

Health Committee

Oral evidence: [Primary care](#), HC 408

Tuesday 3 November 2015

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Written evidence from witnesses:

- [PRI0183 Centre for Workforce Intelligence](#)
- [PRI0200 Health Education England and Department of Health](#)

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Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Julie Cooper; Dr James Davies; Andrea Jenkyns; Andrew Percy; Emma Reynolds; Maggie Throup; Helen Whately; Dr Philippa Whitford

Questions 1-99

Witnesses: **Greg Allen**, Managing Director, Centre for Workforce Intelligence, **Professor Ian Cumming OBE**, Chief Executive, Health Education England, and **Professor Martin Roland CBE**, Professor of Health Services Research, University of Cambridge, gave evidence.

Q1 Chair: Good morning. Thank you very much for coming to the first session of our inquiry into primary care. We are delighted to have you with us. Professor Roland, I understand that you have to leave at 10.45, so we are going to try to focus the initial questions towards you. Could we start with all the panel introducing themselves?

Professor Roland: I am Martin Roland. I am professor of health services research at the University of Cambridge. I was a GP for 35 years but stopped clinical practice last year.

Professor Cumming: I am Ian Cumming. I am the chief executive of Health Education England, which is the organisation responsible for undergraduate and postgraduate training of the health workforce in England.

Greg Allen: I am Greg Allen. I am the managing director of the Centre for Workforce Intelligence. We provide data analytics and modelling to inform workforce planning across health and social care. My background is mainly as a workforce and HR director in the NHS, predominantly in Devon and the south-west.

Chair: Thank you. I am going to ask Helen to open the questions.

Q2 Helen Whately: First, I should say that in the inquiry we are doing into primary care we are not trying to recreate the Roland report—your report. We want to build on that work and other work that has looked in some depth into the problems of primary care, and come up with proposals. We very much want to tease out what needs to happen in practice and how to make it happen. That is what we are about. The report has quite a range of compelling proposals for addressing the problems in primary care, across the workforce, models of delivery and technology. I would be very interested to hear your views on which of those is most important and which will have most impact.

Professor Roland: Absolutely. I was aware that you would be likely to ask that question; clearly it is a comprehensive report with a lot of recommendations, so which ones are key? I have produced a single sheet on what our key recommendations are, which, if you are willing, I will submit as additional written evidence. I have copies if Committee members want them. I will pass them round. Can I briefly summarise?

Our first key set of recommendations is around an expanded and a multidisciplinary workforce. Perhaps I should say as a starter that in one sense there is nothing fantastically revolutionary or new in our report. People are very much saying the same sorts of things in other forums. Also, I do not think there is anything we recommend in the report that is not happening somewhere in the NHS at the moment. The question is how to build on that. In terms of the workforce, first, we very much endorse the 10-point plan for GPs, bearing in mind the significant problems both of recruitment and particularly of retention towards the end of people's careers. We also took very clear evidence that there are similar problems with practice nursing, and we need similar initiatives—maybe, if you like, a 10-point plan—to encourage recruitment and retention in general practice nursing. Secondly, it is obviously not the easiest time, but we believe that resourcing is needed for the new staffing models we articulate, including pharmacists—you will be aware that we are particularly interested in pharmacists working in practices as well as in their own premises—new types of clinicians, such as physician associates, and clinical admin support, which we think could relieve a significant burden on doctors and nurses in general practice.

The second main area is around integrating care. Perhaps the most revolutionary, but simultaneously obvious, recommendation is that the current tariff basis for funding hospitals will not work for the new models of care that are being proposed. If you look, for example, at multi-specialty community providers, we expect hospitals to send their consultants out into the community to support GPs and enable them not to send so many patients to outpatients and not to admit so many patients, and those are the things on which the hospital depends for its income. There is a fundamental flaw, if we are looking for a more integrated model of care, in the current tariff system. We need to incentivise trusts to strengthen their links with primary care, particularly in geriatrics, paediatrics and mental health, which are three key areas.

Thirdly—maybe this a rather minor point in terms of integration—we were very impressed with models we saw where a locality had organised themselves so that one practice was looking after each residential and nursing home, given that patients must have some choice of the doctor they are registered with. At the moment you have a GP going into a home at 10.30, another one from another practice at 11.00 and another one from another practice at 11.30, and there is no real room for proactive thinking about how we are going to look after this very vulnerable population. We saw what we thought were

really good examples where practices had taken a grip on responsibility for a particular home.

We make a number of recommendations on better use of technology, and I will mention just one. It is pretty dotty that it is so difficult for GPs and specialists to communicate by electronic messaging or email. How mad is it that I have a patient who may have seen a specialist in the hospital and needs some alteration to their treatment, and I end up sending them back to see the person in outpatients instead of just communicating much more easily, which we ought to be able to do.

Fourth is federations and networks of GP practices. Our vision is very much general practice operating at a bigger scale, but practices are not going to be able to do that on their own. They will need additional support, and we see networks and federations playing a key role. For example, in terms of the new roles, such as physician associates, how are we going to train them and how are we going to deal with governance issues and liability? Those are the sorts of things that an individual practice will find really hard. Likewise, relating to the many patient groups who really could support patients in managing their own care, it is difficult for a practice to engage with that wider range of community resources. We see that GP federations or networks—or, if you like, super-practices—could have a real role in helping to train new types of worker. Finally, for NIHR—you will see that in the right-hand column of the sheet I have put who is supposed to do everything—there is a good bit of evaluation that needs to go on, both of new models and of some specific things that we recommended as issues for research rather than current recommendations.

Q3 Helen Whately: Thank you. Across those five areas there is clearly a lot that you recommend should be done. Is there any way of choosing which of those should have the highest priority and which would have most impact in addressing the problems in primary care at the moment?

Professor Roland: It depends partly on money, but it was very clear to us, both as we went around the country and as we took evidence, that there is no one size fits all. There is no single solution. For example, in some parts of the country you find it much more difficult to recruit GPs than others. At a practice we visited in Yorkshire, for example, they had employed two physician associates—at one time it was four—simply because they could not find GPs. That might not be the solution for everybody, and that is why we offer a range of solutions; but we note—and I realise it is not a terribly popular time to note it—that for the last 20 years, relative to investment in hospitals, investment in general practice has gone down every single year. As at the same time more work is expected of primary care, it seems to us that there needs to be a change in that. It is clearly not an easy time to ask for that.

Q4 Helen Whately: On that point, has any work been done on the cost of doing these things and the relative cost of the proposals?

Professor Roland: Yes. It was not in our remit to do that, but the Royal College of GPs is currently putting costing figures on. I believe that by the time they give evidence to you they will have some costs.

Q5 Helen Whately: Do you have any insight about that or a feel for the scale of likely costs?

Professor Roland: No, but it would be nice to think that a significant proportion of the promised £8 billion would go into primary care and that it would not all go to hospitals.

Q6 Helen Whately: Elsewhere in the briefing materials we received, I read a request or proposal that primary care funding should go up from around 8% of the NHS budget to about 12%, which would mean an increase somewhere in the range of £4 billion to £6 billion, I think.

Professor Roland: That would be a very big increase, and I think it would be more than the sorts of recommendations that we are making. Mind you, there are some other issues around premises, for example, which we have not considered. One of the issues is that, if you look at models of general practice that are operating at scale, they are often doing so from new and enlarged premises, so there may be some significant issues there, as well as the costs of staffing and, of course, the costs of training that I am sure will come to.

Q7 Helen Whately: Broadly, you are saying to us that we should wait for the Royal College of GPs' work on the financial part.

Professor Roland: Indeed, but if you already have £6 billion in your head, I do not think you are going to be shocked.

Q8 Helen Whately: All I did was the maths based on people saying that it should go up to 12%. That is where that number comes out.

Professor Roland: I do not think I should prejudge the college.

Q9 Helen Whately: The final question from me is: can we have a bit more on your thoughts as to whether the proposals you make can be achieved with the current structures for organising and paying for primary care? You indicated—as we said earlier—that the tariff system needs to change some aspects of the model. It would be good to hear more about that.

Professor Roland: That is a really good question. One of the things we were asked several times—it was not really in our remit—was whether the independent contractor model should continue or whether we needed a salaried service, or whatever. Although we did not go into it in detail, we made a number of comments. First, we can see models in other countries where primary care works perfectly well as, essentially, independent contractors or as salaried doctors. We do not feel there is anything fundamentally flawed with that model. However, it does cause some difficulties. Some of the issues are around recruitment and whether people wish to go into partnerships now, but there are issues around training and education. For example, it is not clear that all general practices have taken education of their nurses very seriously, and if they have not it is not clear whose responsibility that is other than their own. This could cause significant problems if we are talking about new types of workers, such as pharmacists working much more closely in general practice, for example. Who is responsible for their training? Indeed, one of the things which was expressed to us—as it were, vicariously—was someone saying, “Why should the NHS pay GPs to be trained in management? They are independent contractors.” That does not make any sense to me. If we are expecting GPs to step up to new roles in

federations, to expand the scope of general practice and to relate much more actively to other parts of the system, and then say we are not going to train them for it, that does not seem logical to us.

Professor Cumming: Could I reinforce that point? From our perspective, Martin is absolutely spot-on with what he is saying there. At least within NHS organisations, we are able to work with the management of that organisation, look at the training needs of their staff and make sure that we are providing the future workforce; whereas if you take, for example, practice nursing, we have stepped in to provide some training for practice nursing in a number of parts of the country, but the vast majority of it is left to individual practices and individual nurses coming through the system without the same sort of structure or architecture. It is an area that we need to think about.

Helen Whately: Yes. That came through strongly in the report. Thank you.

Q10 Andrea Jenkyns: Professor, I am trying to get an understanding of the multidisciplinary workforce—going into a bit more detail—and task allocation. Is it the case that it will be GPs on the cheap, where you allocate a certain task to other professionals? Will the creation of multidisciplinary primary care teams mean that we have to begin the process of task substitution, whereby some aspects of patient care will be transferred to other health professionals, which may be cheaper than having GPs?

Professor Roland: The answer to that is a mixture of cost, supply and people's skills and abilities. There are some things where it is very clear that bringing other people into the primary care team will enable GP practices to do better. For example, practices which have employed pharmacists to do medication reviews, to help with prescribing—particularly in nursing homes where problems with prescribing are huge—found that employing a pharmacist frees up GP time but also improves care at the same time. In some areas we are looking at an expanded workforce simply because there are not going to be enough GPs, but then we look increasingly to GPs to some extent focusing more on the things which only they can do, particularly for the complex elderly. We have an ageing population, with people with multiple complex problems, and those are people we think that GPs will need to spend more time on, to try to avoid, as it were, the hamster wheel that may end up with people in hospital. It is a mixture of supply—I already mentioned people who might employ physician associates simply because there were not GPs in that area—and finding people who can do part of that job effectively and people who will enhance the quality of the practice offering.

Q11 Andrea Jenkyns: What does that look like in reality? If I wanted to see the GP, maybe for a complaint like a bad back or something like that, what would the process be? How do you signpost that you are going to send this person to this professional? What does it look like in reality?

Professor Roland: I could give you a good and a bad vision, if you like. The bad vision would be that there are all these people working in practices, and patients are a bit confused and muddled and do not know who to go and see. The good vision would be if I bring back the example of the practice that we visited in Yorkshire that employs two physician associates. They liaised very closely with their patient group around the appointment of these new types of worker, being very aware that people would not be

quite clear what they could do. Then they were very active in signposting, with leaflets to patients, notices and, of course, training the receptionists to try to ensure that people are not disappointed when they see the clinician that—

Q12 Andrea Jenkyns: Have you had much patient feedback in that particular instance?

Professor Roland: The patient feedback we were given from the chairman of the patients association whom we met was extraordinarily good. If you think back to 1990, when practices were starting to employ nurses in much greater numbers, the same sorts of concerns were being raised, whereas now for many patients with asthma or diabetes the practice nurse would be their natural first port of call, because they have developed expertise in that area. The current model of physician associates in practices is very much a generalist one of dealing with acute minor illness, but it may be that they develop specialist roles and that you could have a PA, for example, whose expertise was in contraception or in one particular area. That is a partial answer, because there is not a complete answer to that question, and there are risks associated.

Professor Cumming: May I give an example from a practice that I visited a few weeks ago? They had a team that included pharmacists, physician associates, practice nurses, clinical nurse specialists, paramedics, GPs and trainees, all working together in a very highly motivated team delivering what I would consider exceptional care. They spend the first period of time every morning of the week allocating patients to the most appropriate member of the team to care for them depending on their needs. They have paramedics, for example, going out to people's homes to act as a triage system, so they are actually seeing more people in their own homes than perhaps we have got used to in recent years. As Martin said, they have individuals who particularly care for people with long-term conditions, and that tends to be their clinical nurse specialist. The GPs act very much as an overseer dealing with the complex and the difficult, the things that require the GP's specialist training and skills, but also making sure that the team is running appropriately. That was a particularly good example of where we already see this working in practice, using the skills. Delivering healthcare is a team activity. It is not individual.

Q13 Andrea Jenkyns: Can I pick you up on that point? I agree, but I have been in my constituency doing a tour of GP surgeries—I visited one in Outwood on Friday—and the general feeling is that there is not much guidance out there. They very much feel in the dark at the moment. You say that obviously one size does not fit all, but in practice what kind of guidance and support are these GP practices going to have?

Professor Roland: I would answer that in two ways. First of all, outside, we think that groupings and federations of practices are going to be key, because generally it is a real struggle for practices to work out exactly how they are going to do this sort of stuff, but groups of half a dozen practices, or sometimes more, can make a real difference. The other thing we note picks up on Ian's point and it is also a risk. As we went round the country, we selected outstanding places to visit, so they were unusual in a number of respects, but in particular they all made time for thinking—they had little huddles during the course of the day; but many practices really have no headroom. It is very difficult to innovate when you are constantly trying to catch up.

Q14 Andrea Jenkyns: That is my point. With any organisational change, there needs to be a support structure to help them get there.

Professor Cumming: Absolutely. The same applies in secondary care where we would find huge variation in practice between different organisations. Somehow we have to find a way to give people time to step off the hamster wheel, to stand back and think about innovative and creative practice and how they can bring that into their own environment. One thing we want to do in our organisation is to look at what we can do to help to put training time in. If we have a practice, for example, where something is working really well, could we buy out some of the time of that GP to put them into another GP practice to work as a peer mentor, in a support-type role, because we think—as in Martin’s opening comments—the good practice is already out there? We now need to spread it evenly across the country as a whole.

Q15 Andrea Jenkyns: Before moving on to the next question, could I ask, Ian, would you be able to name this practice?

Professor Cumming: I am sure they would not mind.

Q16 Andrea Jenkyns: We would love to find out more about it.

Professor Cumming: It is Cricket Green practice in south London. It was Nav Chana’s practice.

Q17 Andrea Jenkyns: Fantastic. I am sure we would like to look further into that, thank you. I have a final question. How do we ensure that it is not just another report that ends up on the shelf, as quite a lot of reports do? In practice, what steps are being taken to implement the recommendations of the report?

Professor Roland: It is worse than that because it is a cyber-shelf these days, so it does not even take up shelf space. That obviously has been my principal concern, having put a fair amount of work into the report. I am clearly actively engaged in using stages that anybody offers me, such as your own, thank you very much, to try to promote the recommendations. The key actors are NHS England, Health Education England and the Department of Health. They are absolutely key. CCGs are also important, but they will take a lead from above. Then the GP practices and federations themselves are important. The professional societies, the Royal Colleges of General Practice and of Nursing and the Royal Pharmaceutical Society are also key; the RCGP is taking a very strong role in providing support and leadership. If you have any ideas as to how you make reports happen—

Professor Cumming: Perhaps, to help, HEE commissioned Martin to undertake this piece of work for us, so we have a lead responsibility among the ALBs in making sure that the recommendations are implemented. Certainly with regard to the workforce components—our components of that—we took them through our public board meeting last week, when we had a robust discussion about the recommendations. We are now moving into implementation—how we are going to take those recommendations forward and build them into our next year’s plan of activity.

Q18 Andrea Jenkyns: Thank you very much. How do you propose the Government evaluate the success or failure of the commission's proposals? It comes to resource at the end of the day.

Professor Cumming: Partly it comes to resource—

Q19 Andrea Jenkyns: And the process as well, of course, to make sure it is smooth-running.

Professor Cumming: If we take the practice I mentioned earlier as an example—I am sure there are other fantastic practices as well—their level of resourcing is no different from other practices' levels of resourcing. From what we are seeing—Martin's example that there are practices all over the country delivering exemplary care—if they are able to do that within the level of resource that is currently available by reorganising, we should use that as a starting point. I am certainly not saying—

Q20 Andrea Jenkyns: How do you measure exemplary care, would you suggest?

Professor Cumming: It has to be related to outcomes, and those outcomes have to be related to clinical outcomes but also to patients' perception of the quality of care they are actually receiving. Then you can break that down further into two components. There is the component around the clinical quality of the care, but there is also the component, "Could I get to see the health professional that I wanted to see when I wanted to see them at a time that was appropriate and convenient for me?" The measure has to be from the user perspective right the way through to the clinical judgment and prescribing: "Was that appropriate?" and "Are we creating a workforce that is fit for the future?" I do not want to hog Martin's time because I am sure we will come on to this later, but we have to recognise that primary care is going to look very different in a few years' time. I see a number of iPads here today. I think that an iPad is going to be primary care in the future and that we are going to rebadge GPs as something else, because more and more members of the population have access to information; they are googling health issues and they are going to present to healthcare professionals as much more knowledgeable than they ever have done in the past. We have to factor into our thinking what that actually means. A medical student who walked into university this year will come out as a GP in 11 or 12 years, so we need to train that person for the environment that is going to exist in 11 or 12 years, not the environment we have at the moment. Perhaps in the past we have continued to train people for the environment that currently existed, not looking forward to what the future might look like. That is where Martin's report is really helpful, because it describes the future.

Q21 Andrea Jenkyns: I agree with you; it is even in politics. I was in the US recently and some Congressmen do Skype surgeries—massive ones called town hall surgeries—so it is going in that direction.

Greg Allen: Can I make a point about the workforce being fit for the future? That is a fourth dimension in this, making sure you have the healthiest workforce you can. Clearly that comes back to data and the evidence base around the workload, the activity and the consultation rates, which I am sure we will come on to.

Q22 Helen Whately: Can I pick up on the evaluation question? You talked about outcome metrics and the sorts of things that need to be looked at. Is the right sort of data being collected at the moment? Are the right metrics in use, or do new metrics need to be developed, and does more data need to be collected to be able to evaluate?

Professor Cumming: We are probably moving out of HEE's territory to a certain extent, so I will give a personal opinion. Much of what we need is already being collected, but—again I am sure we may touch on this later—we would certainly like to see more robust information about the workforce in primary care. We have robust information about what is happening in our hospitals, because we have an NHS-wide electronic staff record. We can access that, and I can tell you what the vacancies are and how many people we have by grade and by role in different parts of the NHS provider system. We do not have that in anything like the same level of detail for primary care. That causes us a problem in terms of trying to plan the workforce for the future. Some of the other measures—patient surveys and patient satisfaction data—are available, and we have information on outcomes to a certain extent. We certainly have information on admission rates to hospital and we have information on referrals. We have much of it, but that is probably an area that NHS England should be answering rather than ourselves.

Q23 Chair: Before we move to the next section, have you had much feedback from patient groups about the report, Professor Roland?

Professor Roland: We took oral evidence from patient groups, so that has been incorporated to a degree. Since the report has been published, no, we have not.

Q24 Dr Whitford: Professor Roland, you talked about multidisciplinary teams. My background is as a breast cancer surgeon, and they were in the vanguard of working in hospital like that. I remember when we tried to set one up in our hospital it was considered a waste of time by management because it was time away from the coal face. You talk about physios, pharmacists and physician associates, but do you not think there are other groups, such as social work and either psychology or counsellors? I am thinking of the groups where GPs say, "That's what I face today that I don't particularly have the skills for."

Professor Roland: Absolutely. There are various levels of teams, if you like, which a primary care team would need to relate to. I would see psychologists, in a sense, as one example of the specialist mental health team and social workers, absolutely—social work has been one of the things that has been difficult over many years to integrate with NHS care generally, but with primary care certainly. I see that as part of another model where specialists more generally relate in a more effective way to primary care, particularly physicians in the groups that I have mentioned. It is exactly that: the team will never have a tight boundary. There will always be other people out there to whom you need to relate easily and well, some more distant than others.

Q25 Dr Whitford: When you talk to GPs, the groups they identify are the person with musculoskeletal problems, the person who is struggling with stress or difficulties and the person who comes to the GP because they cannot get a house or their benefits are stopped. Those are three groups that are not within the key skills of a GP.

Professor Cumming: May I give a specific example on that? I was in Dudley a few weeks ago where they have started operating multidisciplinary teams chaired by a GP that bring

together social workers, district nurses, allied health professionals and care navigators, who are people typically from a voluntary sector or charity sector background who help patients, particularly more vulnerable people, navigate their way through the system. They risk-stratify the population and select cases to go through the MDTs, and they report a significant speeding up of the resolution of individuals' problems, be they housing or health related, simply by having everybody in the same room at the same time discussing that individual for five or 10 minutes. They are absolutely passionate in believing that this is a very sensible investment of time to save huge resource, but, most importantly, to get the right care for the individual.

Q26 Dr Whitford: Absolutely. The other word Professor Roland used was “huddle”, which is something we do at the start of an operating list to make sure we are all on the same page. It is allowing time off the hamster wheel, as you said; you need that pump-priming. If multidisciplinary teams develop, would you see any risk of them creating demand rather than managing the demand that we already have?

Professor Roland: Absolutely, yes. We see this writ in the NHS every time an excellent new service is provided. If you take the example—a very good one—of musculoskeletal care that you just mentioned, we chose not to make a specific recommendation about whether patients should have direct access to physiotherapists, because we felt the evidence was not sufficiently strong. It might be that people's symptoms would be resolved more quickly and you might save on other resources, particularly if physiotherapists were prescribing—some physiotherapists have had prescribing rights for the last year or so. But there is the potential that you would significantly increase demand and that people with minor musculoskeletal things that would get better anyway would say, “I'll go and see the physio,” whereas they might not have gone to see the less obviously useful GP. That is an area where we need to proceed with a bit of caution. If you provide new, popular and effective services, there is always the risk that you will increase demand. Maybe that meets unmet need.

Q27 Dr Whitford: Sure. Would you see it going back to, in a way, how it used to be 20 years ago, and when you phoned for an appointment the receptionist asked you what it was about, being right at the front line, and perhaps sending people in particular directions? We have come away from that, but that is how it used to be.

Professor Roland: That seems to be a pretty bad idea, and certainly there are practices which use their online access to filter and say, “Tell us about your problems. Have you thought about doing this? Have you thought about doing that?” That may be one way in which practices can direct or indeed deal with issues by email. We cannot quite imagine that in 10 years' time the GP is the only person in the world that you cannot email.

Q28 Dr Whitford: You were talking about emails between hospital and GP. We have that in Scotland routinely, so I am not totally aware of what that issue is, but obviously secure email between the patient and the GP is—

Professor Roland: It happens in other countries. We give the example of Denmark where it is in the GP contract. A while ago I was talking to my daughter—who is a lawyer in her 30s—and explaining to her the importance of the doctor-patient relationship and the

interaction, and she looked at me as if I was completely mad and said, “Dad, why would you ever want to see a doctor if you could sort it out by email?”

Q29 Dr Whitford: For this bigger team to work, there will have to be someone in front of the GP who does that triaging to one group or another. If it all goes through the GP, in actual fact you have created a bottleneck.

Professor Roland: Yes, and we need to give patients themselves the resources to be able to do that as far as possible.

Q30 Dr Whitford: In the report you talked about the issue of practice nurses who, as you say, were the first big change in the primary care team. What is your vision for how they should be trained and given leadership skills so that they have an evolution? At the moment they end up as practice nurses and then they are just kind of sitting there.

Professor Roland: We comment very specifically on the lack of career structure for practice nurses. We think that is really important, in terms of enhancing clinical skills—we chose not to use various phrases that tend to confuse people around advanced skills for nurses, but there are a range of directions in which they can develop—and leadership and management, both within practices and within GP federations. We could see a very good case, for example, for a federation having a lead nurse who would take some responsibility for the training and support of nurses in the practices in that federation. We saw examples where practices were led by nurses. We saw excellent care being given in a practice which was nurse-led, dominated by nurses, employing GPs, and while we do not think that is necessarily a model that will be widespread, it demonstrates that there are a number of ways of killing this particular cat.

Q31 Dr Whitford: You talked about lack of training for staff within primary care being contributed to a little bit by the partnership set-up—the arm’s length. Do you think that is a contributor in the practice-nurse case?

Professor Roland: Yes, that is an issue that needs to be addressed.

Q32 Dr Whitford: Obviously, the discussion around this tends to be about replacements for GPs or someone who is cheaper or easier to get than a GP, but there is the potential, I assume you would think, to come up with something that is much better than we do now.

Professor Roland: Yes. Even if there were going to be enough GPs, which there probably won’t.

Q33 Dr Whitford: Hopefully, it would leave them their time to focus on other things.

Professor Roland: Yes, exactly that.

Q34 Dr Whitford: Thank you very much. Professor Cumming, have you any further comments you would like to add on the multidisciplinary team?

Professor Cumming: I firmly believe that this is about using an individual for their skills and training, not about having one individual who is always the go-to person. I would like to echo the comments about small practices and the lack of career opportunities, particularly for nurses, but as we see more and more physician associates coming through, we are going to have the same problem there if we do not recognise it now and try to build some sort of structure. The concept of training hubs in primary care is something we want to explore, and, as Martin said, that means we can then have a structure with some particularly competent practice nurses able to take responsibility for training others, providing CPD at that level. This week we launched our framework on community and primary care nursing. Our director of nursing in HEE has just launched it. That is specifically looking at what more we should be doing to support and develop a workforce who traditionally have been very much left on their own and left to the individual practices to develop. That cannot be the way forward.

Q35 Dr Whitford: Have you any thoughts about how to deal with the rural situation, where there may not very easily be someone to federate with? Is there not a danger that we end up with an even wider gap between rural, urban or suburban areas?

Professor Cumming: It is more challenging, but technology, again, is an answer in part, with Skype and FaceTime, and using some of the educational technology that is available, like Moodle, for online learning. We are very much seeing the tip of the iceberg in using this in education and training. I predict that in the next five years there is going to be a huge shift in how we all keep up to date and in contact with each other. In the same way as we have seen telemedicine grow to a greater extent in remote and rural areas than we perhaps have in the urban environment, that is going to be the next thing for education and indeed supervision.

Q36 Dr Whitford: I meant from accessing a multidisciplinary team as opposed to just—

Professor Cumming: Yes, absolutely. It is for teaching but also in terms of second opinion, discussion and debate and for creating the huddle; you can do it virtually.

Q37 Chair: Before we leave the subject of primary care nursing, could I bring Mr Allen in on the ageing workforce? We have heard considerable concern that this is an area of the workforce where a large proportion are nearing retirement. How concerned should we be about that and where do you see replacements coming from?

Greg Allen: It comes back to the discussion we have been having, but if you look on the GP side, clearly there are factors around pre-retirement retention, and particular challenges that we consistently need to look at in that respect, which we outlined in our report. In terms of the practice nursing side, generally speaking the practice nursing workforce, as with other groups, is a particularly ageing group itself. This comes back to not looking at it specifically just around age. Age is a factor, as is the age of the population and other issues, but, in the round, there is a balance to be struck, with age being one of the particular factors. If you look at the modelling and the output of our report, in terms of the scenarios we have generated and the work we have done with expert groups, age was clearly one of the big areas that was fed in as a factor that could affect plausible futures.

But there is no one answer to that, in the same way as there is no one answer to the future for this workforce.

Q38 Chair: Thank you. Could I come on to a new professional group—the physician associates, or physician assistants, as they have also been called? Could you set out, Professor Cumming, how many physician associates are currently working in England?

Professor Cumming: I would have to go back and get the specific figure of how many are currently working. I do not have that figure with me.

Q39 Chair: If we are aiming to expand this workforce, who is going to take that forward at scale and pace, holding the ring with professional quality? Can you also touch on the issue of regulation?

Professor Cumming: That is our responsibility. At the moment, we are commissioning from a number of universities either diploma or MSc programmes to train physician associates. Typically, it is a two-year training programme. We have given an undertaking that by 2020 we will have trained into employment 1,000 physician associates working in primary care, plus the demand that is starting to come through from the secondary care sector for those individuals. We are ramping it up quite significantly over the next few years. At the moment we are talking to GP practices and NHS England about making sure that jobs exist for those people. We do not want to train people and then in two years' time have a workforce that do not have jobs to go into. Also, given the age group of those people, they tend not to be desperately mobile; they have first degrees in something else, so they are doing this slightly further on in their career. We want to train people where the jobs are going to be as well, so that they can be based in the practice or hospital where they are ultimately going to be working.

Q40 Chair: Touching on the issue of regulation and professional grouping—unlike many other bodies in the health service, they do not have any professional association representing them—where do you see us going with that?

Professor Cumming: They have found a home with the Royal College of Physicians, which is warmly welcome. The Royal College of Physicians has created a specific faculty to work with and help develop the education needs of physician associates. On regulation, our view is that they should be a regulated profession, because they are interacting with patients. My personal view is that regulation is about risk and that there is a tipping point in which the risk to the individual and the burden of regulation meet, and that physician associates, given what we want them to do around prescribing and what we want them to be able to do around ordering X-rays, should become a regulated profession.

Q41 Chair: Do you think that at the moment, because GPs are vicariously liable for physician associates working in their practice, it is going to act as a barrier to them wanting to take on physician associates?

Professor Cumming: Martin might have a view on this. I will use the example of a physician associate actually working in a secondary care setting who spoke to our conference last year. When he was recruited to that role, the junior doctors were very wary of him and the consultants were very wary about what that individual was going to be

undertaking, effectively in their name. When he was offered a promotion only a year later, it was, “Over our dead body are you taking our physician associate off us. This guy is fantastic.” As always, it is right to be cautious; it is right to recognise the skills and training of the individuals and right to recognise the limits of their professional practice, but I can take you to Cricket Green practice now and show you physician associates delivering patient care with the complete confidence of the GPs in that practice.

Q42 Chair: We have heard two schools of thought about whether physician associates should be prescribing or not, some feeling very strongly that they should not and should be working under direct supervision, others feeling they should definitely have the ability to prescribe because that will offer more to the primary care team and patients. Did you come to a view on that yourself, Professor Roland or Professor Cumming?

Professor Roland: Our view would be that in due course they should have a limited prescribing list, yes, because that would significantly extend what they can do with minimal risk to patients. I think it is a limitation. In the same way we have pretty slowly seen prescribing pharmacists, prescribing nurses, obviously, and now prescribing physiotherapists. There is a case for most clinicians who have first contact having some prescribing rights.

Q43 Chair: In that case, how will they be different from general practitioners? What would be the difference as far as patients are concerned, when they are signposted? As yet we are not sure via what route, whether it will be email or some other triaging process. How will patients be guided?

Professor Roland: They will be dealing with simpler, more straightforward problems. There is a question, for example, as to whether they should be seeing children and pregnant women, so there are physician associates who quite significantly limit their practice at the moment to, for example, acutely ill adults. I do not think at the moment the profession is sufficiently well developed that we have terribly good answers to that, and they need to be sorted out. The experience, for example, of practice nursing, when that was developing, and the more advanced levels of practice nursing, is that a lot developed from clinicians learning to work together. We studied nurse practitioners back in the 1990s, and in those days many of those we studied did not have formal qualifications but they had been working alongside their GP for 10 or 15 years, doing things that were extraordinarily similar because each understood how the other worked. That is an organic way in which people work together. It does not entirely answer your question about who is responsible. While Ian is absolutely correct in his hospital example, the GP is of course not in the same position as a junior hospital doctor. He is in a position of personally, potentially, taking responsibility. The issues of liability are important and for that reason, regulation of the profession would be desirable.

Q44 Chair: But many practice nurses typically go into a practice having had a great deal of experience in nursing before they start in practice nursing, whereas you are talking about a professional group that will come almost straight from a postgraduate qualification with very little clinical exposure. There is the issue that what may seem a trivial problem to a patient may be a sign of something much more serious. Do you feel there are genuine concerns about that?

Professor Roland: I am sure the concerns are genuine, but we do not know at the moment how effectively they can be alleviated. We know, for example, that this group works effectively, and in pretty large numbers, in some other countries. It is not clear that it couldn't work equally well here, but many GPs, as you will be well aware, think it is risky and a bit new.

Q45 Chair: It is evolving.

Professor Roland: Yes.

Chair: Thank you.

Q46 Julie Cooper: We have been talking about multidisciplinary support for GPs, acknowledging that there is a shortage of GPs—problems with retention—and that some of the problems could be seen to be urgent. There is urgent need. Could pharmacists be used in the interim as a sort of quick action to support GPs, given that there is a surplus of qualified pharmacists?

Professor Cumming: Absolutely. With NHS England, we are doing just that at the moment, looking at how we can get pharmacists working both in GP practices and taking more responsibility for the front line, operating out of their own premises. It is a highly skilled, highly trained workforce, and in some parts of the country we have never properly utilised all aspects of their training. As you correctly say, at the moment pharmacy is one of the professional groups where we have a surplus. I can come back with the exact number, but there are somewhere in the region of 200 to 300 pharmacists that NHS England is currently placing to work and deliver clinical care alongside GP practices to help with the current pressure.

Q47 Julie Cooper: Can I ask about the role in educating the public—I suppose the same applies to other members of the primary care team—to get away from the idea that a patient is being fobbed off because they are sent to the pharmacist? Clearly, coming from a pharmacy background, there are a number of roles the pharmacist could take on board, freeing the GP to do what he is really trained to do.

Professor Cumming: Absolutely. I completely agree. That is everything from the health promotion messages, some of the vaccination and immunisation activity that takes place, through to some of the testing mechanisms, tests that are available through pharmacies. There are also prescribing pharmacists, so people are able to go and see their pharmacist. I get quite bad hay fever and take a prescription-only antihistamine, and I still cannot work out, if I am honest, why I have to bother my GP to get a prescription when I could just go to my pharmacy, which is what I could do if I was in Australia—but perhaps that is a separate issue. The role of the pharmacist could help to take some of the pressure off, but it is also respecting their professional status and training for what it is.

Q48 Julie Cooper: You would see that as long-term support rather than short term.

Professor Cumming: Both. They are available now because we have pharmacists in surplus at the moment, but it is very much a role that we need to grow and develop in the future. One thing we are doing is working with the professional bodies and the regulators to look at how we build more of a clinical component into the pharmacy degree—

integrated into the pharmacy degree rather than something people learn at the end—so that when people come out as a registered pharmacist they have already consolidated a lot of clinical experience and are much more ready to go on with patient care.

Q49 Julie Cooper: This has been talked about for many years, has it not? Will the urgency of the situation drive it forward now, do you believe?

Professor Cumming: Yes. It is literally happening in real time as we speak. We are looking at how to change the commissioning of undergraduate courses so that they have that component of clinical practice embedded in the course rather than something that is taught at the end. That is happening as we speak.

Professor Roland: May I make an additional comment? In a sense, it comes back to Dr Wollaston's point. I hear two things simultaneously: I talk to practices who have a pharmacist as a partner who say that it is absolutely fantastic and they would not be able to operate without her and why doesn't everybody else do it, and other practices who ask, "What would I do with a pharmacist? I don't quite know what I would do with somebody like that in my workforce." There is very genuinely a wide variety of experience and we somehow need to show people the opportunities that exist.

On training, physician associates, pharmacists and nurses all need exposure to primary care in their early training and they often do not have it, or have not had it in the past. There is a very good example that we cite in the report, where I think east Yorkshire and Humber asked their nurses in training if they had thought about a career in general practice, and a very small proportion had. Then they simply gave them exposure to general practice nursing as part of the course and the proportion who thought about it as a career went up dramatically. Many pharmacists do not get any exposure to general practice and what it could be as a career, so there are lots of things that need to change at various stages in the career.

Q50 Julie Cooper: There is one very successful scheme that runs in my constituency, which is a very deprived constituency, where GPs are under a lot of pressure, and people often inappropriately seek the time of their GP. They have a minor ailments scheme, via the pharmacy, and the local GPs could not cope without it if that scheme was to disappear. You could see that being a feature going forward as one of the many areas under review.

Professor Roland: I believe that about 90% of pharmacies in the country now have some sort of private consulting space.

Julie Cooper: That is right.

Professor Cumming: To pick up on the issues more generally, pharmacists have a critical role to play, but the point about making sure that everybody has some experience and exposure to primary and community care is just as important. By 2017, every junior doctor will have spent at least four months in primary or community care as part of their first two years after graduation. That is something we are starting now. We need to make sure with some of the medical "ology" specialties—gastroenterology and dermatology and so on—that people see them from a primary care perspective as well as just the hospital perspective. We want to achieve a situation where training follows patients from primary

care through into the hospital rather than just being focused on the hospital end. We know from several pieces of work that have been undertaken that there is a correlation between how much time people spend in a particular area and how likely they are to choose that as a future career. We also believe there is a correlation between the quality of their training experience and how likely they are to choose that as a future career choice. We have seen that in emergency medicine. Junior doctors have said to me, “We went into an emergency medicine department as an undergraduate and hated it. We had a bad experience. We weren’t given any training. We were told they were too busy and to sit in the corner and just observe from there. Why would we want to work in that environment?” Then you talk to people who said it was fantastic. They were motivated, they were involved in everything that was going on, they had a fantastic role model and they wanted to choose that as a career. It is the same with general practice. It is difficult at the moment because GPs are under a lot of pressure, and if GPs are under a lot of pressure, asking them to take more trainees, be they physician associates, nurses, paramedics or whatever, is a challenge. But we have to do it, because if we do not we will never create the future workforce and we will never get out of the workforce problems that we have.

Q51 Julie Cooper: Can I make one final point? As part of pharmacists’ training you mentioned that they ought to have more clinical exposure. One of the things I always found, as a former owner of a retail pharmacy, was that GP practices had very little knowledge of what went on in the pharmacy, so I wonder if understanding that ought to be part of a GP’s training. You said some GP practices did not know what they would do with a pharmacist, whereas a pharmacist is more likely to have spent time with a GP practice than the other way round—that sharing of knowledge and understanding.

Professor Cumming: It comes back to healthcare being a team activity. In the past, there have been relatively unsuccessful attempts to bring different professional groups together for education at undergraduate level. It has not worked for a whole variety of reasons. Equally there are some really good examples now, using simulation around patients, using real-life scenarios to bring people together, starting educating and training in the very early years of an undergraduate and then continuing right the way through professional training and postgraduate training, so that people understand what skillsets everybody has and how they can contribute to the care of an individual.

Professor Roland: We should also note that it is not just GPs who are forming federations. Pharmacists are doing the same, and there are opportunities for pharmacy federations and GP federations to talk together to start developing shared guidelines and better understanding.

Julie Cooper: Thank you.

Q52 Dr Whitford: I have a point of clarification because I am a Scottish MP, so it is a different system. We have quite developed community pharmacies where people go as a first port of call. Is that not something that is available in all pharmacies here? You talk about it as something you want to do in the future for minor ailments.

Professor Roland: It is available in all pharmacies.

Dr Whitford: Okay.

Q53 Chair: Are you impressed with how the Think Pharmacy First scheme is going?

Professor Roland: First of all, there is no doubt that pharmacists can provide good sources of advice. What I do not know is to what extent, if you promote this more, you reduce the workload on general practices, for example; or, the point you were making earlier, do you generate additional demand? I do not know the answer to that.

Q54 Mr Bradshaw: There has been lots of talk about the value of multidisciplinary teams, the importance of huddles and the problems with small practices. In relation to premises and size, you mentioned super-surgeries. What is your view on the desirability of having bigger super-surgeries, polyclinic-type places?

Professor Roland: Super-surgeries may not be a terribly good word. It is used for practices that have formally come together in a single organisation, but it does not mean they come together in a single building necessarily. There are super-practices, for example, covering a substantial area of Birmingham but largely retaining the original GP premises, working together for some of the things that should be done at scale. It is equally the case that in quite a number of places GPs have been able to invest in much larger premises, offering a single team on site. That will work in some places. It is clearly not going to work in rural areas particularly well. I am sure that in many cases we should be able to look at the opportunity for bigger, more modernised premises, but we have to find a model that does not require that, I think.

Q55 Mr Bradshaw: Why? What is the argument against it in urban areas?

Professor Roland: I do not think there is a particularly strong argument against it in urban areas. If you are looking at, as it were, a big edifice, people still want to be able to have personal contact, and one of the things we have pointed out, against currently available metrics, which is getting worse year on year, is people's ability to see the doctor of their choice. Continuity of care is a real issue. It is going to become more of an issue as people increasingly have complex multiple problems and it becomes safer to see someone who actually knows about your care and does not start from a blank sheet. Then the question is how you provide that sort of continuity within the wider team we are talking about, with doctors, for example, increasingly working part-time.

Q56 Mr Bradshaw: Is there any evidence about improved outcomes or better patient experience depending on the size and multidisciplinary nature of the practice?

Professor Roland: There has never been a very strong relationship between patient experience and practice size, no. I do not know the explanation for that. It may be that doctors who work on their own, for example, come into two groups—ones who are so wonderful that they will not work with anybody else, or so un-wonderful that nobody will work with them. But there is not a strong relationship between patient experience and practice size.

Q57 Mr Bradshaw: What about outcomes?

Professor Roland: I think there is in terms of emergency admissions and things like that. I am not sure. I do not think there is a strong relationship either.

Q58 Mr Bradshaw: You mentioned choice. How realistic is choice currently for patients?

Professor Roland: Not.

Q59 Mr Bradshaw: Not at all.

Professor Roland: Of the people who have a particular doctor in the practice that they choose to see, which is most people, our research shows that even among the 18 to 25-year-olds more than half of people have a particular doctor they prefer to see. It is not just the elderly who have their own doctor. Most people have a doctor they prefer to see, and we know they are finding it more difficult to get to see that doctor. One of the reasons is the continued focus on improvement in access and extending opening hours. It is quite difficult within the working week of a doctor, if you are going to provide longer opening hours, how you also provide continuity. That is a real tension. Our view, if nothing else, is that the ability to see a doctor of your choice is a key metric that should be monitored by the NHS, not just the opening hours that are available.

Q60 Mr Bradshaw: How easy is it for patients to make their own comparisons of GP performance/outcome/patient satisfaction? In a hospital you can go online, can you not, and check out how your hospital is performing on a range of metrics? What about with GPs?

Professor Roland: You can certainly do that for GPs too. For GP practices, rather than individual GPs, every single indicator on the quality and outcomes framework and all the individual questions on the GP patient survey, plus the patient opinion-type individual feedback, are available through NHS Choices. Whether people use that or not is a different kettle of fish, because the general view from research in this country and others is that the main people who use performance data are the clinicians themselves, who do not like seeing themselves as less good than their neighbours, and patients make relatively little use of them. We know much less about how people will use the Trip Advisor-type information that is now becoming more widely available and indeed how reliable that will be.

Mr Bradshaw: Are you happy for me to jump to my other questions, Chair?

Chair: As long as James is happy with that, yes.

Q61 Mr Bradshaw: What is your solution to the problem of getting GPs to work in deprived areas?

Professor Roland: There is extensive evidence on that from this, and it is mostly from other countries, and it is a similar problem of rural and deprived areas: how do you get doctors to work in areas they do not particularly want to go and work in? A wide variety of solutions has been used. Probably the summary of the evidence is that non-financial incentives are as important as financial ones. Financial ones are commonly used—for example, loan repayment is often used in the United States to get people to work in either very remote or very disadvantaged areas—but offering people a job that is going to look doable and fulfilling when they get there is equally important. If you are going to expect someone to work in a very remote area or where it may not be particularly safe at times, are they going to feel well supported? Will they be able to find people to cover for them

when on holiday? Those sorts of non-financial incentives and making the job look good are just as important as financial ones.

Professor Cumming: One of the things that we are piloting at the moment—it is too early to give a factual answer, but all the evidence suggests that it is going to be very successful—in hard-to-recruit areas is offering people an extra year of training. They qualify as a GP, they get their certificate of completion of training, and then we say, “If you go to this part of the country, we will give you an extra year of training. In that year you will work as a GP for part of the time, but you will also train in mental health, paediatrics or emergency medicine, something that is needed in the local area, but also something that is a particular interest of yours. We are training you up, and at the end of that we expect you to stay in that area and practise as a GP but also practise in your specialist skill area.” Although it is very early days—we only piloted this for the first time last year and we have taken more in this year—there seems to be some strong anecdotal evidence coming through that this is going to be popular.

Q62 Mr Bradshaw: Where are you doing this?

Professor Cumming: We are doing it in several parts of the country. The west midlands and the east of England are the two main areas.

Q63 Mr Bradshaw: When do you think you will be able quantify its success?

Professor Cumming: It will probably be two or three years, to be honest, because we started with small numbers and we will build. I was talking to a GP recently who was doing one of these and he felt that it was very rewarding to him and was what he wanted rather than money. Picking up Martin’s point, giving him the time to train in something that interested him and that he could practise in alongside general practice in an area where that skill was needed meant that he would be likely to stay there. It is anecdotal but, hopefully, we will have something more robust soon.

Q64 Mr Bradshaw: Forgive me, Chair, for jumping about a bit, and I know other colleagues want to come on to this in more detail. Given the huge cost of training medics and the growing exodus that the NHS is suffering from, with medics simply leaving the country and going to work abroad, has any thought ever been given to some system of golden handcuffs for medical trainees, and, if not, why not?

Professor Cumming: Yes. We have had that conversation in terms of whether or not we require people to work for the NHS for a period of time in return for the investment in their training. To quantify this, to take somebody from year 1 medical school to be a GP costs the NHS about £500,000 in terms of investment in that individual. To take somebody through to be a consultant neurosurgeon costs about £750,000, so we are into very significant investment in individuals. Some countries already have some form of lock-in that requires people to work for a period of time. One of the things we have to be mindful of—and again it is too early to say whether we are seeing a shift at the moment—is that, by and large, the number of doctors that leave this country has been pretty static. It has not been going up year on year. Whether or not we are seeing the start of a peak at the moment, it is too early to say, but our view is that, if we could find a way that worked to

get people to recognise the amount of money that the NHS had invested in their training, that is something we should be working towards.

Q65 Mr Bradshaw: It has been discussed, but why has it been ruled out?

Professor Roland: We have done it. We gave GPs a golden handshake in—other Members of the Committee might remember better than me—about 19—

Q66 Mr Bradshaw: Was that handshake or handcuffs?

Professor Roland: Handshake—well, it was a £5,000 incentive to work in deprived areas sometime around 1996 or 1997.

Q67 Mr Bradshaw: That is different, though, is it not?

Professor Roland: Most schemes around the world have obligated service for a period of time. I think Australia is possibly the only country that, for immigrant doctors, has sometimes made a permanent requirement that registration would only allow them to work in certain areas. Mostly it is for a period of time. One of the features of those financial incentives is that they work for that period of time. They are effective at retention but not necessarily effective for recruitment. Once their five or seven years are up, those doctors may move on, hence the key is making the job good, which would encourage people to stay.

Professor Cumming: I do not think we should rule it out, but we want people who are motivated, enthusiastic and who want to be delivering patient care, rather than saying, “Well, I have got to stay here and do my two years, because if I don’t I will...” There are definitely strong reasons for considering it and for doing it, but part of the ask for HEE and the wider NHS is to make sure that these are jobs that are attractive, that they are jobs that people want to do and they want to stay in this country once they have trained.

Q68 Maggie Throup: I want to explore some of the barriers to change. By the nature of GPs being independent contractors, they are used to having autonomy over what they do. What type of culture change is required for GPs to accept that they may be just one part of a leadership team?

Professor Roland: Is that an easy question?

Professor Cumming: Let me start, and I am sure Martin will come in. There are some real strengths in having GPs working in small teams looking after a local population, where they know the population and the population know them. We have already outlined some of the disadvantages in terms of small employers and problems with staff training, but it is more than that. It is hard for GPs to get access to continuing professional development in the same way as perhaps staff in hospital environments may be able to. We have a bit of a culture running throughout the NHS—and primary care is no different—of “not invented here”. We do not quite know where this comes from, but the “not invented here” syndrome suggests that just because it works in Derby it does not mean it will work in Nottingham, Bristol, Bath or wherever it may be. We have a culture of reinventing the wheel. As we have already said, the cultural change that we need is that of people embracing new ways of doing things that have been proven to work elsewhere, instead of

saying, “I need to do that differently because my population is not the same.” There may be occasions where that is true, but in many of them not. I would not want to be critical of the GPs and the environment in which they work at the moment, but we need to do more on leadership development for GPs. Health Education England takes over the NHS Leadership Academy on 1 April next year, and one thing we want to do is to broaden its remit out into primary care to a much greater extent than it has been in the past. That is GPs but also practice managers—we have not talked about them yet—who are fundamentally important members of the practice team. Using practice managers to help change the culture is something we really want to focus on in the same way as we have done in some of our more successful changes in other parts of the healthcare service.

Professor Roland: I agree with all that. I think the GPs have been pretty smart and entrepreneurial over the years in the NHS. Given the right environment, they may not need that much encouragement. They are not needing encouragement at the moment to develop into groups and federations. If you think back to the 1990s, for example, nobody told GPs that they needed to employ nurses to improve chronic disease management, but they did, and so when QOF came along they got all their points in the first year because they were largely doing that work already. So I have a reasonable degree of confidence in my own profession.

Q69 Maggie Throup: Do you think some of the changes that are proposed will require GPs to give up their authority and therefore their perceived status?

Professor Roland: Yes. I think that is true. In many cases GPs will continue to have substantial leadership roles—often leadership roles within practice and within federations—but I do not think that is exclusive, and other professions and managers are certainly going to be important. There has been a slow trend in general practice, for example, for practice managers to become partners and to be seen as a part of the business and not—

Professor Cumming: And nurses and pharmacists.

Andrea Jenkyns: My sister has been a practice manager for years; she has become a business partner and is really integrating the system. They have been quite innovative.

Professor Cumming: The full range of clinical expertise is there with the GP; the GP is the clinical expert. Some GPs will want to embrace the leadership role, the management role, the redesigned role. Other GPs will want to excel at being a clinician and I do not think there is anything wrong with either of those. We must not force every skilled, competent clinician into a management and leadership role. If they do not want to take on that role and they have another way of using a practice manager, or using other people within their team to take more of the leadership role in the practice, allowing them to focus on the supervision and the delivery of the clinical care, I do not think there is anything wrong with that.

Q70 Maggie Throup: Obviously we have quite a lot of vanguard sites—and you talked about “not invented here”—and there is a lot of investment in that. Do you think that because the vanguard sites are spread around the country we have more chance of them being accepted?

Professor Cumming: I hope so. The vanguards are all slightly different in terms of what they are doing. One of the challenges, when we have identified that something in a vanguard is working really well, will be how we spread it and make sure that it does not just become contained in that vanguard and that vanguard becomes a centre of excellence, so that population are getting fantastic healthcare but the population 20 miles down the road perhaps are not. I absolutely support the concept of vanguards, but we need to make sure we are working with NHS England and others on a wide spread of what works coming out of those vanguards.

Professor Roland: Can I respond also—and it possibly ought to be my last response—that an absolute key part of this is allowing time for change? We are constantly too impatient for change, thinking we will change something in the NHS, including culture, and it will happen suddenly. It does not. Therefore, we reorganise—or some people re-disorganise—and we never give initiatives a chance to bed in, for learning to spread. That is a constant prayer: let us really give these new initiatives time to bed in and to learn from them.

Q71 Chair: Thank you. That is a very good note to end on for you. Is there anything else you wanted to touch on finally before you leave, Professor Roland?

Professor Roland: No, it has been a very interesting discussion. Thank you very much for giving me all that time.

Q72 Helen Whately: I want to pick on something you said a moment ago, and it will hopefully be a good thing for you to end on as well. You mentioned “given the right environment” a few moments ago, that you had confidence in GPs and this would happen. Could you give little more insight into what you mean by “the right environment”?

Professor Roland: Yes. They were obviously unguarded words, weren’t they?

Q73 Helen Whately: I was listening to you.

Professor Roland: Morale is poor in general practice at the moment. The University of Manchester has run a series of worklife surveys of GPs since 1998. Last month they published their eighth in the series, and work-related stress is higher than it has been at any point in that series. GPs are really under stress. There is a kind of a feeling that things are getting worse, people are retiring earlier and some of the other problems we have mentioned. What needs to happen—and hopefully will happen as a result of the things in the report and other things going on—is that that starts to turn. If it starts to turn and people can see things are getting better, and maybe we give people different career opportunities toward the end of their careers so that they can use their skills in different ways, if people can start to see a way forward, I would be hopeful. I am not sure that is a very good answer.

Helen Whately: But I am aware of the time.

Chair: Maggie, you have a couple more points.

Q74 Maggie Throup: Yes. Is there sufficient leadership capacity across the whole of primary care to deliver the vision in the report? I know you said it was your last answer, but perhaps you could—

Professor Roland: This will be a quick one then, because the answer is no. I think the GPs—and other professions within primary care—are in real need of stepping up to provide both headspace and leadership skills to do some of the things that we have been talking about. That is a partial answer to your question too, because opinion leaders are hugely important in this area. If you have an experienced clinician who is actually giving local leadership, that can make a real difference. Providing space for people instead of retiring, to use their skills in galvanising the profession, is something that could make a real difference. In the 2004 GP contract there was a suggestion that we might offer portfolio careers to GPs towards the end of their careers and it never happened. It now needs to happen more urgently, because instead of just carrying on they are leaving, when we could be using their skills and experience to lead some of these changes.

Q75 Helen Whately: Are you seeing that there is a gap particularly around the opportunity for leadership locally and regionally, as it were?

Professor Roland: Yes, although I also see examples of very young doctors wanting to move into leadership and management positions, and that is fantastic too.

Q76 Maggie Throup: Can I develop that a bit further, and it is probably one for Professor Cumming? What are HEE doing not just to get the right type of staff for delivering the report but to develop the right people who are able to lead the federations and networks of the future?

Professor Cumming: There is no point in focusing on the future workforce if we want to deliver change in the next couple of years. The only way we can deliver change in the next couple of years is by focusing on the current workforce—because the future workforce are way down the line, and that is a mistake that perhaps has been made in the past—around giving people time, as we have already mentioned, to step back, to reflect and to learn from others. It is Martin's point about having some good role models and using people who may otherwise choose to retire as they come towards the end of their career. I have said on a few occasions that we have to redesign a lot of healthcare professional careers. It is no longer going to be two phases of somebody being a GP: the first phase, when they are newly appointed, they are keen and enthusiastic but they still have a huge learning curve; and the second phase, when they are delivering the job that they do for the rest of their career. There is now a third phase, because at the age of 65 you cannot do what you were able to do at the age of 32; it is simply not possible. We need to recognise that and to offer people perhaps more 9-to-5-type roles, roles that have less hands-on clinical care, but using them to lead more research, to mentor, support and develop the new workforce coming through, and use them to be the leaders of primary care in the future. We have far too many GPs who are choosing to retire at or before their 60th birthday and we need them all for five years longer. It is a key part of making sure—

Maggie Throup: We lose so many skills, yes.

Professor Cumming: Yes, and we lose the clinical expertise. They have gained 30 or 40 years of knowledge and expertise, and if they simply decide, “I can't do this any more.

I've had enough; I'm going," that is a tremendous loss to the NHS. We retain that group partly by redesigning the job we ask them to do, give them more flexible options, a bit like we talked about for the fourth year, the year after training, to encourage people into difficult-to-recruit areas. What can we do to say, "We would like you to spend a day a week doing this piece of work as a mentor, as an ambassador, as a role model for primary care"? Practice managers are an area that we want to work specifically through the Leadership Academy because the level of training, knowledge and background they have is very variable. There are some really up-to-speed, up-to-date fantastic practice managers and there are others who have had basically no development since they were first appointed into their post. It is not their fault, but we can, want and will step into that when we take over the Leadership Academy. That is one of the new programmes that we want to run.

Q77 Maggie Throup: Mr Allen, do you want to add anything to that?

Greg Allen: No. I think all the points have been made there, but there is this bit about expectations in terms of people's career aspirations and bringing it back to the culture and leadership piece. The line of thinking on culture and leadership is an NHS-wide challenge and there are some really good things out there to help support people, but expectation is a key thing.

Chair: Thank you. We will go on to James next.

Q78 Dr Davies: I am going to probe the Government's workforce targets for primary care. The Government have said that they have an ambitious target of 5,000 extra GPs, although the terminology used is quite interesting in that it is 5,000 additional doctors working in general practice. Should we read anything into that terminology?

Professor Cumming: With your permission, may I spend a couple of minutes explaining this, because there is some misunderstanding in some of the targets? It is probably helpful to set the scene. There is a perception at the moment that nobody wants to train to be a GP and the number of people entering GP training is falling year on year. That is not the case. The average number of people who have entered GP training over the last five years has been 2,681 and, although the exercise has not finished yet, for this year we will recruit more GPs into training than that 2,681, which is the average over the last five years. Last year we were at something like 2,688. The number of people who are entering GP training, who are choosing to train as GPs in this country, is a flat line; it is not going down.

Where does the story that nobody wants to be a GP come from? It comes from the fact that over the last few years we and our predecessors have created more GP training posts. The percentage fill rate has gone down because we have not been able to attract more people into general practice, but we have not attracted any fewer. That is then compounded because I know that in some of your constituencies you will be being told, quite correctly, that you have fewer GPs in training now than you had a few years ago. That is correct, because as we have created more training jobs we have continued to have 100% fill rate for GP training in London and the south-east. Effectively, we have filled all the training jobs in London and the south-east and drawn predominantly from the north and the east, with bits of the west midlands and the east midlands thrown in. In the north and the east

numbers have gone down, in London the numbers have gone up, but we have maintained the same level overall.

We have an average of 2,681 people a year entering GP training. Using Greg's figures, we know that that is giving us a net increase year on year in the GP workforce of about 500, because, give or take, about 2,100 or 2,200 people are leaving general practice every year. We are seeing a net increase at the moment.

Why do we have a workforce that is still in crisis? I will be the first to admit that the pressures of work on GPs in many parts of the country are simply unacceptable at the moment. We have that because we have a change in demographics in that the population is getting older but not getting older and in good health: the population is getting older but with a range of long-term conditions, which means they are seeking many more appointments with their GP, so there is much more interaction with individuals. We have also seen a growth in population that is mopping up those extra 500 GPs on an annual basis, and we have seen an increase in the number of people choosing to work less than full time. That is partly because women in general practice will typically take some time out to have a family, but we are seeing now increasingly people coming out saying they want to do four days a week or four and a half days rather than five days a week. In part, we think that people choosing to do that is probably related to the pressure of work. None the less, that has an overall impact. If you put that lot together, that is the position we are in.

The 5,000 figure is broken down into 4,000 additional GPs that HEE have a responsibility for producing and work on getting people to come back to GP practice, or work on persuading people not to leave. The point I made earlier about getting people to work an extra couple of years in a different role will account for 1,000. We will have 1,000 through return to practice and better retention, and 4,000 through new trainees that HEE are putting in the system. The reason it is worded as "doctors in general practice" and not "GPs" is because we count GP registrars in the figure. These are people who are training to be GPs but they are in practices delivering care alongside the GPs, not when they are in the hospital period. So they are in both sides of the equation. It is still a net 5,000 increase, but that is why it is not GPs; it is doctors in general practice, although—and we may return to this later—we do think that there are more opportunities for doctors other than GPs to work in primary care. If the Committee was interested, that is something we would also like to explore.

Q79 Chair: Can I clarify? Do you mean whole-time equivalents or actual physical people—

Professor Cumming: The 5,000 is whole-time equivalents.

Chair: Thank you.

Q80 Dr Davies: Just to be clear, the 5,000 is England only presumably.

Professor Cumming: It is England only.

Q81 Dr Davies: Is it reflected elsewhere in the UK in terms of the general strategy, because, of course, doctors move around?

Professor Cumming: I am not sure is the honest answer to that. I know that Scotland, Wales and Northern Ireland have similar challenges with recruiting GPs, but certainly the work that we have been doing with the BMA GPC, the RCGP and NHS England has been very much England-based.

Dr Whitford: We have just increased our training places in Scotland. We have the same issues.

Q82 Dr Davies: Government strategy also focuses on another 5,000 other professionals in primary care, I think. If those professions were able to be expanded to that extent, or even to a greater extent, do you think the need for the 5,000 GPs is still there? I personally think it is, as a GP, but what are your thoughts are on that?

Professor Cumming: Absolutely. I see—and our organisation sees—the GPs as the linchpin of delivering primary care. The rest of the team work with and alongside that GP, but the GP is the expert clinician who is the bedrock of the delivery of primary care in this country, and we do not envisage change to that.

Greg Allen: Can I come in on that as well? It is not just about the numbers of the non-GP primary care workforce; it is also about the skill mix and, looking at new models of care, what kind of modelling is done potentially nationally and locally as well around the kind of roles that we need, as we have been discussing.

Q83 Dr Davies: You would not share the views of the Nuffield Trust, who say that focusing on GP numbers will reinforce old ways of working.

Professor Cumming: If we were focusing exclusively on GP numbers, that would be right, but of the 10,000 increase in the workforce we have been asked to train, 5,000 are GPs, 1,000 are physician associates and the balance is a mixture of nurses and allied health professionals. If we had simply said, “We need 5,000 more GPs,” that assertion from the Nuffield Trust would be correct, but it is not. It is creating a multidisciplinary team. We are simply saying that we need more primary care. Full stop. That is a multidisciplinary team, but a key part of it is GPs.

Q84 Emma Reynolds: Building on those questions, I want to ask about fill rates. Last year over 12% of GP training places went unfilled. You set out in your written evidence to the Committee some of the initiatives and policies that you are taking forward to improve that. I have two questions. First, are those initiatives being successful? Are you seeing an improvement, and do you think that we will see an improvement in the future? Secondly, what do you regard as an acceptable fill rate?

Professor Cumming: I suppose the flippant answer to the last point is 100%, because we create the number of training posts that we think we need for the future. We would want to get towards filling every training post that we have. To be honest, if we get above 90%, personally I will be delighted, but we need to fill all of them.

On the initiatives, we do not want to lower the bar—to reduce the standard of GPs coming out in this country. The population have a huge degree of confidence in their GPs. It is a rigorous and robust training, delivered by HEE and regulated by the GMC. The royal college sets the curriculum, and we have a very robust standard. We could simply say, “We are going to make it easier. We will have more,” but we do not want to do that. That would be the wrong thing to do. The same applies to entry to GP training. If you look at the figures around the number of people who apply for GP training every year, you will see that those figures are significantly higher than the number of people we select for GP training. That is because we set the bar at a particular level, to make sure that we get the right people, who will be competent GPs for the future. Every year we have a number of people who fall very close to, but just underneath, that bar. What we are piloting at the moment, but moving into quite big numbers this year, is to say, “If you are within a small percentage of passing selection for GP training, and we give you an extra year’s training and then you go through the full application process again, are you likely to pass?”

These are very small numbers, but I will give an example from a scheme that was running in the east midlands, where we piloted this last year. We took a small number of people who had nearly but not quite passed that entry bar and gave them a year’s experience in primary care and hospital settings, with education built into that; 82% of them are now on the GP training programme this year. We think that that pre-GP year, as we are calling it, is part of the solution. The round 3 recruitment to GP training is live at the moment. We expect to see quite a large number of people coming through who we will be able to put into that pre-GP year. We are not changing the bar or the standard; we are simply giving them some more training to help them get to that entry standard.

I have mentioned the post-CCT year already. That is an important part of getting people to particular geographies, but it is also an important part of getting people to choose general practice. The other thing we have to do is to work really hard at properly explaining to young people just how rewarding a career general practice is. We know that somewhere in the region of 22% of medical students walk into university on day one wanting to be surgeons. That is not terribly helpful, because we need less than 5% of medical students to be surgeons. Actually, it goes further than that. If those people have set their heart on being surgeons and 15% of them are not going to be surgeons, do they become demoralised and demotivated? What are we doing in schools to explore the fact that 50% of people who choose to become doctors in this country will be GPs, because that is the specialty we need them to go into? How do we go back into schools to convince people that it is not all about colds and sore throats? Recently, I was talking to a hospital trainee who had spent some time in general practice. He said that he had seen more pathology in a day in general practice than he had seen in a week in his hospital environment.

We are running a campaign at the moment. It is controversial in some sectors, but it is a marketing campaign called “Nothing general about general practice,” to try to encourage young people to consider general practice. We have seen 676 people apply for round 3 training. We do not know yet whether or not there is a direct link, but when you consider that last year we were in the area of 100, 676 applications for round 3 is a very significant increase in levels of interest. How many of those will turn into actual posts being filled we do not yet know.

The final point that I would make is this. I accept that it is challenging, but if we talk down primary care and talk about how difficult, how stressed and how pressured it is, we will not motivate young people to choose it as a career. To a certain extent, we saw that in emergency medicine a few years ago. Without in any way downplaying the pressures primary care is under, we need leaders of primary care to talk about what a fulfilling and rewarding profession it is. Yes, there are pressures at the moment, but we need to turn the corner. We will turn the corner by getting more people choosing to work in primary care. In that way we will grow, develop and expand it, and it will become a rewarding career. Otherwise you get into a vicious cycle.

Q85 Emma Reynolds: Could I press you on what happens later in the process? You said earlier that trainee doctors are more likely to specialise and choose to become a GP if they have had substantial exposure to a GP practice, especially if it is a good-quality experience, as you suggested with A&E as well. It is therefore very concerning that SIFT payments seem to be resulting in reduced access to GP practices for those people. Could you say something about that and the disincentives that some GP practices see as important? We have even heard reports that some GP practices are not taking on trainees as a result. Could you explore that?

Professor Cumming: Certainly. I will answer that, but it starts at undergraduate level. We need to make sure that we have good exposure at undergraduate level. That links into the SIFT or clinical placement fee that is paid. HEE does not pay the placement fees to primary care. We pay the placement fees to hospitals for medical students' placement, as part of their undergraduate degree. The fees to primary care are paid typically, not quite 100%, by universities. The tariff is variable across the country.

A couple of things are happening. We commissioned Professor Val Wass, who recently retired as the dean of Keele medical school, which has one of the highest numbers of medical students choosing general practice as a career and has a curriculum embedded in teaching in the community. We asked her to undertake a piece of work for us, looking at what more we can do across the country at undergraduate level to encourage people to become GPs and to embed more of the training in the community. One of the things she will inevitably get into will be the issue of remuneration. We know that it costs to train; we just need to be up front about it. For those of you who are GPs, if I put a medical student or a trainee alongside you and you train them properly, it will slow you down. We need to be realistic about that and, therefore, to recognise that a cost is associated with it and we need to fund that. Val Wass is undertaking that piece of work for us, which will report by the end of March. We and the Department of Health are also doing a piece of work looking at tariffs generally, both for secondary care hospital placements and for primary care placements.

Q86 Emma Reynolds: Could I press you on reports we have heard that there are some areas in the country where GP practices are refusing for financial and other reasons to take on GPs? Are those specific practices and areas being looked at?

Professor Cumming: To take on GPs or—

Emma Reynolds: To take on trainees.

Q87 Chair: Undergraduates. We hear that there are some areas where there are no opportunities for undergraduate placements in primary care. Is that the case?

Professor Cumming: I am certainly aware of practices that have decided that they do not wish to take undergraduates, because it is an extra pressure on the practice when they are already busy. I am not particularly aware of whether there is a whole area, but I am aware of practices—in some cases, quite big practices—that have chosen to focus on postgraduate training, rather than undergraduate training. That is fundamentally wrong. These are the workforce of the future. We need to make sure that the costs are appropriately covered, but we also need to make sure that people recognise that if they do not train they will never be able to recruit.

The same applies—perhaps slightly outside the remit of today’s conversation—to work experience for schoolchildren. The NHS seems to have invented health and safety legislation about why children cannot go into hospitals, general practice and other healthcare environments for work experience, yet we are trying to encourage and recruit people in the future. We have to look at the whole spread to make sure that we show people just how rewarding a career it is.

Q88 Emma Reynolds: My final question is to Mr Allen. Do your projections for the future requirements for training places take into account the expansion of other primary care professions? In your modelling for the projected number that we need, do you take into account trainees dropping out and some newly qualified GPs choosing to move abroad?

Greg Allen: Going back to the in-depth review that we conducted, it is really similar to the answer that I gave before. If you look at the way we run the scenario-based approach—the people we involve and the depth we get into to look at different plausible futures—that work involves identifying numerous factors from across the board around the GP workforce and other parts of the wider primary care workforce. Although I could not give you specific numbers in answer to that question, there is a very robust approach. It is not something that we do in a dark room ourselves. We talk with experts throughout that process to come to conclusions.

Q89 Chair: Could I ask a question that goes back to the process of the wider workforce and the issue of bursaries versus student loans? We have heard that we have an adequate pharmacy workforce in part because there is no limit on the numbers that universities can take on. Professor Cumming, do you have a view on whether we need to move more to that kind of model in other areas of the workforce, particularly nursing?

Professor Cumming: There are pros and cons—advantages and disadvantages. At the moment, student nurses in this country can train, graduate and practise as a nurse debt-free, because HEE funds the tuition fees for those individuals, and we fund bursary costs for individuals who are eligible. We also pay a clinical placement fee for each nurse to the hospital or community environment in which they train. If we open this up to everybody, an issue arises over who pays the clinical placement fees, which are £3,000 per nurse per year. Also, a very significant percentage—from memory, somewhere in the region of 40%—of all people who enter nurse training are mature students, so it attracts a lot of people who choose later in life to go into a caring profession. There is some evidence to suggest that more mature students could be put off by thinking that they will incur a significant debt associated with student loans.

On the positive side, the student loans approach would certainly allow a lot more nurses to be trained than we are training at the moment. That being said, the number of nurses we are training at the moment is predicted to meet demand. We have a huge shortfall at the minute—somewhere in the region of 15,000 to 20,000 fewer nurses than we actually need—but that is because the NHS, as a result of Mid Staffordshire and the focus on quality, has increased the establishment for nurses by about 25,000, and we train 20,000 nurses a year, give or take. The crisis we have at the moment is because a sudden increase in funded nursing posts is being created, predominantly by hospitals; very few of them have gone into primary care. By 2019 or 2020, we should be back in equilibrium in terms of supply and demand. The debate about fees or not, and about bursaries through the Student Loans Company or not, is one that needs to play out. We are talking about very significant sums of money. We spend £1.2 billion a year on tuition fees and bursaries for nurses, allied health professions and some components of doctors and dentists, so it is a very significant sum of money.

Q90 Dr Davies: The GP shortage is an issue of concern to me particularly. Although it is not directly your remit, because it is in Wales, one of the GP practices in my constituency, serving 18,000 patients, has essentially collapsed through inability to recruit and retain. You talked before about GP trainees being focused in the south-east, and there being a shortage in the north and elsewhere. How severe would you say that the shortage of GP trainees is in the under-served areas?

Professor Cumming: We know that we are somewhere in the region of 20%, as an average, off the fill rate we would like to be at—that is with all the numbers we would like to create—but it masks huge variations across the country. In some parts of the country, you would find that one in four training posts is not filled. Those training posts are linked to what we know is the demand for GPs in the future. If you have one in four training posts not being filled, it is fair to say that there will be a 25% shortage of GPs coming to take posts in that area. It does not quite work like that, because people move around to some extent, but geography tends to trump a lot of other factors. You tend not to find people training as a GP in London, for example, who then want to practise as a GP in the east midlands, unless they have some particularly strong family tie or connection.

Greg Allen: There is the figure in England that nine of the 13 local education and training boards have the highest and lowest deprivation areas, with a resultant effect on numbers of GPs.

Q91 Dr Davies: You talked about some of the strategies that might be employed to deal with this problem and referenced the fact that you did not think that just financial incentives were required, but evidence we received from Essex County Council referred to the GMS contract and suggested that it is lucrative in areas with young and affluent populations. How would you respond to the council on that?

Professor Cumming: Fortunately, matters of contract are not for HEE, but all the conversations, and the evidence Martin referred to earlier, have suggested that there are some much more powerful drivers than simply money in terms of why people choose careers and why people choose where they live. On finances, for example, you could argue that it is much more expensive to live in London than in some other parts of the country where they cannot recruit. In terms of standard of living, people would actually be better

off in some of those places. But it is about connections to universities, for people who are interested in teaching. It is about opportunities for them to have a rewarding and refreshing career. It is about opportunities to network and work as teams. One of the big issues—again, this was an issue in emergency medicine—is how we get busy GPs some time to think, to develop themselves and to continue learning through their career. If you are working in a small, very hard-pressed GP practice and you are a long way from a university or anywhere offering you those CPD opportunities, it is pretty impossible, whereas if you are in the middle of London it becomes much easier. We have to recognise that and do something to counter it.

Q92 Dr Davies: My final question is about the model of primary care and whether it influences new GPs moving to the area. It is often said that GPs do not want to buy into partnerships—that in fact they do not want to be partners. I am not sure that there is a big surplus of salaried GPs either, but this is not something that is particularly covered in the background reading that I have done.

Professor Cumming: No. That is an NHS England area, but I agree with what you are saying. There seems to be an increasing number of younger people who do not want to invest in bricks and mortar. They want to work and to deliver care, but they do not see the business side of it as of quite as much interest to them as perhaps people in earlier generations did.

Q93 Dr Davies: Do you have any further points to add?

Greg Allen: None from me.

Q94 Chair: Before you leave, Mr Allen and Professor Cumming, does either of you have anything that you feel is important for us to know that we have not touched on today?

Professor Cumming: Can I raise one thing? It is the point that I made earlier about the opportunity for other doctors to work in primary care. At the moment, we have something called the performers list, which restricts people who can practice as GPs in this country. Going back to the comment I made about the three phases of a doctor's life, I will use the example of a physician working in a busy hospital, responsible for acute medical take, who as part of that responsibility works nights, and is therefore likely to retire in their mid to late 50s, because they cannot cope with it any longer. My personal opinion is that that individual, if we could keep them and use them in primary care, would be an absolutely invaluable resource to a big practice. They could work on a much more structured basis, Monday to Friday and 9 to 5. They could work with and alongside the GPs. They could help to manage and reduce the flow of patients into secondary care and help to take people out of hospital earlier by putting a pull into the system.

Why doesn't that happen at the moment? One reason is that the performers list gets in the way; they cannot get on to the performers list. They could work in primary care, but only if the hospital seconded them out to primary care. Why can't they become part of the primary care team? Why can't they work alongside GPs? One thing the Committee may wish to consider is whether or not there are ways we could look at being more flexible about the medical workforce, particularly people who have skills in a different specialist area, and how we bring those people into primary care. If we are trying to create an NHS

of the future that is delivered in primary care, with reach into hospital, we have to remove some of the barriers around having expertise in primary care.

Q95 Chair: I have heard similar comments made about returners who have worked in general practice in countries like Canada—that we are putting too many barriers in the path of their coming back. Would you say that that is also the case with the performers list?

Professor Cumming: Yes. It is variable. In terms of the returner programme people go through, people have to be safe, competent and up to date. We need to make sure that we do that in the least bureaucratic and quickest way that we can. As long as safe, competent and up to date are met, we should be doing everything we can to streamline it.

Q96 Helen Whately: We have talked a lot about changes that would ideally happen very widely across the country in many GP practices. Given the dispersed nature and independence of GPs, how can we make this happen? What national levers might there be to make some of the changes you have talked about happen?

Professor Cumming: We have all the training levers. For every GP trainee, their basic salary is paid and their training is overseen by HEE. Obviously, it is regulated by the GMC, with a curriculum devised by the RCGP, but we take responsibility for all trainees. We have a huge influence and a huge responsibility for making sure that we produce the next generation of the GP workforce, which obviously includes recruiting people to training posts.

With the leadership academy, we want to broaden out into practice management, which is not an area where we have been previously. We will look at covering every practice associated with that. Historically we have not trained practice nurses, because traditionally we have taken responsibility for nursing only at undergraduate level. We want to move much more into taking responsibility for making sure that practice nurses are available and trained across the country as a whole. The same applies to district nursing—what can we do across the country as a whole?

We have the levers around training. We also have a lever around CPD or lifelong learning for the current workforce. We do things such as raising the knowledge level of the whole of the NHS workforce in genomics. We train on dementia awareness. We are going to do some work on end-of-life care. If I am critical of my own organisation, we have probably focused very significantly on the secondary care, mental health and organisational-type sector and not enough on the primary care sector, because it is harder to get to. We need to stop using that excuse and find ways of engaging. There is the concept of the education and training hubs that we want to create in primary care. I mentioned Dudley earlier. Dudley has created an education and training hub that is for all the GP practices in the area. It is running a series of programmes, many of which we are co-funding. That sort of model is the way of getting into it. The other issues—contractual and service delivery issues—are NHS England's responsibility.

Q97 Emma Reynolds: Earlier, you made a very strong point about making sure that all of us do not talk down primary care and being a GP. You said that, in a way, we need leadership to promote it as a profession, and that, hopefully, will make it as attractive as possible to go into. Related to that, have you done any assessment of what would happen if

GPs' work patterns were to change dramatically—if it was Wednesday to Sunday, for example, to cover the weekend, rather than Monday to Friday? What are your thoughts about how that could impact on the attractiveness or otherwise of going into the profession?

Professor Cumming: Some people would not want to do it, whereas other people would find it something that they would be interested in doing. I do not believe that there is a single answer to that. If you have children at school, for example, and the only time you get to see them is on Saturdays and Sundays and all of a sudden you are asked to work every Saturday and Sunday, it is something that many people would not want to do. Equally, I am aware of a consultant in secondary care who is now working on Saturdays and Sundays. He said, “You know, it is fantastic, because I get two days off during the week, which is great for me. I can park the car, and there is not the same level of pressure and intensity around the work that I am doing.” But his children are grown up; he is in a different situation.

I do not think that there is one answer for everybody. We certainly cannot see a return to expecting people to work or to be on call 24 hours a day, seven days a week, because people simply will not do it in this day and age, but in many places the population have a desire for some sort of access to primary care at weekends. As long as it is appropriate, the majority of the GP profession would support it. It is about appropriateness.

Chair: Thank you. Maggie has a final point.

Q98 Maggie Throup: You mentioned the performers list being one barrier to increasing the workforce in primary care. From talking to GP friends of mine and GPs in my constituency, I know that there is another problem. We have talked about the ones aged 50 or 55 who are taking early retirement and find it very restrictive to come back just to do two days a week, because of the cost of clinical indemnity. Obviously patient safety is of paramount importance, but is there a solution to that?

Professor Cumming: Again, it is one of the differences between the hospital sector and primary care. In the hospital sector, the NHS takes responsibility for liability issues. That is another factor associated with the cost. It is one of the things we are talking to NHS England about, as it is one of the barriers to people staying on and doing a bit when we need that, particularly at the moment. The other conversation we are having is around the potential impact on pension caps and whether people are choosing to retire earlier because they have maxed out their tax-free pension contributions.

Q99 Maggie Throup: I have heard that as well.

Professor Cumming: They are simply making a decision to go, rather than be taxed on their future contributions to the pension.

Helen Whately: I meant to pick up on the points that you were making about practice managers, which are incredibly important. In some practices in my constituency, I have seen the difference that a good practice manager can make. It is really valuable. It is great that you mentioned that.

Chair: That is it. Thank you very much for your time today. We really appreciate it.

Professor Cumming: Thank you very much. If there is any other information that we can provide, do not hesitate to ask.

Chair: Thank you.