HOUSE OF COMMONS

Health Committee

Oral evidence: Primary care, HC 408

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Written evidence from witnesses:

- Chartered Society of Physiotherapy
- The King's Fund
- Nuffield Trust
- Royal College of Nursing
- Royal Pharmaceutical Society

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

Questions 100-182

Witnesses: **Professor Karen Middleton CBE**, Chief Executive, Chartered Society of Physiotherapy, **Sandra Gidley**, English Pharmacy Board Chair, Royal Pharmaceutical Society, and **Janet Davies**, Chief Executive and General Secretary, Royal College of Nursing; **Professor Chris Ham**, Chief Executive, The King's Fund, and **Candace Imison**, Director of Healthcare Systems, the Nuffield Trust, gave evidence.

Q100 Chair: Good morning and thank you very much for coming to our second session on primary care. Could I start by asking you to introduce yourselves for those following outside this room?

Professor Middleton: Hello. I am Karen Middleton. I am chief executive of the Chartered Society of Physiotherapy, which is both the professional body and trade union for physiotherapists across the UK.

Janet Davies: Hello. I am Janet Davies. I am chief executive of the Royal College of Nursing, which is also a professional organisation and a trade union with 430,000 nurses as members.

Sandra Gidley: I am Sandra Gidley. I chair the English Pharmacy Board, which is a board of the Royal Pharmaceutical Society, which is the professional leadership body for pharmacists and represents pharmacists in all sectors.

Chair: Thank you very much.

Q101 Andrew Percy: Could you begin by giving us your organisations' views with regard to the conclusions and recommendations of the Roland commission?

Professor Middleton: In terms of the report that was produced, we at the CSP were very pleased to see that primary care has such a strong focus in terms of general practice and primary care, being the first line that patients and the public would use to access healthcare. We were particularly pleased to see that the wider primary healthcare team is looked at in depth. The third area that we are particularly pleased to see is that in workforce planning and development, in terms of primary care, there is a strong focus on looking at what the nature of demand for primary care will be in the future. Personally, I am very pleased as a physiotherapist to see in the commission's report that Martin Roland is talking about clinicians working at their maximum competence and capability in their contribution to primary care.

Janet Davies: We would agree with a lot of that. There is recognition in the report of the multi-professional nature of primary care today. We were particularly pleased to see the reference to the role of practice nurses and their development. It is very light, I think, on some detail for us, and there seems to be some blurring of what is primary care and what is community care, which are distinctly different at the moment with nursing; it does not mean that they would need to be in the future. The focus on education was really key but again fairly light on what that might be, and I am not sure it explores enough the potential of nursing roles, both as leaders as well as practitioners. The start is there and that is very positive.

Sandra Gidley: As pharmacists, we are very pleased to see pharmacists for once being recognised as part of the primary care workforce because, as the third largest health profession, we feel we have often been overlooked. What the report had to say was very positive about the inclusion of pharmacists. In fact, it chimes with some of the work we have been doing at the Royal Pharmaceutical Society working with the Royal College of General Practitioners to develop a scheme whereby there will be a number of pharmacists based in GP surgeries taking on a more clinically focused role. That seems to me not only a good use of pharmacists but a benefit for the patients. If they are getting the best of each profession within a GP's surgery or other primary care setting, it can only be positive. I was also pleased to see the RCGP take a certain lead, post the report. They have convened a group of us to discuss it and there are a number of next steps—some for NHS England, some for the royal colleges—to try to progress it, so that it is not a report that is gathering dust but actually becomes something that is a reality to benefit patients.

Q102 Andrew Percy: We have been talking for over a decade about creating multidisciplinary teams and better integration. I have sat on this Committee for a number of years and everybody comes, and we all talk about how vitally important it is that everybody starts to work more closely together and all the rest of it. In your assessment, how far along that route are we in terms of establishing these multidisciplinary teams in general practice?

Sandra Gidley: We certainly have a way to go. The scheme for pharmacists working in general practice is new. There were originally 250 places. That has been expanded to 400, because there was such an interest in professionals wanting to work in that scheme, but they have not started yet. There will be a robust assessment of the scheme. I am fairly confident that not only will the scheme be beneficial to the patients in those surgeries because it will free up GP time so that they can use more of their expertise in a more focused way, but the pharmacist will be a link with the existing community pharmacy network and we can make better use of that network.

Q103 Andrew Percy: That is happening with the vanguard projects.

Sandra Gidley: It is not a vanguard. It is a specific one-off project developed by the RPS working with the RCGP.

Janet Davies: From a nursing perspective there has been a lot of progress. It is just that it is very mixed because it is quite hidden; there is not really a national system for primary care. Looking at nurses, for instance, we have seen a slight drop, sadly, in the number of practice nurses, but within that group we have seen quite a significant increase in those with advanced skills and advanced practice, which obviously shows that they are taking on broader roles. There is a move as well for nurses to take on more leadership positions. We were really pleased to see the CQC report into the Cuckoo Lane practice in Ealing, for instance, which is a nurse-led practice; the nurses actually employ the GPs. It is a different way of doing it. It is not just one solution, but it was one of the very few practices that got "Outstanding" from CQC.

Q104 Andrew Percy: The nurses employ the GPs.

Janet Davies: Yes. There is a practice in Ealing that is nurse led; two nurses own the practice. It is a different model and they work very multi-professionally. It got an outstanding report from the CQC. It was really good to see the evaluation of that. It is not necessarily the solution, but it demonstrates that there is more than one model, depending on the area, and it is about professions working together. We have been working with the Royal College of GPs for some time and we recently signed off joint competencies for nurses. It is significant that the Royal College of Nursing and the Royal College of GPs have done that together, so that it gets buy-in from all the professions. There has been quite a shift. The problem is consistency. There are some surgeries that are fantastic employers—there is lots of opportunity for continuing education and nurses are encouraged to develop their skills—and then there are others where the terms and conditions are poor, they do not get paid very well and they do not have those opportunities. It is not consistent but there is a shift, I think.

Q105 Andrew Percy: Given that there is lack of consistency, when you have an example of a new approach in general practice, do you think the public understand what is available and what is on offer?

Janet Davies: It depends on the practice. Lots of the work we have done, particularly on specialist nurses, demonstrates that the public evaluate them very highly. Quite often it is because the nurse has more time, which is obviously significant because they have more time for an in-depth conversation. It does evaluate very well when patients are being cared

for by a nurse in primary care, but that is once they have actually seen the nurse. I think there is still some hesitation, and it is important that people feel comfortable and confident that the health professional they see, whatever their discipline, will be able to meet their needs. They need to have that confidence. Once they have seen the nurse, the overwhelming evidence is that, for the majority, it is a really positive experience.

Q106 Andrew Percy: A final question from me, with your permission, Chair, is around nutrition. Poor nutrition costs the NHS about £13 billion per year. I met some dieticians recently who were keen to lobby for their involvement at the primary care level. Do you have any thoughts on that? Are there any examples of where it is working well? Is it actually happening, or is it something that you think is a natural extension to what you have already outlined?

Janet Davies: It is a key area for keeping people well, and for people with long-term conditions, for instance, it is a real problem. We see it as part of a nursing role when managing long-term conditions. We do not have any examples, but we can certainly look and get back to you with any.

Professor Middleton: I wonder if I can help. In terms of dieticians, there are examples—I do not have them with me—of their working in primary care, but dietetics is another example of a profession, similar to physiotherapy, where we need to look at the wider primary healthcare team and at using their expertise to their maximum capability. Clearly, around diet and nutrition, dieticians are the experts and it would be far better if the workload of a GP around nutrition and diet was seen in the first place by a dietician. When it comes to physiotherapy, 30% of what a GP will see in their caseload is musculoskeletal—neck, back and joint pain, for example; if you put a physiotherapist in the practice to see those patients first off, so they are not seeing a GP first but a physiotherapist, that is 30% of the workload taken from a GP, and they perhaps refer less to further secondary care.

Chair: We are going to explore that in more detail later on.

Professor Middleton: Okay. I think dieticians are another example of a profession that could be used more in primary care.

Andrew Percy: Thank you.

Q107 Helen Whately: We are talking about future models of care, often where activity can be taken from the GP and given to other members of the primary care team. I would be very interested in your view on what share of work could be taken from GPs and given to members of your professions instead, and any assessment you might have done of that shift in activity.

Professor Middleton: In terms of physiotherapy, as I say, 30% of what a GP sees, according to the British Orthopaedic Association, is MSK. Physiotherapists are ideal to see those patients first off. Physiotherapists have had clinical autonomy since 1977, and if you are able to pay you can see a physiotherapist immediately without having to see your GP first. There are countless examples across the country where that works in practice. I visited a practice in Suffolk during the summer where they provide physiotherapy as the first point of contact across 27 sites. They have not only taken 30% of the caseload that the

GPs were seeing before but they have reduced referral to secondary care. Hip and knee replacement surgery has reduced by 40%. The conversion rate for surgery for orthopaedics has gone up to 100%, so all those referred to secondary care actually need surgery. There are many examples. In the vanguards, we have two sites where physiotherapists are working in general practice to do initial assessment, diagnosis and treatment and discharge, if necessary, or referring on, if necessary.

We are finding that not only are patients very satisfied with that approach but we know from all the evidence that has been accumulated around patients self-referring that they are seen quicker, outcomes are better, they return to work faster and it saves a considerable amount of money for the taxpayer when a physiotherapist sees the patient rather than a GP. Physiotherapists are able to independently prescribe, call for X-rays and tests, and so on, and there is evidence that those costs reduce if a patient is seen by a physiotherapist first. There is less need for the patient to keep coming back. MSK—musculoskeletal—conditions are the main reasons why patients have repeated appointments with their GP. When I talk about 30% of a GP's caseload being MSK, it is not 30% of the patients, it is actually many patients coming back again and again or then being referred unnecessarily to orthopaedics. Definitely, in terms of MSK care, there is evidence that a physiotherapist being the first point of contact works, is safe and saves money and that patients love it.

Janet Davies: It is slightly more complex in nursing because there is a whole career framework within primary care. You have nurses at different levels who can contribute in different ways. We have healthcare assistants and nurses who support the GP, taking on some of the support roles, doing some of the observations and some of the skilled tasks, but not necessarily taking on the GP's role. Then we have nurses who work to an advanced level, who can prescribe, and who come into their own, I believe, with chronic conditions, people with multiple conditions and people with things such as diabetes, pulmonary disease, and so on. They work in two ways: one is taking some of the workload off the GPs, but the other is about keeping patients well so that they do not need to see the GP or, even more importantly, do not need to go into hospital because they are being maintained very well at home. A bit of it is support and a bit of it is alternative, but it is also something very different that prevents the problem in the first place.

Q108 Helen Whately: I imagine there must be some practices that are doing much more with nurses and others that are doing less.

Janet Davies: It is very mixed. That is why the career framework that is being developed is so important, but it is important that everyone signs up to it. It is a very mixed picture because of the way the GPs are. The size of the practice makes a difference as well, of course. The number of staff you can support in a very small practice is different from some of the large practices where you have a whole team of nurses all at different levels. There is something about how practices might join and work together to enable that sort of work to take place. Also, of course, employing nurses is different; the way people are employed is different. There are no terms and conditions and no salary generally agreed in primary care, and sometimes that gets in the way of people wanting to work there, or they move a lot to try and get a better deal, which sometimes happens as well in primary care.

Q109 Helen Whately: What if far more practices moved to the end of the spectrum where they are making a lot of use of nurses? Do you know of any work that has been done on that question?

Janet Davies: There is, and we can demonstrate some of that and send you the details. Individual practices have done work to see the difference that it makes, but we know that it keeps people out of hospital, and that is a really big thing now; it is the worst place for people, particularly older people with chronic conditions. People with diabetes, for instance, are much better managing their own diabetes with the support of a specialist nurse than they are having a crisis and then going into hospital with people who are perhaps not dealing with diabetes in quite the same way. It is much better for them to be managed with that expert care in the community. Primary care is the perfect place for that.

Sandra Gidley: We have identified a number of areas. It is partly about keeping people well. Many pharmacies are now healthy living pharmacies where the emphasis is on giving healthy advice. Pharmacists in the community provide the medicines use review, and a section of that is to provide healthy living advice as well. To come back for one moment to the core expertise of pharmacists, pharmacists have a four-year master's degree in medicines and the use of medicines, with the science underpinning that. It seems almost criminal to me that we are not making the best use of that specific expertise. For example, surveys have shown that approximately one hour a day of the average GP's time is spent on medicines-related queries. If you have a practice-based pharmacist, the pharmacist could deal with that on behalf of all the GPs. A lot of it is around transfer of care, which is where people move from secondary care or a hospital setting back into the community, or vice versa. Often there are problems with translating the medicines history. Medicines that have been changed in hospital are not always changed in the GP surgery. There is a whole area where we can make the patient experience so much better. Other studies—I think by the PAGB—have shown that something like 20% of a GP's time is spent dealing with common ailments, which could easily be dealt with by a pharmacist. There are common ailment schemes—or minor ailments schemes—around the country, but unfortunately the provision is patchy and each scheme is different. It is very much a postcode lottery as to what you get.

The pharmacists who will be based increasingly in GP surgeries have a role in making the best use of what the pharmacies in the community are doing. The medicines use reviews are a provision for helping with managing long-term conditions, because we see patients who are on regular medicines. We also provide something called the new medicine service, which is often under-utilised; GPs do not really see the point. When patients are put on a new medicine, the GP may explain something very well, but some of that message is forgotten, so it is about reinforcement. There are also occasions when services are duplicated. For example, we can manage asthma very well in a community pharmacy, but the asthma nurse would probably feel that they do the same thing. It makes no sense to duplicate services, but there are some people who will not go into a surgery but are quite happy to have a review in a community pharmacy. For example, evidence in Hampshire showed that an advanced medicines use review for people using asthma inhalers that measured and improved their technique had a noticeable reduction in hospital admissions. We now have the evidence for that, so that service could be more usefully utilised elsewhere. We would say that, where there are long-term conditions where there is a significant amount of drug use, we would be ideally placed to manage that, but our key

role should be making sure that every patient gets the right medicine at the right time. That is not always happening at the moment.

Q110 Helen Whately: The key is in improving the clinical care. There is the patient experience I mentioned, and you said there is some opportunity to shift or reduce the work that GPs will be doing because pharmacists can take it on.

Sandra Gidley: We can do it. At the moment, the GPs have their contract, so the GPs will be doing work related to that contract, understandably. Why wouldn't you? The pharmacists have another contract and do a separate piece of work, and there has been absolutely no alignment of the two contracts. We believe that it makes some sense to have not a combined contract but a look at ways in which you can merge the contracts in some way so that work is not duplicated. There should be a mechanism, particularly when pharmacists get proper access to records, of ensuring that medicines use reviews are not duplicated. That would appear to me to make sense. At the RPS, we have been working with people in NHS England who will be responsible for negotiating the contract just to give some ideas—we are not the negotiator—about how the two contracts could possibly be slightly more unified in approach.

Q111 Helen Whately: We will come on a bit more to the how of it later on.

Sandra Gidley: That is fine.

Q112 Helen Whately: I have one more follow-up question on this. We were talking about the opportunity in terms of the shift of workload and patient benefits. Do you each have a sense of the investment that might be required in your area of the workforce in order to make the most of that opportunity? Karen, do you want to answer first?

Professor Middleton: In physiotherapy, the examples—particularly the ones around the vanguards—where you have physiotherapists seeing the patient as the first point of contact have been achieved through upstreaming the physiotherapy contact. These are patients who would be referred to physiotherapy anyway. By shifting the physiotherapy from secondary care or outpatients in the hospital into the general practice, you are reducing the caseload that then gets referred on, so it is not costing any more in terms of the physiotherapy workforce. In south Hampshire, for example, there is a vanguard where you have physiotherapists working just two afternoons a week. Not only has there been a significant reduction in the referrals to onward physiotherapy, but the physiotherapist in the practice has been able to take 50% of the people they have seen; they give advice, reassurance and exercise and the person does not need to come back again. Actually, in terms of investment, much of what I have described, and is in our written evidence, can be delivered through shifting the workforce from secondary care into primary care.

Secondly, in terms of the nature of the future demand on primary care, we know it will be older people, more people with long-term conditions and co-morbidity, and we need to encourage much more self-management. Because physiotherapists spend longer with a patient, we have a significant role in terms of physical activity and enabling people to manage their own conditions. Because of that rising demand, we have modelled the workforce, and over the next three years we are going to need 500 additional physiotherapists each year to meet that demand.

The third area for investment in the workforce in primary care, from a physiotherapist's perspective, is in training and development and ensuring that physiotherapists learn alongside pharmacists, nurses and doctors in primary care. We know that teams that learn together work together better. That would be the other area. It is about extending the training and development that is available for those professions to the wider healthcare team.

Q113 Helen Whately: That is very helpful. Actually there is not a need for additional workforce because of the shift. The need for additional workforce is because of the growth in demand.

Professor Middleton: Yes. We know already that the shift can be done, but we are seeing a shortfall as the demand for this type of care goes up because of the nature of the patients that are coming through primary care.

Q114 Chair: On that point, can I ask a quick follow-up? We heard from the Primary Care Workforce Commission that they thought more research was needed, and also from Professor Roland a note of caution that we might be seeing supply-induced demand. How would you respond to both of those points?

Professor Middleton: Yes. The latter—supply-induced demand—has been an issue with the AQP contracts, where you have had a scenario that it is almost in the provider's interest to generate demand. That has been a definite problem in terms of commissioning. In terms of physiotherapists being the first point of contact, or patients and the public being able to self-refer to physiotherapy, there is absolutely no evidence that demand increases. Keele University is just about to publish a randomised controlled trial of 1,000 patients over the last year where we had two practices self-referring patients and two practices where the GP referred. With the practice population where self-referral was allowed, they notified every single household in that practice population that they could now self-refer and there was not one patient increase in demand.

Q115 Chair: We will look out for that. You do not know when they are going to publish, do you?

Professor Middleton: No. All we know is that it is imminent. They were clear that I could use that information but they are due to publish very soon. Actually all that does is reinforce the evidence that has been produced since 2006 and 2008 when the Department of Health did its self-referral pilots in England. There is 100% coverage in Scotland, and demand does not seem to have increased.

Chair: I am conscious that we have to move on, unless you had any other questions, Helen.

Q116 Helen Whately: It was only whether Janet or Sandra had anything to say on their side. I was trying to get both sides of the equation, the potential benefit and then the investment required, and whether you had any particular view.

Janet Davies: For nursing it is a slightly different situation because we are short of nurses at the moment. There is a definite need for investment in more nurses, and particularly moving nurses into primary care. One of the difficulties we have seen over the past years

is that the investment in community has not been there: in fact, the opposite. For instance, with district nurses, who support people in the community and work very closely with primary care, there was a 28% reduction in the number of specialist community nurses between 2010 and 2014. We have quite a lot of investment to do just to put us where we were before. But, also, I think for nursing the investment is in education. We have to invest in nurses when they are student nurses going into general practice, getting placements in general practice, and then their ongoing education to enable them to do that advanced practice.

Chair: We are going to come on to that in more detail.

Sandra Gidley: In pharmacy, we are in a slightly different situation from nurses. We have an unusual situation where we seem to have a new school of pharmacy opening up every year. The number of graduates has almost doubled over the last 10 years. A workforce is there—there is capacity in the workforce—to take on some of these roles. It is not necessarily about funding a lot of additional training, because actually very little training is needed for much of this, but about redesigning services. For example, the use of minor ailments services has meant that patients have been getting a cheaper but equally effective service from pharmacists, and not going to the GP where the price for that service is much higher. We have to think quite radically about how we are designing services. If we were starting from scratch today, I do not think we would be where we are. This is not a party political point because I think Governments of all colours have tried very hard to move funding from secondary care to primary care and it has never really happened, but a very small transfer of 1% of the secondary care budget to primary care could absolutely transform services, so somebody somewhere needs to be bold.

Q117 Emma Reynolds: I think this relates to that very essential point. If we are to shift the workload in general practice away from GPs but also, as you say, keep people from being referred to hospital unless they really need to be, is the shortage in the number of nurses—I think this is different for physiotherapists, from what Professor Middleton was saying—we have in general practice going to prevent us from making that shift away from GPs, and what can we do about that?

Janet Davies: That is the case at the moment, I know. Talking to GPs—because we work very closely with them—we have GPs who desperately want a nurse practitioner in their practice but they cannot recruit one. There are a number of things. The first is about getting more nurses into general practice, making it a career framework. Health Education England have done some work around that, which is a step in the right direction. It is a little bit static. Perhaps we ought to look at what it has to be like in the future. The way we practise will be different. It is about investing in the workforce generally. We talk about investing in the number of GPs. I think we need to look at investing in the primary care workforce, particularly nurses. Once we have nurses, it is about ensuring that they have a career framework to work towards. Not everyone wants to be an advanced practitioner and not everyone wants to do specialist work. There is a role for a general practice nurse but there should be some way of them progressing through their career so that people do not feel they have to leave. It should also be an attractive, professional role. Traditionally, some nurses quite often went into general practice when they had their children because they could work good part-time hours, it was local and they were not having to travel to the hospital. They could take their kids to school and go to the practice, and the hours were

much more flexible. Here we are talking about a much more structured career for nurses based in general practice, which is a shift from the traditional. It is happening, and it is happening because of population need. That is a really good thing because it is happening for the right reason, but now we need to have a bit more of an organised focus on how we make it happen.

Q118 Emma Reynolds: Is that career development and professional satisfaction as important as or more important than what you talked about earlier—terms and conditions and remuneration?

Janet Davies: It is as important, but there is something about having consistency of employment, which would help, because it is very patchy. You find that the best practices not only have the best training and education, but they usually have a fair reward package as well. It tends to go hand in hand. It is about how you recognise and value your staff and work together in partnership across all the professions. It is not one or the other. It is about the whole team working closely together and doing what they are best at. One thing the vanguards have shown is that there is less duplication and much more working in partnership. We all know each other's strengths, and when we get together and work out who is doing what, that is usually the best way of working.

Sandra Gidley: I might argue with that slightly—that we know each other's strengths. In theory, we do, but I do not think even between the health professions there is full appreciation of what each other can do. It seems to me that there needs to be greater focus on interdisciplinary learning. That happens to a certain extent at undergraduate level but it needs to happen post- qualification as well. There are a number of barriers to that—simple ones such as GPs locally preferring lunchtime meetings, which are impossible for a community pharmacist. Some thought needs to be given there. I am a locum in the community and I recently entertained a trainee health visitor who was not even aware that pharmacists trained for four years. She said, "That is more than me." If there is that lack of understanding, we have a long way to go.

In pharmacy we tackled the problem slightly differently. With the pharmacists in GP surgeries, the pilots will have two levels of pharmacist. A senior level 8d equivalent pharmacist, who has a prescribing qualification, will oversee five pharmacists in different GP surgeries as a way of bringing on and developing the workforce, because some of the more junior pharmacists may not have a prescribing qualification. In addition, as the Royal Pharmaceutical Society, we have developed a foundation scheme and a faculty scheme that encourages pharmacists to develop their professional portfolio, because it is not all about rising up steps on a particular ladder; it is about developing your professional practice. The emphasis should be on that rather than a career progression with grades, if you see what I mean.

Q119 Emma Reynolds: Yes. That is really interesting. Professor Roland told us that there were some GPs who really valued having a pharmacist in their practice and others who said, "What would I do with a pharmacist?" That seems to be a barrier to spreading that best practice. We were also told that Health Education England were trying to deploy 200 to 300 pharmacists to work alongside GPs. Sandra Gidley, could you say something more about how we get past the barrier of some GPs not seeming to appreciate what the opportunities are, but

also, if those additional pharmacists are deployed, what kind of difference that could make to general practice, more widely rather than it just being the best leading the way?

Sandra Gidley: We had a breakfast fringe meeting at the Royal College of GPs; it was the night after the ceilidh and quite a large room was packed, which shows you that there is significant interest in this scheme from GPs. A straw poll showed that only about half of them were currently employing a pharmacist. Some have dipped their toe in the water very gently and are trying it on a sessional basis until they work out what is going on. Others have embraced the scheme. It is the same scheme—the pharmacists and GP surgeries scheme. Originally, funding was available for 250 places and there were cynics out there who thought that we would be lucky to get that many responses. The response was so overwhelming that there will be 400 places. There is an appetite for this out there, and the Royal College of GPs have been very supportive in helping develop the model. It has been a joint initiative, which is almost unprecedented in royal college territory, because it can be very territorial. Where pharmacists are currently based in GP surgeries, it is quite evident that patients are very passionate about it because they see the advantages of being able to benefit from the expertise that the pharmacist has, and they know when to go to the pharmacist and when to go to the doctor. In a number of cases, pharmacists have become partners in the surgery because their contributions have been valued, but this is very much not one model. Different surgeries have developed it in different ways: in some you will have pharmacists managing long-term conditions and in some you will have them sorting out very complex polypharmacy. It is not unknown for people to be on 20 medicines these days, and a lot of work could be done in reducing the number of medicines that somebody is on, with consequent savings on the drugs bill.

Then there is what I mentioned earlier about dealing with the medicines-related enquiries that clog up the GP's day, stopping them from using their skills. There is a whole range of skills, including some long-term condition monitoring, which includes taking bloods and that sort of thing. It is not for me—I hate blood—but where pharmacists do it and provide anticoagulation services, those services have really benefited. It is very much what the practice wants them to do, and there is a range of roles that have expanded rather than contracted where those services have been taken on.

Q120 Maggie Throup: Apart from the exception we heard earlier in the Ealing practice where nurses were taking the leadership role, traditionally, GPs have always been the leaders in primary care. What national policy reforms do you think are needed so that professionals other than GPs can take on those leadership roles?

Janet Davies: They already can. We know that there are a number of practice partners who are not GPs. In England in particular—it is slightly different in other parts of the UK—it is possible to do that. It really is about what is right for the practice, and enabling people to do that and to develop. There are partners from all the different professions. There are quite a number of nurses now who have practices. I think Ealing is one of the very few that is totally nurse owned, but often there is a partner who is a nurse, and I think you just talked about one who is a pharmacist. There are other professions that I know are partners in practices. There is no reason at all why people should not take on more of those leadership roles.

Professor Middleton: You can exhibit leadership without necessarily having the job title, as it were. Certainly in the vanguard that I was describing in south Hampshire the extended scope physiotherapist, Neil Langridge, would be regarded as the person who is leading the MSK pathway. He is not a partner in the practice, but people can lead and exhibit leadership without necessarily having those roles as well. As the primary care team widens, and as membership widens and it is more accepted that primary care means something more than the GP, we will see different roles being taken up by different people and different clinicians as a result.

Sandra Gidley: It is not really about policy as such. We are talking about two things. There is better co-location of services in a GP surgery, which is traditionally regarded as the hub, but you have lots of spokes which are community pharmacies, and it is about how you get the best out of those. One of the problems with the Health and Social Care Act was that when CCGs were developed it was changed so that nurses now have a seat on CCGs. Pharmacists do not have a seat as of right, so at the very top level of influence in a locality the pharmacist's voice is sometimes absent. That is why the provision of services, the commissioning of things like minor ailments schemes or emergency repeat prescription schemes are very patchy.

Q121 Maggie Throup: Do you think changing the structure of the CCG would be helpful?

Sandra Gidley: It would help, but aligned with that is that we all have to work harder at understanding each other; we do very much at a royal college-type level and at our level, but the folks on the ground are so busy doing the day job that they do not have time to think about whether the practice nurse could be doing it. There is not really very much cross-fertilisation. As leadership bodies, it is probably something we have to work a little bit harder at as well, to try to encourage our members to understand each other a bit more.

Q122 Maggie Throup: Are you saying that professionals would have the capacity to take on leadership if they knew that the opportunity was there, at the grass-roots level?

Sandra Gidley: Yes. I think sometimes working is quite siloed. I can only really speak about community pharmacy. Where you have a small town such as Romsey there is quite a lot of inter-professional working; it works quite well. In some locations it is much more difficult. In Southampton it is much more difficult to get people together in their natural localities to talk about what services could be provided or what could be done. GPs have done a great job of federating, and I have to say the pharmacy profession is only just beginning to realise the power of that. There is a scheme in Brighton, I believe, but we will be encouraging the formation of other schemes to work alongside the GPs, because that is possibly a way that we could move things forward in a locality.

Q123 Maggie Throup: Obviously we have been hearing about professions other than GPs taking on a wider workload in the primary care setting. Do you think they also have the capacity to take on the leadership roles?

Professor Middleton: Definitely. I think it is not only capacity but also the capability to step up and to lead. Those skills certainly, I would say, do not just rest with doctors and nurses. It is something that all the clinical professions, as far as I am aware, train in, in

terms of leadership skills and expertise that they develop. It is not just the capacity but the capability to do so.

Q124 Maggie Throup: Specifically talking about primary care nurses, Health Education England said it needs to "think about" how training is delivered to nurses working in general practice to support their career development. If they were in this room today, Janet, what would you be saying to them?

Janet Davies: I absolutely agree. We really need some clear commissioning of nurse education that covers primary care. It is important that we keep an eye on how we commission places for nurses, and how we determine the number of nurses we need in the country based on population. We know the health of each population, and we should be commissioning nurses to reflect that. Nursing is an interesting profession; although it is a graduate profession, it is different from other university programmes because it is not getting a degree for a degree's sake. It is almost like a graduate apprenticeship, so nurses are trained partly in university and 50% of the time is in clinical practice. In that 50% of time we need to ensure that nurses are all exposed to what they are likely to be doing in the future, not just focusing on hospital, which I know is not the case. There has been until recently very little exposure to primary care, working in general practice at that level. That is often where you get your idea of where you want to be in the future. We need to keep hold of that commissioning, and we need to look at what we are commissioning for, but rather than commissioning for the next three, four or five years, which is what we tend to do because of the way it works at the moment—people say how many nurses they are likely to need in three years' time—we should be looking at 10 years, and if care is really going to be in community settings and in GPs, that is where we should be focusing our attention and putting our money.

Q125 Maggie Throup: A bit more forward thinking.

Janet Davies: Yes.

Q126 Helen Whately: Can I pick up on making some of this change happen a bit more? Janet talked about the range—nurses having more extended roles in some places and not so much in others—and Sandra talked about the need to work harder at understanding each other between professional groups. What is needed to achieve the kind of multidisciplinary team working that is being envisaged, and are some contractual changes needed to achieve that?

Janet Davies: Contractual changes would be very useful. We know from nurses that having some consistency in the terms and conditions and the way they are employed would make a huge difference. The fact that we have very different ways of being employed and very different salaries gets in the way, certainly in terms of looking at the workforce for the future—developing the workforce. Some consistency—based on Agenda for Change, for instance—would be very helpful. Some of the best practices do that; others do not. That really does create a problem in developing a consistent workforce. Consistency would help significantly.

As well as looking at different employment models, the federations, for instance, are absolutely key when you have smaller practices who cannot engage in this way. If it is a

very small practice, obviously they cannot employ these people. There has to be a different way of working. I think, as Sandra said before, there is definitely something about learning together, and that is much more possible when you have wider confederation. It does not need to be one organisation, but if people can work together it makes a big difference. It is beginning to move. I spoke this year at the National Association of Primary Care conference, which I also did last year. Last year I was there with Maureen Baker doing a bit of an argument, like we are having today, on "We should be working together", and in the audience there were probably 10, 15 or 20 nurses. This year they had a session running alongside it and, jointly, there were nearly 1,000 nurses. That is just one year apart, so it is beginning to get some traction, and certainly some of those nurses had been released from their practices—not all of them; some were doing it in their holidays and days off—to go to a conference and learn more. There is a general feeling that there is a shift, but we need to speed it up a bit by setting terms and conditions in some of the areas that will make it easier.

Professor Middleton: I would say a couple of things on that. One of the lessons is from GP fundholding from quite a long time ago. I was a physiotherapist at that time working in general practice and it was very difficult, so there are lessons to be learned about the importance of career development, terms and conditions and so on, that we must not go back to. In terms of scaling up, with self-referral or physiotherapy being the first point of contact for a whole range of conditions, it is not contracts that are limiting that ability at the moment, because there are lots of different models where it is working, and trusts or social enterprises are providing the service in the practice. It is not a contractual issue. It is more about publicity and knowledge, and understanding that a whole range of professions can see people at the first point of contact. I find it fascinating that in the private sector, as I say, you would have been able to do this since 1977. Most people know that if they want to access physiotherapy they just ring up a physiotherapist in the private sector. But actually in the NHS that is simply not the norm. Certainly on what Sandra was saying about understanding other professions, I still have conversations, probably two or three times a week, with commissioners and with other clinicians who have no idea that a physiotherapist can be seen without the person ever seeing a doctor.

There is something to be done about knowledge and sharing that, and also dispelling some of the myths, in our case, around demand shooting up if you switch the form of access, which is simply not the case. The vanguards are really helping with that. Because of the issue of GP capacity and the workforce issues facing general practice at the moment, there is a real catalyst for looking at different opportunities. In the past, although it has always been there, and switching to self-referral access or first point of contact with a physiotherapist has always been available, I do not think the driver has quite been there, but now that we have this primary care scenario hitting us we will see it, as Janet described, begin to scale up. The workforce issues that are facing general practice in terms of physiotherapy are not the same. Although I described how we could move the workforce, we also recognise that we need to look to future demand, which is going to be a need for more and more physiotherapy in the future. Although at the moment we are only beginning to see a problem with supply, in the future, if we do not get the additional 500 places each year, it will be a problem. In physiotherapy, we have 12 applicants for every training post, so it is quite different from general practice and the issues there.

Sandra Gidley: As I said, better inter-professional learning would help. At the moment it is a bit of a tick box in the curriculum, and more thought needs to be given as to how the students get benefit from it. Alignment of contracts would help, but, as Karen said, there are areas in the country where people have got together and made this happen. It is the age-old problem of the national health service that there is probably a beacon example of best practice somewhere in the UK on almost anything, yet spreading that best practice is very difficult. If we could have cracked that 20 years ago, we probably would not be where we are today in so many ways. I do not have any answers for that, but certainly these things can be done. A lot of it comes down to individuals, but—this is not anybody's policy, just something I have been considering—we are all regulated professions and we all have to do CPD. If you want to get the health professions working together, shouldn't a proportion of that have to be across the professions rather than in the current silos?

Q127 Chair: Can I touch on something you have already mentioned, Janet—about how we get more exposure to primary care within the training for each of your disciplines? Professor Middleton, what would be your thoughts? How are we going to drive more exposure to general practice for physiotherapists during training?

Professor Middleton: It is about student placements being much more diverse and in primary care. Physiotherapy students are trained to assess, diagnose, treat and discharge in a clinical, autonomous way. The frustration is not that they are not exposed to that during training. The frustration is that once you qualify, unless you are in one of the vanguards or working somewhere where there is a beacon of good practice, you suddenly find yourself retrenched back into a different place. I think it is placement exposure during training that is important.

Q128 Chair: How are we going to drive more placements, to be more specific? That is what I meant: how are you going to get people out of the universities into primary care for exposure in that setting?

Professor Middleton: We are finding that more community and primary care providers are taking students, so it is about scaling up what we already see happening and making sure that part of the contract that providers have includes an element of training and taking students as part of their placements.

Sandra Gidley: Pharmacy is slightly different. Obviously there are community pharmacy placements, but they are very much based in a community pharmacy. It is only in recent years that there has even been the slightest amount of cross-fertilisation. You might, if you are lucky, get a trainee GP for half a day, usually when you are very busy and it is a last minute, unsatisfactory arrangement. There needs to be more thought given to how GPs can have a meaningful experience and knowledge of what community pharmacy can provide, and community pharmacists can have greater knowledge of the challenges facing a GP surgery. But we now have this new role, which are the pharmacists based in GP practices, and there has been absolutely no provision for a pre-reg placement. My feeling is that will not happen until the pilot has been evaluated and the service is more embedded. But then I would assume that six-month placements could be offered in primary care like anywhere else, but that is something for the future. The worrying thing is that there is a rumour—I stress it is a rumour—that the funding for pre-reg places for pharmacists is going to be cut, and that does not seem to me to be entirely helpful.

Janet Davies: There is a relationship issue that is really important when we are training our health professionals, and that is between the NHS, the employers, the commissioners and the universities. It is about tightness. We are employing people for our NHS, obviously, and beyond, but we are employing people for a health role, and having involvement with and a relationship between the future employers, some of whom will be GPs, of course, and the people who are commissioning that education and the universities. It is such a key relationship that makes that happen. Without that tight arrangement, and if it became a less tight relationship, it would cause problems. It almost needs to be tighter so that people are owning these students as their future workforce and working with the universities, rather than seeing it as something that is happening elsewhere.

Q129 Chair: How much of the postgraduate training budget currently goes to each of your disciplines from the NHS?

Professor Middleton: I don't know. I would definitely have to get back to you on that, but I know that compared with medicine it is a relatively small amount for all the other professions, relative to medicine. It is quite disproportionate in terms of the numbers of the workforce in the other professions.

Janet Davies: It is very small and a lot of it is quite hidden. Some of it is hidden within other figures in providers. In hospitals, for instance, sometimes it is quite hard to get to where that actual training budget is, certainly for the placement type, the experience work; it is quite hard to find just where that is. It is not always as explicit as it should be, but it is small as towards the medics; it is very little in reality.

Sandra Gidley: One of the problems we have at the moment in pharmacy is that, with the uncontrolled expansion in the numbers of schools of pharmacy, there is greater demand for pre-reg places at a time when fewer are becoming available, so people are increasingly having to self-fund a place, which does not seem ideal.

Q130 Chair: What kind of barriers are there in the way of professional regulation to expanding roles in each of your disciplines? Are there any barriers you are facing, thinking about the reviews of regulation that might need to happen with legislative change?

Professor Middleton: In physiotherapy, there are no barriers. The scope of practice of a physiotherapist is very broad, and physiotherapy is defined as what a physiotherapist does. Over the time that I have been qualified we have gained the right to independently prescribe, we inject and there are some physiotherapists doing minor surgery. It is about the confidence and competence that people can demonstrate. From a regulatory point of view, there is no problem. We are not regulated on task.

Q131 Chair: When a bill finally gets taken up by Parliament there is nothing you are suggesting should be changed.

Professor Middleton: No, not from our perspective.

Janet Davies: It is the same in nursing. The scope of practice is very broad. The last barrier was prescribing, which we have had in nursing for quite some time now, so there is not a barrier there. Sometimes it is about enabling the regulators to recognise those roles,

not that there is any prevention, but sometimes when they look at cases they do not necessarily recognise those roles.

Q132 Dr Davies: Could I bring us back to pharmacy and the commissioning of pharmacy services, particularly the common ailments service? We know that perhaps that is provided to only 42% of people, or areas, in England. What are the factors that determine whether CCGs commission those kinds of services?

Sandra Gidley: I think I alluded to some of them earlier, so I am sorry if I pre-empted your question. Certainly, there is the lack of the voice of pharmacy at the very top, a lack of understanding among some commissioners—let us not forget that not all commissioners of health services have a health background—of what pharmacists can do. We are working quite hard to try to address that. The current move to localism is not exactly helpful. The Royal Pharmaceutical Society are very keen to see a national service because we think the public would have a greater understanding of what to expect. For example, we recently visited Manchester because we were taking an interest in the Devo Manc project. Of the 10 or 11 CCGs that are embraced by the scheme, five did not have a service, so they are developing a service for those five. The other five or six have completely different services. They are hoping to unify it all. That is an example of the challenges. At the moment, you get different things in different areas, and the barrier is the commissioners not looking at the bigger picture. The urgent and emergency care review is quite clear about pharmacists. I do not know if you have seen the picture, but there is a triangle, and by diverting more work to pharmacists it takes the load off GPs and should, in theory, take some pressure off A&E. We were very close, I understand, to having a national scheme commissioned, but, for reasons unknown, at the last minute it did not happen.

Q133 Dr Davies: When you look at the areas without commissioned services, do you see similarities? Are they areas with socio-economic deprivation, for instance?

Sandra Gidley: Absolutely not. It is completely ad hoc. On the south coast there are some areas with very similar demographics; some have commissioned a service and some have not. It seems to be pot luck, depending who is working where at the time.

Q134 Dr Davies: What about those same areas having a lack of other services such as general practice?

Sandra Gidley: I have not seen any correlation on that; I think it would be quite hard to put together. That is not always the driver. The driver is sometimes pressure. With the minor ailments service what is particularly interesting is this. I work in inner-city Southampton and leafy Winchester. In leafy Winchester, parents will go and buy their Calpol because they can afford it. In inner-city Southampton they are on benefits and they clog up—the only word I can use to describe it—the GP's surgery wanting another prescription for Calpol. Surely we can provide a service that helps the GP do what they are best placed to do.

Q135 Dr Davies: We have already talked about pharmacists working within general practice and how pharmacists can be, potentially, partners or employed by partnerships, but

of course some CCGs fund pharmacists to work within the practice setting, do they not, where there have been particular challenges?

Sandra Gidley: Yes.

Q136 Dr Davies: Do you see any particular pattern in how that has been adopted?

Sandra Gidley: Again, it has been very patchy, according to CCGs, but for the pharmacists who have already been commissioned their role has very much been finance-driven in the past, so it has all been about reducing the drugs budget. There is a bit more to it than that. The new scheme emphasises the more clinical skills. Obviously there will be a benefit, hopefully, to the prescribing budget, because they will be able to sort out some of the complex polypharmacy, but the focus is on clinical services for the patient rather than solely cutting drug costs or dispensing medicines. That is not what the pharmacist and GP scheme is about.

Q137 Dr Davies: Very good. If we think about the barriers that you identified in CCGs in terms of commissioning, do you think there should be additional scrutiny, let us say, of a CCG's decisions and, if so, how would you go about achieving that?

Sandra Gidley: That is a difficult one, because the idea behind CCGs was to have local decision making, so if you are having top-down scrutiny that seems to me to be against the spirit of CCGs.

Q138 Dr Davies: Or at a local level.

Sandra Gidley: There certainly should be more scrutiny. I must confess I have not really given any thought to how that is. I have attended the occasional AGM of a CCG—not very well attended. The public do not take an interest in it. Maybe as health professionals in an area we should take more interest and challenge, but by the time they have done the day job a lot of people do not have the time or energy to do that.

Q139 Dr Davies: I understand. It applies to other areas, of course; health and wellbeing boards have been talked about as possible vehicles or mechanisms for increased accountability.

Sandra Gidley: That would be useful. I would question whether all health and wellbeing boards have the depth of expertise and knowledge to do that. Some have, but the composition of health and wellbeing boards ranges from a very small number to a very large number, and again you have local variation. It depends on whether you are content to have services commissioned locally and end up with a mishmash or a postcode lottery, or whether you think there should be a little bit more of a design. Is the patchwork quilt completely random or is there a pattern to it?

Q140 Paula Sherriff: Professor Middleton, in a previous life I managed a primary care musculoskeletal service. The debate around self-referral has been going on for many years and I find it really interesting. You alluded to many of my questions earlier in this session, but there are a couple of areas that I would like to ask you about. How has the feedback from the actual physiotherapists themselves been established? Has some survey been undertaken in terms of the appropriateness of those presenting?

Professor Middleton: The appropriateness of the patients presenting?

Paula Sherriff: Yes.

Professor Middleton: Yes. A number of the pilot schemes that were looked at by the Department of Health and the vanguards looked at the appropriateness of the referrals to physiotherapy depending on whether the person self-refers or is referred by a GP. If I go back to the Keele University example, they have shown that, of those that are referred to physiotherapy by a GP in the two practices where the GP was still referring, about 6% were deemed inappropriate by the physiotherapist, whereas the two practices—

Q141 Paula Sherriff: Was it as low as that?

Professor Middleton: Yes. It is improving all the time, which is good. However, with patients who self-refer, only 4% are inappropriate referrals. Again, that is busting the myth that if you open up access, if you improve access to physiotherapy and musculoskeletal care, suddenly all these patients are going to come out of the woodwork and start referring themselves for treatment. In terms of physiotherapists themselves and their approach to opening up access and how they feel about it, as long as there are sufficient physiotherapists to meet the demand, it is like "mañana" because that is what we are trained to do. There is nothing more frustrating than not being able to work to your full competence and capacity, and certainly personally when I was practising clinically in the early 1990s I got that fulfilment working in private practice but during the day it would be limited working in the NHS because I was unable to take self-referrals. Of course, the other thing that is more rewarding as a physiotherapist and also great news for the patient is that, because you tend to be seeing them earlier, the patient has not had to go to the GP.

Q142 Paula Sherriff: That was my next question. It was about whether there is evidence to support a better prognosis, given the fact that the patient has not had to wait for a GP appointment.

Professor Middleton: The outcomes are better as a result of the condition not becoming chronic. You are removing a hurdle really. The other thing is that the outcomes also show that there is less prescribing as a result and fewer tests ordered. The other thing that Steve Boorman showed and which is now being looked at extensively within the NHS for NHS staff is that people who self-refer are less likely to be off sick and they get back to work quicker. That is a significant contribution when you think of the demands on productivity that we want to see in UK plc. It is really important. It is very rewarding for physiotherapists as they are working to the maximum of their capability, it is good for patients, it saves money and it frees up time for the GP. In the vanguard that I talked about in south Hampshire, it has been so successful that they are now looking at extending the appointment time that GPs have available to them. Because that workload is being taken off them, they are now looking at extending their appointment time from 10 minutes up to 20 minutes. It is a proposal, but it is freeing up so much of their time to see the patients that really only they can see.

Q143 Paula Sherriff: Can you tell us briefly how the facility of patients being allowed to self-refer was communicated throughout the community where these pilots were initiated?

Professor Middleton: It has been done in a variety of ways. In the Keele University randomised controlled trial, as I say, for the patient population for the two practices that switched to self-referral something was sent through the post. I have never encountered an example like that before. What tends to happen is that it is publicised in the general practice and what you see is often a shift from the GP referring to physiotherapy to GP-suggested or receptionist-suggested. Often you ring up for an appointment and the receptionist will ask what the problem is. If you say it is an MSK issue, a back or neck problem, they will often suggest, "Why don't you go straight to the physiotherapist?" It tends to happen in a sort of evolutionary way, but different practices have communicated it in different ways.

Q144 Paula Sherriff: Thank you. May I turn to Ms Gidley? You described an urgent need for effective medicine management and optimisation in care homes. Are the NHS England enhanced health in care homes vanguards making progress in this area, and, if not, how do you go about achieving some progress?

Sandra Gidley: I cannot speak on the vanguards because we have not had feedback from them yet, but there have been a number of pilots, if you like, working in care homes, which effectively, particularly in homes with dementia specialists, looked at what is being prescribed, and consulted with patients and with family about the range of medication. The consequence has been fewer medicines prescribed and very positive outcomes, because the patients involved were getting fewer side-effects from their medicines and there was a significant cost saving. At the moment we have a very patchy situation, whereby there may not even be a pharmacist going into a care home on a regular basis. Some care homes do not have consistent GP cover. A home opened in my location and no surgery would take it on because it was a complex workload, so three surgeries divided it between them. That is not the best patient care. It seems to me that any care home or residential home should have the benefit of one practice of GPs and also a named pharmacist, because by reviewing the medicines that are prescribed and assuring proper administration there are savings to be had. I think we put something in the submission and I cannot remember the figures off the top of my head, but if that was replicated around the country it would be a significant amount of money.

This is not about care homes, but there are a lot of patients who are at home, housebound, who benefit from services that community pharmacies provide. They send out their medicines; patients ring up and reorder what they need. The problem in some areas of the country is that those patients never benefit from a medicines use review or a medicines review, so there is a whole population that we could be serving much better. They could probably benefit from a similar service—having a review and potentially a reduction in the medicines prescribed. The savings are nearly all to the drugs budget, but as that always comes under scrutiny this seems to be an appropriate use of that. The evidence we have so far is very encouraging, and I suspect that the vanguards will show equally encouraging results.

Chair: Thank you very much for coming this morning.

Examination of Witnesses

Witnesses: **Professor Chris Ham**, Chief Executive, The King's Fund, and **Candace Imison**, Director of Healthcare Systems, the Nuffield Trust, gave evidence.

Q145 Chair: Thank you very much for coming this morning and for your patience. I am sorry we overran slightly earlier on. Could I ask you to start by introducing yourselves?

Candace Imison: I am Candace Imison. I am director of policy at the Nuffield Trust.

Professor Ham: I am Chris Ham, chief executive of the King's Fund.

Chair: Thank you very much.

Q146 Mr Bradshaw: Professor Ham, first thank you very much for your briefing—commendably clear and succinct. You sum up the challenges facing primary care as ones of investment and reform. It sounds familiar. What reform are you talking about?

Professor Ham: Reform is probably more important than investment because, given the big challenges in primary care, it cannot just be more of the same—more money, more doctors, more nurses—partly because there are not people out there to recruit into general practice. On reform particularly we would argue for more development of what we are already seeing around federations and networks of practices being established in different parts of England. Patients still look to their practice to receive their care, but practices are collaborating across bigger footprints, sharing more of the workload and the responsibility, providing access at more convenient times for patients—because they do not have to do it individually—and providing a platform on which you can then deliver a much wider range of out-of-hospital services. Our argument in a paper we published last year at the Fund was for what we called family care networks. It is another way of describing federations, not just of general practices, but general practices working hand in hand with community nurses, social care and out-of-hours services to provide a much wider range of care led by general practice.

Q147 Mr Bradshaw: What are the current obstacles to achieving that vision?

Professor Ham: The main one, we would say, is the way in which we commission, contract for and fund general practices. In our paper we argued that there should be an option for a voluntary contract. The recent dispute around junior doctors is a clear warning about forcing a new contract on any group of healthcare professionals. We think for federations, not just practices, that have an interest in delivering a wider range of services in that way there should be an option for them to be commissioned by NHS England and CCGs together to do precisely that, and to be funded in a different way, beyond the current GP contract, to provide the resources and the contracting mechanisms to build on what already exists. The exciting thing from our point of view is that GPs themselves are taking the initiative. About a third or 40% of the country is already covered by federations of GPs set up by GPs, not because they have been told to do it by NHS England or anybody else but because GPs see that as the future.

Q148 Mr Bradshaw: But if it is going to be voluntary—we are all aware of the challenges in renegotiating contracts with medical professionals—how is that going to work universally? How can you be sure that that is a system that can be implemented universally?

Professor Ham: By definition, it will not happen universally. If it is a voluntary option for GPs who have the interest and the capabilities, it will start in places where there is that interest. We believe that, once it gains some traction and other practices in different parts of the country see what can be achieved, they will want to become part of it too. It is nudging people in that direction rather than mandating them to do it.

Q149 Mr Bradshaw: What about the challenge in rural areas?

Professor Ham: The challenge is in rural areas, but if you look at the federations we already have they are not confined to the big conurbations.

Q150 Mr Bradshaw: Finally, do you think that the GP's status as a private contractor is sustainable for the long term?

Professor Ham: Yes. I think we are seeing already, though, greater variety in the contracting arrangements and the employment status of GPs. Quite a high proportion of GPs now have chosen to become salaried GPs, or there has not been the option of them becoming partners and continuing with the model that we all know and understand. That variety will continue to be the case in future, but there is no reason, it seems to me, why the changes we would like to see around family care networks cannot be delivered through the independent contractor model.

Q151 Mr Bradshaw: Candace, do you want to add anything to any of that?

Candace Imison: I want to underline something that I do not feel has necessarily come through in the discussions you have had hitherto as a Committee: what Chris described sounds in a way quite easy—maybe it doesn't to you—but actually the scale of change that is required within general practice in terms not only of how GPs work but, exactly as the conversation came out earlier, how they work with other professionals, is very significant. We want and need general practice to do things it has not historically done, so there is a need to think very strongly about population health management, proactively manage chronic disease, support people to do self-care and relate very differently to patients and local communities. Those are all things that move general practice away from its traditional model, and that is going to require significant investment and change. As Chris said, the federated model is a really crucial step to facilitating that. But it is a facilitation to do something very different. It is not just scale for the sake of it.

Q152 Chair: Thank you. It is interesting, to return to your point, Chris, that it is not just about investment; the key is reform. You have often yourself spoken in the past about the need to front-load some of the money from the £8 billion coming through for the NHS in order to create this transformation and to create the headspace for change. Given that the spending review is just around the corner, could you set out your thoughts about how much we need to see invested in the NHS and what the consequences are for these kinds of reforms if that is not available?

Professor Ham: I can best refer to what both Simon Stevens and Stephen Dorrell said yesterday about the importance of the spending review and the announcements on 25 November. It is a really welcome commitment the Government have made to further investment—£8 billion by the end of the Parliament. We do not yet know how quickly that

will come in. I think Simon Stevens echoed what many of us have been arguing: it needs to come in soon, not later, because the current financial problems will get worse if that money does not arrive next year. If there is a delay in the injection of the funding, I think the Government have to be honest with the public about the consequences for patient care. There have been welcome commitments around seven-day working and improved access, both in primary care and secondary care. We would all like to see that, but they come with a price tag attached and that £8 billion is needed to keep existing services running. It will not be sufficient to fund some of the new commitments that have been made. They are really important and welcome commitments—let me be clear about that—but if we want improved access in hospitals at weekends and if we want seven-day access to GPs, we need to provide both the money and the staff to deliver that. Front-loading is essential, and we would also say so is protection for social care, because of the close relationship between health and social care, which I think was Stephen Dorrell's key point yesterday, and some pump-priming. We have done some work with colleagues at the Health Foundation making the case for a transformation fund over and above the money we need to put into the NHS to keep existing services going. That would help to promote more of the vanguards and the innovations in care we are seeing in different parts of the country, including perhaps this idea of family care networks.

Q153 Chair: Over the years we have heard so much talk about the need to put more funding back into primary care, but, if anything, we are continuing to shift in the other direction. What proportion of that £8 billion do you think the Government absolutely have to insist comes into primary care in order to create some of this change?

Professor Ham: Can I answer it in a slightly different way, if I may, Chair? Rather than say what proportion of the £8 billion it is, we need to restore the share of the NHS budget going into primary care as it was four or five years ago, because there has been, as we know, a steady decline in the priority and the resources attached to primary care as more money has gone into hospital care, also for good reason. From memory—Candace may correct me on this—it was about 12% of the budget going into primary care, and it has come down to 9% or 10%. We need to go back to the figures as they were in about 2010.

Q154 Chair: Thank you. In terms of the capitated payment systems being successful, could you talk a little more about that, and how we can move more towards that system?

Professor Ham: In arguing for family care networks we said that they require a different contract, a different way of commissioning and paying for primary care leading extended out-of-hospital care. We suggested that is best done through a capitated budget, which would be negotiated between NHS England working with CCGs and federations and networks of practices, or in some cases the super-partnerships we are seeing begin to emerge in cities like Birmingham, and there would be a negotiation about how big that budget should be, reflecting the range of services that would be taken on by those federations in collaboration with the other out-of-hospital services. There would not be a single national approach. We believe there needs to be some flexibility. A lot would depend on how capable the federations are, and, to echo what Candace said earlier, there are big challenges in making a reality of a very different way of working in primary care. Some of the federations are very new, embryonic organisations that are not yet in a position to lead in the development of this new model of care. Others are quite well

established, and we would be confident they had the wherewithal to do it. It needs to be a bit horses for courses within a national framework.

Q155 Chair: In other words, just empower it where people are ready to move to that model.

Professor Ham: Yes.

Q156 Chair: Thank you. Candace, is there anything you want to add?

Candace Imison: I would certainly underline leadership capacity within primary care—I know you have picked up questions previously—and certainly the leadership capacity within the emerging federations requires support in order for them to have the potential that we want them to have. I would like to go back to the funding issue, because we must be under no illusion—that £8 billion is going to leave extraordinary challenges within the NHS. Previous people have talked about it as if it was an extra sum, and, as you will know better than most, it is actually £22 billion less than the NHS needs to meet future demand. I would absolutely echo the point that Chris made about rebalancing back to primary care. In the Nuffield Trust's submission about financing for primary care in the future we cited a piece of work that had been done in NHS London, which said that, if you are going to get this new model of primary care, you need in the order of 2% to 5% of the NHS budget extra to go into primary care, which would exactly mirror what Chris has just been describing.

Chair: Thank you.

Q157 Andrea Jenkyns: I am trying to get an understanding of how long, realistically, it will take to develop the new team envisaged by the Primary Care Workforce Commission. What timeframe should we attach to the development of the new team?

Candace Imison: Goodness. The first point I would make, and I think it came out very clearly from the previous submissions, is that everyone is starting from a very different place. There are elements of good practice in all places. As you know, I sat on the Primary Care Workforce Commission, and when we looked at examples around the country there was no one place that had everything. Everyone had something. Chris famously cited others who have talked about the future; it is just unevenly distributed. That is exactly what we would observe. Depending on your starting point, your rate of progress to your end point is going to vary. The vanguards are going to be a helpful vehicle for, hopefully, accelerating some of that development. That will teach us something about the way in which people can develop. If you think about a place like Whitstable, which has been developing a broader range of primary care services now for, what, five to 10 years—

Professor Ham: Yes.

Candace Imison: They will really be able to give us a vision of what the future might look like relatively rapidly, I would say. They are using paramedics to assess patients in the community. They have extended roles for nurses. They have relationships with specialists coming into the practice. They have many of the things that we would want to see in the future of general practice. In other areas, particular professions have been brought in. One of the places we cited in the Primary Care Workforce Commission was the Old School in

Bristol where they had made use of the pharmacist that you talked about earlier. That pharmacist was not only improving pharmacy practice and improving long-term conditions management, but actually— something that has not come out of the discussion today—they were driving forward the improvement programme within the practice as a whole. The pharmacist was acting as the lead to help the practice think about itself and how it met the needs of its population, and driving an ongoing set of improvements. The practice was then starting to think about other roles that it would incorporate in its team. That, it seems to me, is a really critical element.

Q158 Andrea Jenkyns: I understand that we are coming from different starting places, depending on the GP practice, but you have to start with the end in mind really.

Candace Imison: Absolutely.

Q159 Andrea Jenkyns: How long is a piece of string? You must have an end goal in your mind. Realistically, is it going to take five years or 10 years to develop this new primary care team?

Professor Ham: Can I come at it in a slightly contrary way? I do not think we are moving from stable state A to stable state B. We are moving from unstable state A to unstable state B, and then to somewhere else in future. It is a very dynamic environment out there. Just to add one point, in the discussion earlier with the previous witnesses one bit that was really missing—Karen Middleton mentioned it once—was not just the role of the healthcare professionals in the team but the role of patients in the team. A wise man—it was a man—said to me about 10 years ago that the most important members of the primary care team are not doctors, nurses, pharmacists and therapists but the people receiving the care, particularly in an age when chronic medical conditions represent a huge proportion of the workload presenting in general practice. We all know from our own experience, and from friends and relatives, that there is so much we can do to remain in good health by taking our medications and adopting healthy lifestyles. Frankly, we have not given enough attention, in my view, to what we need to do to support people to be more confident in managing their own health and wellbeing.

Q160 Andrea Jenkyns: What policy measures are required in the short term, would you suggest, to alleviate the challenges facing primary care, particularly in the case of general practice?

Candace Imison: Goodness me. If you are thinking about underpinning GPs with that broader range of healthcare professionals, one thing that I have been really struck by is the fact that at the moment we do not have a consistent approach to defining those roles and explaining what competencies sit underneath them. I know it is something that HEE are thinking about, but it is absolutely critical, it seems to me, that we are clear about what these roles are and what competencies they equate to. Certainly, if you think about practices trying to develop these roles for themselves, having that clarity would be incredibly important.

Professor Ham: Can I add one thing? Going back to the idea of a new voluntary contract, the Prime Minister spoke about it—I think just before the Conservative party conference—and Alistair Burt, the care and support Minister, has reiterated that it is very

much part of the Government's thinking. To put it on the table and to be very concrete about what it might look like and how it might work with the emerging federations would be a very big and welcome step forward.

Q161 Andrea Jenkyns: Health Education England is confident that by 2020 there will be equal supply and demand of nurses in England. Do you share that confidence?

Candace Imison: There are significant threats to the supply of nursing and they come from a number of places. There are particular threats within primary and community care because of the age profile of that nursing workforce, and because it is not traditionally a preferred career pathway for nursing. The points that were made about increasing exposure to primary care for nurses in training are incredibly important. But there are significant threats from the international migration of healthcare workers, not only to nurses but to doctors too. We have underpinned our nursing workforce—traditionally—from international sources, and as things change internationally people who have come here may well go back again. That argues for an active policy to oversupply nurses, not to try to land the jumbo jet on a pin, which is traditionally what we have tried to do in workforce planning and inevitably come unstuck.

Professor Ham: If there is equilibrium in demand and supply, it will be the first time in the history of the NHS.

Q162 Andrea Jenkyns: Good answer. Moving on to pharmacists, should the surplus of trained pharmacists be harnessed by directing patients towards community pharmacy or attempting to create roles for pharmacists within the GP teams?

Candace Imison: I think it is a "both and". There clearly are big opportunities within community pharmacy for pharmacists to undertake medication reviews and support people with long-term conditions. What was very interesting in the Old School surgery that we visited as the Primary Care Workforce Commission was that they had "both and". They had the pharmacist who was the partner in the practice but they also had a community pharmacy sitting within the practice itself. Interestingly, one of the real facilitators of the potency of that community pharmacy was them having access to the summary care record and therefore understanding the conditions that somebody was coming to them with. Again, it may not have featured as much as it might in your discussions, but the role that IT is going to play is really key, in terms of facilitating people both within the practice to work in a multidisciplinary way but, crucially, to get the links into secondary care, which is another important part of the piece for primary care going forward, and indeed into community pharmacy.

Professor Ham: I cannot improve on that answer.

Q163 Andrea Jenkyns: Do you think it is realistic to expect pharmacists to take on a greater share of the primary care workload and, in the short term, possibly to relieve the burden on general practice?

Candace Imison: I think it is highly realistic. What really struck me were the significant benefits this brings. It is not just about substituting for GPs. It is actually bringing a whole new skill set to play within primary care, which has huge benefits for patients as well as professionals. You got the same message, I think, from Karen when she was describing the

opportunities around physiotherapy. There are some real win-wins with these extended roles.

Professor Ham: Especially around the challenges of polypharmacy. That was referenced earlier too—the medication reviews that pharmacists are particularly well placed to undertake. I think somebody said that about an hour a day of a typical GP's time is spent on those issues. That is a lot of time for patient consultations and using the skills of GPs to best advantage.

Q164 Helen Whately: You were talking about the cost side, the investment and the impact, and I want to pick up some questions on that. One of the things you mentioned, and it was mentioned last week as well, was the shift in spend from acute to primary and the need to go back to where it was, at the 12% kind of level, from where it is now. Clearly, that translates into quite large amounts of money, be it in the £2 billion, £4 billion to £6 billion range, when you are talking about something like a 2%, 3% or 4% shift, depending on where you see the starting point. I have seen different numbers, so I am not being specific, but given that they are quite large amounts of money, do you have a view on what aspects of primary care they should go into? What is a good model by which the money should be distributed—change of payment models? What impact on patients will that increase and shift in spending have, and will we be able to say what difference it has made compared with where we are now?

Professor Ham: Part of it for me here is something that we have not mentioned in this session, which is recognising the impact of the funding pressures in primary care on GPs and members of the primary care team. In the evidence that Martin Roland gave to you last week, I observed he said that, in the survey the University of Manchester does, the most recent results this summer show the highest level of reported workload stress among GPs in the many years this survey has been undertaken. I certainly recognise that from the discussions we have with GPs. It is the ageing population, the more complex presentations that GPs receive from that ageing population and the difficulty of providing the care that GPs, nurses and others want to provide in the treadmill of the 10-minute consultation. The resource, I think, ought to help particularly in addressing that set of issues. The challenge is that we are not going to magic up 5,000 more GPs and 500 more physios every year, given the time it takes to train them. That is why I go back to this having to be about reform and doing things differently in the workforce—not just more.

What does that mean? In discussions among GPs, should GPs become much more consultants in primary care—consultants to the nurses, the pharmacists and the other members of the team—because if they are increasingly a scarce resource perhaps we expect them to do too many things in that team, and we should focus on what their particular skills, training and expertise can offer? That is already happening in some parts of the country. Going back to a previous point, we ought to do much more to support patients and people, to take more responsibility and provide them with the skills and the training to do that for their own health and wellbeing. It is about the workforce, because primary care, above all, is workforce-intensive.

Q165 Helen Whately: The impact is particularly on the sustainability of the model.

Candace Imison: There is a very quick win, which I think Martin cited to you, which is that if you brought in medical assistants to primary care—his calculation, which is in the report, was that it is the equivalent of about 1,400 GPs—those would be people whom you could very easily recruit.

Q166 Helen Whately: In this approach we try to learn from many international examples. From your experience of looking at those, are there any mistakes that we need to make sure we avoid, things we have to make sure we do not do?

Professor Ham: Generally—I am glad you have asked the question—we are lucky to have the system of general practice primary care that we have. In my work and the work we do at the Fund we have the privilege of visiting many other healthcare systems, and I would say that, eight times out of ten, people in those systems would give their eye-teeth to have our general practice primary care arrangement, warts and all, compared with the one they have. One of the common mistakes is around the payment model for GPs, and particularly those systems that persist with a fee-for-service payments system, which incentivises activity and contacts rather than continuity of care. Very often, it gets in the way of GPs delegating to other members of the team because they will only get paid when they personally see the patients. What incentive is there in that arrangement to build the team that I know you are looking at as part of this inquiry? Getting the payment model right is really important.

Q167 Helen Whately: Is it your view that it should be a capitation model rather than a fee-for-service model?

Professor Ham: Every country generally has a mixed-payment model rather than going for a purist fee for service, capitation, what have you, and we need to do the same. I would argue strongly for capitation as the foundation stone but also argue for linking payments to the quality of care that practices are able to deliver. Don't get me wrong: I am not talking about QOF here. I think QOF in its current form is past its sell-by date, so the model of family care networks operating within capitated budgets would have incentive payments linked to population health improvements because they would be covering much bigger footprints, rather than the narrower, clinically defined QOF incentive payments.

Candace Imison: I would totally underline that point but also add a note of caution. People can all too often see the payment mechanism being the solution, and the learning from ACOs and others in the US is that the outcomes are very variable and you need a whole load of things that sit behind the payment model to make it really have the impact that you want it to have. So be under no illusion: that is not a quick fix in terms of solving things.

Professor Ham: Occasionally there is a debate, is there not, about whether we need to migrate away from GPs as gatekeepers and have more open access to specialists? My view is that we should not. Whatever the disadvantages of our current primary care system, there are clear benefits in having that relationship between people and their families and their practice, seeing GPs and the teams as the first point of contact, and making sure there is much better communication between what happens in the primary care teams and what happens in the specialist teams in the hospital. I do not know if you want to go in this

direction, but we would certainly argue for much greater collaboration between specialist teams and primary care teams of the kind that you see happening in some places.

Candace Imison: I would really underline that point. That is a huge opportunity and is important. While people absolutely celebrate the quality and the focus on a registered population of primary care in this country, they find the division that we have between primary care doctors and secondary care doctors very confusing, and patients suffer as a consequence of that division. We really have to bridge that gap. It is very welcome that the vanguards are experimenting with models that do that, but it is utterly critical, and both the Fund and the Nuffield Trust have really pushed that this is a divide we have to get across.

Q168 Emma Reynolds: What is the barrier to that working?

Candace Imison: There are many. Some of you practising GPs will probably be able to tell me more eloquently than I could tell you, but going back to some of the payment models for informal interactions between GPs and secondary care has not helped. Putting people in these very clearly distinct geographic areas has not helped either. But there are emerging models of really good collaboration between secondary and primary care, and, as I said, this is where new technology will come into its own. Email consultations and teleconsultations will all enable a much stronger working relationship.

Professor Ham: History is important, is it not? Roy Porter, the pre-eminent medical historian, talked about the division in British medicine that happened 150-odd years ago: specialists got the hospitals and GPs got the patients. That is a divide that you do not see in all other healthcare systems. In the best integrated systems that you see outside this country you have co-location of some specialists with family doctors; you have much more of a multi-specialty model of medical practice where you turn up and, down the corridor, if you have a problem, you can go and see the dermatologist or the orthopaedic surgeon, and there is that ease of communication and contact that we can only envy. We cannot do that everywhere in that sort of way.

History is a big barrier, but people are overcoming this. Eileen Burns, a geriatrician in Leeds, is working across hospital and the community. There is a good paediatric service in west London that is doing something similar around children's health. There are good examples in diabetes care. Partha Kar, who is a diebetologist down in Portsmouth, works across hospital and the community. This is not a kind of drag-and-drop model where you simply shift outpatient clinics from hospital into the community. It is a model where the specialist teams support the primary care teams to do much more of the routine work, and only the patients with more complex needs get referred into the hospital where there are those expert facilities in diagnosis and treatment that you need for that cohort of patients. But surely these are the models of the future of which we need to see much more.

Candace Imison: Yes, and the job plans of consultants in hospitals change so that they have dedicated sessions to supporting primary care. They genuinely become a consultant to primary care, as it were, rather than to patients.

Q169 Helen Whately: I would like to pick up on the "GP as gatekeeper" point that you made. I heard you emphasising that that should broadly stay, although there is an argument for a shift from having the individual GP as a gatekeeper to the future world where

you have much more multidisciplinary working. Will it shift from being a GP to a more multidisciplinary team that somehow acts as a gatekeeper?

Professor Ham: Yes, which I think it often is these days in those practices that are working as they are in Whitstable or Bromley-by-Bow, which would be another favourite example I have, where you have a much more innovative holistic approach to primary care through Sam Everington. So yes is the answer.

Q170 Chair: We have heard some really clear examples of excellent practice, but listening to the State of Care report and Steve Field's comments on it afterwards commenting that the "poor" is very, very poor in a general practice, how can all of these models do more to reach out to failing practices to bring them up? What are the key drivers that are going to make that happen?

Professor Ham: This is why we need federations and networks. In a different context, Mid Staffs, as Robert Francis said, was an isolated hospital where progress had passed it by; it was not benefiting from the opportunity to collaborate with other specialist services. Much the same applies in primary care where we have poor standards because we still have this outmoded corner-shop, cottage-industry model of general practice, which has served us pretty well until recently but is not fit for purpose in future. If we can get practices to come together much more in federations and networks, we are breaking down that isolation.

Q171 Chair: One problem, though, with that—and I know this myself having been in practice—is that practices generally are not keen to take on a failing practice. It is much easier to federate with other practices that want to take on change and be progressive than it is to take on a practice where nobody wants change or where there may be other difficulties within relationships within a practice. What are the things that are going to encourage federations to scoop up failing practices?

Professor Ham: It is partly what you are saying about the reluctance, but also can I give a different example that might help on this? When Candace and I, and others, talk about challenging poor standards of primary care, we keep on going back to what happened in Tower Hamlets about 10 years ago. The PCT, if we can remember PCTs before we had whatever they are today, had a man called Doug Russell, a medical director, a GP by background, who originally worked in Wales and came to Tower Hamlets. He was shocked at the time—and he has spoken about this publicly—about the appalling standards of primary care and the variability: some of the very best, like Bromley-by-Bow, and some simply unacceptable. He found the levers and the courage to challenge those poor standards, with support from local GP leaders in Tower Hamlets, as the medical director, not himself a practising GP but responsible for quality and the planning of GP services. My belief is that, if we encourage federations and family care networks, they will see the benefit in recruiting people like Doug Russell and working with the practices to achieve those much more consistent standards of care that we all would like to see.

Q172 Chair: Currently, are the levers held by bodies like the CQC, who go in to a failing practice and say, "This is unacceptable. You must federate"? Who makes that happen? Is it that they close the practice down because it is unacceptable and somebody else takes over?

Professor Ham: NHS England has the formal responsibility, but, increasingly, as we know, it delegates responsibility to CCGs where there is an interest in co-commissioning of primary care. The problem has been that NHS England itself, frankly, has not always had the capability or the understanding of quality in primary care.

Q173 Chair: Whereas local organisations do know who the failing practices are.
Professor Ham: Exactly.

Q174 Chair: What levers will they currently have? I am sorry to press you on this, but I want to know where are the levers now to force change on underperforming practices to make sure that they come in and come up to standard?
Professor Ham: The main levers are with the CQC on the individual practices and the quality of care they deliver through Steve Field and his teams, and greater transparency around outcomes of care and performance, but there ought also to be levers through CCGs as they take on more co-commissioning responsibility; and the levers are the same as the levers that Doug Russell used 10 years ago. But you need people with the courage and the understanding of primary care to be able to go in and do it at a CCG level. This is probably a topic for another day, but our current distribution of scarce commissioning expertise around 200-plus CCGs does not seem like the right model for the future.

Candace Imison: When I have spoken to leaders of some of the more advanced federations, they are very motivated by the population health picture and it disturbs them greatly to see some of their colleagues not supporting that and some patients in their area not getting an equivalent quality of care. Principia went in and challenged individual practices to improve and meet the standards of others. I do see those GP leaders as prepared to take on that task, and I suppose it then underlines again the importance of developing and supporting those leaders in a federated model and, crucially, supporting succession planning for them too, which is something that we traditionally do not do nearly enough of in the NHS.

Chair: Thank you.

Q175 Julie Cooper: Carrying on with the theme of consistency across the country in good practice and trying to address that, recognising that GPs everywhere are under pressure, as to the teams that have been developed in primary care, Professor Roland said there are no tight boundaries. In your opinion, which specialist practitioner should be included in every primary care team?
Professor Ham: That is a good question.

Candace Imison: I would echo Martin's point that you do not necessarily have to be a core part of the team. The key is to have the linkages across to others. It would seem to me that it is absolutely essential that you have the nursing roles in their various guises and you have the underpinning administrative support. Pharmacy is a critical component of it, and then the challenge is to have the appropriate linkages to the other specialties that need to support it. I would pick out geriatrics, child health and psychiatry as being the three core areas, and then, crucially, the specialists for the other specialist input. But, again, something that maybe has not come out of the discussions as much as it might and that has

really struck me is that we do have a significant issue within general practice as a consequence of the way that GPs have historically been trained, which has not always equipped GPs with the skills that they need to manage the workload that they face. Hilary Cass will speak very potently about how many GPs got their paediatric training through working on a neonatal intensive care unit, but they face a huge body of children coming through their practice and need broader skills to manage those. We know that a huge proportion of our patients, and certainly the most needy patients, have psychiatric disorders and mental health problems, and those are all skills that general practice has not traditionally had as a core part of its training.

Q176 Julie Cooper: Would we agree then that some of the patients coming through the door have additional needs in terms of—I suppose what might be described as—social needs rather than medical needs, and therefore would you think it appropriate to have someone within the team that assists with social prescribing, or is that going beyond a boundary that GPs should not? Is that a separate service? Should it be separate or should it be an incorporated part of the team?

Professor Ham: It could be either, could it not? That is what Sam Everington and colleagues do in the Bromley-by-Bow Centre. They provide advice on claiming benefits, on housing, on a very wide range of issues that in their community are probably more important than the clinical advice they get within the centre itself. So it works there. I am just thinking about some of the smaller practices and some of the rural practices too that might find it more difficult to offer that wider range of expertise, but with the technology available today there must be creative ways of providing access, if not in person, remotely.

Q177 Julie Cooper: We have come across that a lot today, people citing—you and other witnesses—good practice in different areas, and you are mentioning now, geographically, this happens here and that happens there. How do we make sure there is a consistency across the country? How do we stop people falling through the gaps where, for different reasons, different good practice develops? How do we make sure that this is very best practice, and, therefore, that is why I come back to the core team that would be a requirement perhaps of every primary care team?

Professor Ham: I would not want to argue for uniformity.

Q178 Julie Cooper: You would not.

Professor Ham: No. In general practice, a degree of variety and innovation in different parts of the country is something we should welcome and encourage. The concern I would have is the one that Sarah raised earlier: the unacceptable and poor standards of primary care that still exist in a proportion of practices that Steve Field has spoken about. We need to tackle that and get everybody up to a basic minimum. Over and above that, for me, we will only see what works and where the future models are if practices have quite a lot of local flexibility to do what we see in Whitstable, Bromley-by-Bow and other places that we have been talking about.

Q179 Julie Cooper: Thank you. I have one final point. Do you see there being any role whatsoever for volunteers in terms of support with social issues? In some areas I think that has been piloted. Do you think that is a possible way forward?

Candace Imison: It is not an area I know a lot about. I have experience of it in a secondary care context where volunteers are an increasingly important part of how many trusts are operating. The huge advantage of volunteers is that they can facilitate the engagement of patients and act as an advocate for patients—that patient voice that Chris was underlining. It was striking to me when I was a non-executive director in a trust that had volunteers that our dining companions in that trust were the people who ensured that the food was changed, because they saw it as totally unacceptable. They will argue for things in a way that patients will not. For me, that is one of the big pluses of volunteers, but there is a whole range of issues that runs alongside that. As Chris said, it is a whole subject in itself.

Q180 Julie Cooper: It is a can of worms, is it not?

Professor Ham: We are going to do some work asking what we know about the current use of volunteers in general practice next year, because, to my knowledge, there has not been any serious work on that topic, whereas there has when it comes to hospital care.

Julie Cooper: That is an area to be explored further. Thank you very much.

Q181 Chair: Does anyone have any further points that they would like to ask? Can I ask you both before you leave, and from the work of both the King's Fund and the Nuffield Trust, are there areas we have not touched on so far during this inquiry and in our previous session that you feel we should be exploring in more detail or you would like to tell us about?

Candace Imison: One point—and it may seem like a very tiny one—which may have come up slightly in your first session, is the role of indemnity insurance. At the Nuffield Trust we run a learning network for some of these larger federated practices, and a number of them have fed back that it is a big obstacle to recruiting these extended roles. The MDU likewise has said it is a big challenge for them particularly, and it goes back to the point I was making earlier about needing clarity about what these roles are and the competencies that run alongside them. Because there is general confusion out there, there is not a clear framework for the MDU to link into around offering insurance, as I understand it, and it can be large sums of money that practices are facing as an obstacle. I would urge you to have a look at that.

Professor Ham: I have two quick points, if I may. One is that we have not talked in this session about the role of technology as a mechanism of reform and changing access, and the relationship between patients and primary care teams. We know there is some interesting work in some parts of the country. To use a different example, the Hurley Group in south London is an innovator in the use of technology to help patients access information and to facilitate email and other contact between patients and GPs. It is an issue that has been widely debated, but particularly in primary care there is huge potential there if we can get it right, and we are making some progress. There has always been the functionality within the main GP information systems for patients to email their doctors, but it is just that very often it has not been used, and I think there is more encouraging evidence that it is being used. That is one theme.

The other thing—again, you may have touched on this in previous sessions—is the challenge of GPs coming towards the end of their careers and the worrying evidence about more of them retiring early and then not coming back. We know that they often have retired in their late 50s or early 60s, but, historically, they have chosen to come back having taken their pensions and work on a part-time basis. Anecdotally, it seems that is happening much less frequently now. So we are losing a lot of really experienced doctors for a variety of reasons. I think it is partly, again, the workload pressures and the stress, and partly to do with wider changes in pension arrangements that are impacting on people across public and private sectors. But we need to find creative ways of stemming the outflow because the loss of all that experience of people who still have a lot to give is a real worry.

Q182 Chair: Again, I have been hearing some reports that it is professional indemnity insurance that is also a deterrent for people coming back part time towards the end of their career. Is that something that you have heard?

Professor Ham: I have not heard that specifically in relation to general practice. I know it is an issue for other professions, but if that is a concern then absolutely.

Chair: Thank you both for coming today. We appreciate your evidence.