ability to listen to what people are saying they need in the way of changes and then bring about those changes in the way funding flows through the NHS. That is what we are committed to doing.

Thirdly, yes, we have a role with CCGs collectively and with hospitals and other partners in urgent and emergency care services in thinking about what the new clinical models are. That particularly shows up in terms of the way A and E departments might work, and the work that Keith Willett and Bruce Keogh have been doing around major emergency centres and making sure that the really complex patients end up with the most skilled teams so as to produce the kinds of improvements we have seen in stroke care, heart attack care and so forth. It is not one of those three; it is all three in tandem.

Q89 Austin Mitchell: I just want to talk about variations. Paragraph 1.17 and figure 2 show wide variations in the cost of out-of-hours GP service. Paragraph 2.21 says that there is a "significant geographical variation"—I do not know whether this is because Yorkshire people grumble more—"in patients' experience of out-of-hours GP services", and therefore in satisfaction. What is the cause of those variations, and do you examine the correlation between cost and satisfaction?

Simon Stevens: Yes. So we have been looking at that prior to, and certainly subsequent to, this stimulating report. As you would expect, there are some variables that you would predict. People who use urgent care services most tend to know more about how to get access to 111. Among older people and people with chronic disease you see awareness and satisfaction rates

higher. Among younger people and people from minority ethnic backgrounds there is lower satisfaction not just with out-of-hours services but with GP services and with the NHS in the round. There is a set of patient-related differences. There is a set of geographical-related differences, in that, obviously, if you are—

Q90 Austin Mitchell: So the patient differences related to age.

Simon Stevens: They related to age, language and intensity of health care need. The groups that have lower awareness or lower satisfaction are younger people, people from Chinese backgrounds, people from Bangladeshi backgrounds and people from different parts of the country. London has lower satisfaction than some other parts of the country. That is true for the NHS as a whole. There is a set of patient-related variables. There is a set of geographical-related variables, in that it is more complicated to run home visits in Cumbria than it is in a densely populated part of Leicester, for example. Then, there are still unexplained differences when you have done all of that. Getting a better fix on what those unexplained bits are—

Q91 Austin Mitchell: How about the costs? Do they relate to distance?

Simon Stevens: Yes, they relate to distance. They also relate to what is included in the out-of-hours contract. In some places, the out-of-hours contract includes running urgent care centres next to the A and E department and in other places it does not. There are apparent differences between the types of provider, but when you standardise for the different numbers of calls they get, the cost per call is pretty similar. We are doing further work in that area. Frankly, so long as these things are also independently and objectively procured, in a sense that will tell us what the efficient price is for providing these services going forward.

Q92 Austin Mitchell: Are these figures going to be published? I was interested when we heard about the proportion of services provided by private sector organisations muscling in on the health service. Do you have any system of checking which private sector organisations provide the cheapest or the best service, or the most consumer satisfaction? Do you rate them?

Simon Stevens: The data suggest that the commercial providers are providing at the lowest cost at the moment—£6.40 a patient a year, compared with £8.90 for NHS providers. When you standardise for the number of calls they are then having to act on, however, it comes out at about the same cost. Obviously, they are all subject to independent inspection by the Care Quality Commission, and the CQC found that generally all out-of-hours providers are providing safe, effective, responsive and well-led care.

Q93 Austin Mitchell: Can't we see these tables to see which organisations are providing the best or the least expensive care?

Dame Barbara Hakin: Some of it has come out in the CQC reports, which have been published individually. The CQC has not published its collective report.

Q94 Chair: How many has it published so far?

Dame Barbara Hakin: I think it's about 30.

Simon Stevens: It is 30.

Dame Barbara Hakin: What we have said is that every CCG, by the end of this year, has to publish comprehensive data—on its website and accessible to the public—on its out-of-hours service, including where they get it from, the patient satisfaction rates and the access rates, so that by the end of the year, local communities and local individuals, if they choose to, can get that sort of information. At the moment, we find that only two fifths of CCGs are publishing that, but we did say that the deadline is the end of—

Q95 Chair: But what they need to be able to do is compare, so how will they be able to do that?

Dame Barbara Hakin: What we have also said is that we have got a range of conditions for CCGs that they have to have in place by the end of 2014-15. One we have talked about already, which is the conflict of interest. One is about publishing data. One is about being party to a national benchmarking scheme and publishing that. In other words, they need to be able to benchmark not only on cost, but on patient satisfaction. There are 13 national quality indicators and by the end of the year every CCG will have to publish across that range.

Laura Brackwell: May I just remind you, Chair, that you recommended in your report on Cornwall in September 2013 that CCGs should publish comparable information? That was a year ago.

Q96 Chair: It has taken two years.

I have got three things left. One is that this clearly all depends on having enough GPs, so long as you do not double pay or triple pay them too much. They are going to be in their surgeries, in A and E and in out-of-hours services, if those carry on. They will be on NHS 111. Are you recruiting enough?

Simon Stevens: We do need more GPs. There are a record number of GPs—numbers are up by more than 20% over the course of the past decade—but we clearly need more. The Department of Health has commissioned Health Education England to increase the number of GP training places quite substantially—

Q97 Chair: By?

Simon Stevens: By 10,000 more GPs.

Q98 Chair: Which is what percentage?

Simon Stevens: Well, there is a debate about how many GPs in total the country should need, and different GPs have different staffing models, with practice nurses taking on more roles—

Chair: Yes, but what is the percentage nationally?

Simon Stevens: That is an increase in the number of people coming off training. There are obviously retirements at the other end so there is no single forecast for what the net number of GPs will be by the end of the decade. However, we are working on that with the Royal College of General Practitioners, the GPC and others to think about what can be done around primary care.

Q99 Chair: But do you have a model that tells you that GPs must increase by 16%—that is the proportion I have seen floating around—for you to be able to meet all the service requirements?

Simon Stevens: It would be fair to say that different interest groups have different models.

Q100 Chair: And what is yours?

Simon Stevens: We haven't published a model.

Mr Bacon: That is not the same as saying you do not have one.

Simon Stevens: We don't have a single model for GP numbers to 2020.

Q101 Mr Bacon: Do you look at everyone's models?

Simon Stevens: The simple reason is that we have no idea what resources are going to be available to the national health service come 2020—

Mr Bacon: That's true.

Simon Stevens: As and when Parliament sets us a budget through to the end of the decade, we will then be able to work out what our staffing can be from the resources available.

Mr Bacon: I can understand why you might not necessarily want to publish everything, but do you look at all the different models?

Simon Stevens: I don't think we look at them all, but we look at a number.

Q102 Mr Bacon: I am told that the population of this country is going to be significantly higher in 30 years' time. In 2050 we are apparently going to be a lot larger than Germany—we will be pushing towards 80 million. I don't know whether or not that is true, but in your work, although it is true that you don't know what the NHS budget will be in 2020, separate work is available on the likely population of the country in seven, 10, 20 or 30 years' time. Do you factor in that information when trying to work out how many GPs you think you will need?

Simon Stevens: We do. Health Education England has published a strategy for training places, including GPs, that goes out to the next 15 years, precisely for the reasons you identified.

Mr Bacon: That is quite reassuring.

Q103 Chair: Are you recruiting on the right time scale? Are there even enough people to meet that 10,000, the only figure you are prepared to share with us?

Simon Stevens: GP numbers are increasing, but there are clearly substantial pressures. One thing we have to do is make coming into GP training more attractive, including more attractive relative to hospital medicine, because one of the great unplanned consequences of the past 10 years is that whereas GP numbers are up by between a fifth and a quarter, the number of hospital consultants is up by 76% in whole-time equivalent terms. If someone had said 10 years ago that the NHS's game plan for the next 10 years was to have between three and four times more hospital consultants added to the roster than GPs, people would have said that that was crazy, but that is what has happened.

Q104 Mr Bacon: To what do you attribute that, mainly?

Simon Stevens: There will be different points of view on that.

Mr Bacon: I wasn't asking for different points of view; I was asking for your point of view.

Simon Stevens: My personal point of view is that one of the things that has driven that is the way in which the European working time directive has been implemented, which has had the effect of sucking doctors into hospitals to create legal rotas. To some extent, training has been the tail that has wagged the dog. I will get into trouble for that comment, but there you are.

Mr Bacon: Yet another reason to add to Mr Mitchell's list, and mine.

Q105 Chair: I want to go back to the issue of Cornwall. When we looked at Cornwall, the deliberate manipulation of data was really of concern. If you look at what the NAO Report says on who checks the data, on page 32, paragraph 3.11, it says, "Most did not". How are you tackling that? It is one thing to get the data, but it is another to monitor and use them. Nevertheless, it is really important, particularly given the fragmentation of providers, that you have systems in place to verify.

Dame Barbara Hakin: This is something I am very aware of, and on which I have a focus across a range of providers, not only for out-of-hours services. There were issues about data from hospitals—from trusts. It is sometimes very difficult for commissioners to verify the level of detail that would give the confidence that we would really want from these services. So one of the things we are talking to CCGs about is how they might get independent verification of the data that out-of-hours organisations give them.

Q106 Chair: They won't have the money for that. That might theoretically be an answer, but they won't be able to pay for it.

Dame Barbara Hakin: They could certainly look at it as part of the contract. Some CCGs are already doing spot checks to identify and verify the number of staff, because often the issues involve how many staff are on the books and how many are available at any given time. Particularly around the NRQs, it is about triangulating that with patient satisfaction and some of the other areas in the

NRQs where there is independent verification. As a whole, being absolutely certain that we have got the right information from providers is an issue that NHS England, the Health and Social Care Information Centre and the Department of Health are looking at.

Simon Stevens: I think there is perhaps one other thing to add, Barbara. As of April this year, we changed the GP contract to make it a contractual requirement that GPs report on the experience that their patients are getting in out-of-hours services where there is cause for concern. They now have a contractual obligation to bring that to the attention of the CCG from the front line of services.

Q107 Chair: I have two final questions. We have said that on the whole, people were happy with GP services. Actually, page 19, figure 4 says a quarter did not start urgent cases within 20 minutes as they should have done, 27% did not start other cases within the hour as they should have done and 10% did not start the other ones in an hour. They failed to deliver on the standards set by you, yet if you look at financial penalties, which are the one stick that people have to encourage better performance, they are hardly used: £1 million, or 0.3%.

Dame Barbara Hakin: Particularly with NHS services and particularly when providers are not commercial, there is a reticence to use penalties, because they reduce income to the provider and people worry about the potential knock-on effect to patients. This is particularly true with hospitals, and it is also true with some out-of-hours providers. Again, we are working with CCGs to identify where there is non-compliance. With a lot of them, there is partial compliance: they are within the 5% tolerance margin. In general, our approach to NHS services is that where there is a clear contract and there is clear failure to deliver that contract, penalties ought to be imposed.

Q108 Chair: What is your sanction if they do not?

Dame Barbara Hakin: Well, for NHS England's sanctions on CCGs, we would need to be convinced that they were seriously failing to deliver and putting patients at risk in order to intervene. That is how the system was set up in the Act of Parliament. The intervention powers that NHS England has over CCGs are limited to CCGs that are failing significantly. That is not to say that we cannot achieve a great deal through personal relationships with our NHS England area teams, benchmarking, peer pressure and guidance to show people the best way to deliver the best services, but our sanctions are limited.

Q109 Chair: Very finally, how much did we pay out in redundancy to wind up NHS Direct?

Una O'Brien: I haven't got that figure with me, but we can let you know.

Q110 Chair: And how much did the chief executive get as a severance payment?

Una O'Brien: I will write to you with that information. I am not aware that he got anything, but I will give you the full facts.

Q111 Mr Bacon: This is for Una O'Brien. I will be very quick. On our report on emergency admissions to hospitals, the Treasury minute in response said: "NHS England is leading the work on

assessing the impact of seven-day services. Lack of rapid access to senior decision-making and supporting diagnostics at weekends is being addressed through the delivery of a set of clinical standards for safe care on every day of the week...By 2016-17, all clinical standards should be incorporated into national quality requirements in the NHS standard contract". Do you have any information on what the shift to 24/7 consultant cover is going to cost?

Una O'Brien: I am going to ask Keith to comment in detail, but the central point here is that I think that some of the complexity may have been lost in the brevity of the way things are expressed in the Treasury minute. However, the point is that we are talking about 24/7 cover for the urgent and emergency care system and that—going back to your own report—is what was at issue in that discussion. If I may, Keith can provide you with more detail on that.

Professor Willett: Thank you. We are talking here about looking at how patients would have the same consultant support within the hospital across all seven days of the week, because that is where the issues have been, so that will be different in different areas. In the critical health areas, like ITU or an emergency department, clearly, the number of hours of a consultant being present needs to be much higher. In lesser specialities there would be fewer emergencies and we would need to work in different ways across the organisations to do that. Obviously, perhaps in dermatology—rarely in skin disease would there be an out-and-out emergency.

Taking that, we have commissioned some work through NHS finance to look at the sections of care that will really be impacted by increasing consultant involvement in senior decision making across seven days: that is, looking at the demand for urgent care; looking at those admissions that are avoidable because things were not done at the time, in terms of discharge, with enough senior input, or in terms of assessing them when they came back; patients' experiences of care when there is not senior input; and around the thing that was obviously of great concern, which was the recognition of increased mortality over weekends; and the fact that the length of stay of patients is longer. So there is an efficiency thing as well as a patient outcome.

We have work under way now. Stage 1 has been completed. It was looking at all those elements and working out what elements, both within hospitals and equally, as we have talked about today—many of the solutions to give the headroom to the hospitals to do the work properly are out there in the community services and in out-of-hours, rather than that. Then, from that, we will create an impact analysis, looking at the financial costs of doing this, what the work force issues are and what it clinically means for patients. They will form products which we will then look at to prioritise, going forward, into contracting over the next two years.

In terms of the bit that this Committee is perhaps most interested in, which is A and E departments, we had a particular problem, which was discussed at the last session, where the emergency medicine consultant numbers were low and we were not recruiting, and it was a big concern. We have done a lot of work—or Health Education England, in particular, with the College of Emergency Medicine have done a great deal of work in this area, so that this year there will be 340 more junior doctors going into A and E, which is over 100 more than previous years.

Looking at trajectories, in terms of reaching full recruitment for emergency medicine, if we can maintain that for the next three years, and in that same way by decompressing the system make life more tenable for those who are in the system, within five years we will have reached full recruitment in emergency medicine. Clearly, that is one of those services that are critical and one of the areas where people say, "Is this going to cost more?" We were spending a lot of money on locums because we did not have trained staff coming into the system. That is sort of the turnaround

we have to achieve, but clearly, when you are talking about the whole breadth of urgent and emergency care—whether hospital consultants supporting general practitioners in hours or out of hours, to make good decisions in the community when they need a bit more advice—we are looking at costing all of those elements and looking at the implications of that.

Q112 Mr Bacon: So that's a no, then?

Professor Willett: That is a yes. We are doing it.

Mr Bacon: I said, "Do you know the cost?" It was an interesting answer, actually, and very helpful. I was being a bit facetious. My question was about whether you knew about the cost, and it sounds like you don't yet.

Professor Willett: Not yet, but we have a clear programme to do that.

Mr Bacon: So it was a no.

Una O'Brien: Yes, not yet, but the crucial point is that we have to find ways to do this, to recycle existing resources, to put it bluntly—

Mr Bacon: Yes, I fully appreciate that.

Una O'Brien: In the old days, you would make a list and you would say, "That new thing I want costs all of this", and you would just give an answer, like that.

Mr Bacon: If the gross costs aren't netted off by hugely reduced costs elsewhere, that is—

Una O'Brien: Exactly, and that is why it is actually harder to do it, and it needs to be done much more thoroughly in an environment where we are in a resource constraint situation.

Q113 Mr Bacon: Sure. Can you give me, Professor Willett, some indication of when you think you will have firmer answers on costs?

Professor Willett: As I said, we hope to have enough that the key interventions, which we think will really change practice, we can hope to get into contracting for next year. But all of them will obviously take time to work up and some will have a lesser impact than others. They will follow in subsequent years.

Simon Stevens: To clear up one important point, the cost of doing this in part depends on the cost of overtime pay. The Government has just asked the NHS Pay Review Body to look at what changes might be needed to support seven-day working for those folks involved. That in turn will then affect the costings that Keith is able to produce.

Q114 Chair: The other thing out of that report—you sent us a very woolly Treasury minute with a response—was intervention if things go wrong in A and E. Can you just say again how the Department is going to intervene when the performance of an A and E is substandard?

Dame Barbara Hakin: That is ultimately the responsibility of trusts and their boards.

Q115 Chair: When they fail to perform, who is going to intervene and how?

Simon Stevens: The legal power of intervention for hospitals rests with Monitor and the TDA. That is the statutory framework.

Dame Barbara Hakin: But commissioners have a responsibility to support and there are contractual penalties. We are increasingly seeing the use of contract penalties when providers fail to deliver the standards.

Q116 Chair: Except that you said earlier that they don't use them because that just takes the money away and creates an additional problem. It is a theoretical.

Simon Stevens: Yes, but ultimately this is a shared responsibility at every level through the national health service.

Q117 Chair: Including you?

Simon Stevens: Yes, it is. Of course it is—absolutely.

Q118 Chair: Including you?

Una O'Brien indicated assent.

Simon Stevens: We have a national responsibility, together with Monitor and the TDA, regionally, locally, in every part of the NHS. There is no doubt about that. It is the only way, in practice, that we can get the kind of changes we want.

Q119 Chair: I look forward to the impact of that in Barking and Dagenham.

Simon Stevens: Yes. Might I just give one other thought—perhaps a warmer thought—to conclude on the out-of-hours thing? As far as I am aware, there has been one international survey that has asked patients across the industrialised world, “How well do you think your out-of-hours services are doing?” I am pleased to be able to let you know that the NHS scores far better than those health care systems in France, Germany, Sweden, Canada, America or Australia. Patients here are far more satisfied with their ability to access out-of-hours services than they are in any of those other countries. Notwithstanding the fantastic agenda you have set us today through the NAO Report, we start from a good place, relatively speaking.

Chair: That is why we love the NHS. Thank you.