



Health Committee

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

Tuesday 12 January 2016

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Written evidence from witnesses:

- [Rt Hon Alistair Burt MP, Minister of State for Community and Social Care](#)

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

Questions 357-440

Witnesses: **Rt Hon Alistair Burt MP**, Minister of State for Community and Social Care, Department of Health, **Ben Dyson CBE**, Director, NHS Group, Department of Health, **Rosamond Roughton**, National Director of Commissioning Development, NHS England, and **Ian Dodge**, National Director of Commissioning Strategy, NHS England, gave evidence.

Q357 Chair: Good afternoon. Thank you very much for coming to this final session of our inquiry into primary care and welcome to you, Minister, Alistair Burt. You are very familiar to everybody, but can the other members of the panel introduce themselves to those following this debate from outside the room, perhaps starting with you, Mr Dyson?

Ben Dyson: Thank you. My name is Ben Dyson. I am the director for the NHS group in the Department of Health.

Ian Dodge: I am Ian Dodge, the national director of commissioning strategy in NHS England.

Rosamond Roughton: I am Rosamond Roughton. I am the director of NHS commissioning in NHS England.

Q358 Chair: Thank you. Thank you as well, Minister, for your very helpful opening statement, which, because there are so many questions we would like to get to, if you do not mind, we have published on our website. We are keen to press on with a busy schedule of questions and clarifications if that is all right. Please do not think we are being rude.

Alistair Burt: That is perfectly all right.

Q359 Chair: Can I start initially by addressing the issue of seven-day services? I wonder, when resources are so tight in general practice, whether you have looked at the emerging evidence from the Prime Minister's challenge fund pilots at the uptake on Sunday mornings. In one area—for example, in Rushcliffe—there is an uptake of appointments as low as 29%. Could you set out what you have made of the accumulating evidence of relatively poor uptake on Sundays? Do you feel this is a good use of resources when there are so many other priorities for primary care?

Alistair Burt: Thank you very much for the question, for the opportunity to appear in front of you, and for the inquiry which you are doing. My overall impression of the pilots and the attempts to look at different ways of working in general practice in primary care is that there is no one particular part of it that needs to be focused on to say whether or not the whole experiment with different ways of working is a success or a failure. The truth about whether or not people are going to be interested in Sundays will emerge over time and it will be different in different places. There are places, certainly Greater Manchester, Bolton and Bury, where the Sunday has worked very well and people are using it. There are other places where it has not been of much interest. Frankly, I am not particularly bothered. The whole point is to say that general practice is changing.

Demand for access is very different from how it was in the past. Your evidence from the Patients Association and Healthwatch says right up front how important access is to people. The attempt that the Department and the Government have made over time to widen access and look at what that means in practice, whether it is extending hours during the week or the opportunity of having weekends, needs to be tested out. I am quite convinced from what I have seen that the widening of access is popular and successful. It is different in different places: in some places it is the extension of weekdays that is working better; in other places the weekend working is more popular. We will see and we will evaluate. As the Committee has found out—quite rightly, you have explored the notion of what seven-day working really means—seven-day working does not mean, and never did, that every surgery in the country will be open eight till eight, seven days a week: that myth has been dispelled. It means, over a network, where that is possible, if it is possible to arrange routine appointments at times that are convenient to members of the public who want to access them, it is worth looking at. We will evaluate in due course, but I am not surprised that take-up is different in different places. That is the whole purpose of running these pilots.

Q360 Chair: Is it not rather unfortunate, though, to use the phrase “I am not particularly bothered” when money is so tight? Can you clarify this? When you talk about evaluation, because we need to have evidence-based policy, if uptake is relatively poor on Sundays and continues to be, if that is not best value for money, at what point will you make a decision that there is not demand—if indeed what it shows is that there is not demand—for Sunday and therefore we are best to use that resource elsewhere?

Alistair Burt: The pilots have their own length of life. There are two waves, as you know, and they will come to an end in due course. As far as I am concerned, I would look at the evidence individually from each area and make a decision based upon that.

Q361 Chair: Could you envisage that you might have it available in some areas and not others if it is not good value for money?

Alistair Burt: If the pilots demonstrate that people's use of, say, a Sunday is different in one place from another, we do not want, as Dr Whitford was saying, doctors sitting in a surgery on a Sunday morning reading the papers. I do not see the point of that, but I do not think we have reached anything like the point where that can be considered. It is true that, if people are not used to a pattern of access, it takes time for that to become clear. That is not clear yet and it should be given a decent run.

Q362 Chair: You are going to give it time.

Alistair Burt: Exactly.

Q363 Chair: One thing we heard in evidence was that in some areas having this dual system operating is undermining the out-of-hours service provision, both financially in some cases but also in terms of staffing. There is not the capacity with current levels of staffing and it is not cost-effective to fund both in parallel. If you have evidence that out-of-hours provision is on the verge of collapsing, will you take action?

Alistair Burt: Of course we would, but we have no such evidence at this stage. As to the commissioning of out-of-hours services and of 111, the connection between the two, as you know, is now being looked at in areas where you can get that commissioning done collectively and jointly to make sure there is no duplication and no confusion over access to emergency care and all that. There is an opportunity to do just that. We have no evidence to suggest that it is causing a crisis in any particular place, but of course that would be important.

Q364 Chair: Are you not hearing the evidence that it is difficult to fund both in parallel?

Alistair Burt: I can understand that, as we experiment and get the opportunity to do this, there may be pressures in different places, but I have not been given any indication that any place is in crisis and cannot deliver this.

Chair: We were certainly hearing some concerns on that point.

Q365 Mr Bradshaw: Minister, you quite rightly talk about the importance of evidence and evaluation. What evaluation have the Government done into the impact of the current Health Secretary's predecessor's decision to abolish the 48-hour patient guarantee—the guarantee to patients of an appointment with a GP within 48 hours—the ability to book ahead an appointment at a time convenient to them, the widespread closure of the GP-led walk-in centres that your Government inherited that were open 12 hours a day, seven days a week, and the downgrading of the QOF incentives for extended opening that had incentivised GPs to offer appointments in the evening and at the weekends? What evaluation and assessment have you made about the impact of those decisions on patient access?

Alistair Burt: The general sense was that the 48-hour target did not work. People reported that it was a failure; it did not deliver.

Q366 Mr Bradshaw: What people? Who reported that?

Alistair Burt: We had complaints that patients could not book an appointment in advance, could not get through on the phone to make an appointment and the target was too blunt an instrument. That was the reason for making the change. What is being done now and through patient surveys and everything else is to try and evaluate whether there are new methods of making sure that people can get their appointments and get them on time.

I would like to say to the Committee, if I may, right at the outset that in my six months or so in office I have been very struck by the evidence that suggests that there is such variability in the system and very often outcomes depend on leadership, management and the way in which resource is handled. You will have heard evidence that the practices that are most in trouble, and often the practices where there are most organisational difficulties, are those that have become isolated, are not in contact with others and are not using new methods. The places where appointments are easier and access is better are where new opportunities have been taken to contact people, new technology has been used and the like, and there is better organisation. My sense is that that is the best way to proceed. I have been struck by trying to see how we can make sure that the practice in the best areas can become the best practice of all. That is what Professor Steve Field is seeking to do in using the CQC evidence and the support for struggling practices—and struggling can mean in an organisational as well as a clinical way—to get a better result.

Q367 Mr Bradshaw: Could you answer the question I asked about the impact of the abolition of those guarantees, the closure of GP-led walk-in centres and the QOF changes? You talk a lot about evidence and evaluation, but you do not seem to have done any proper evaluation. I recall all those initiatives having been highly successful when I was a Health Minister. They were very popular with patients and they were delivering improved GP access. If you have the evidence that they were failing, I would be grateful if you could send it to the Committee.

Chair: Yes. Perhaps you could send us a note on that in more detail.

Alistair Burt: I am happy to do that.

Q368 Chair: When you talk about the need to tackle variations, do you think those would have been greater priorities than having access for routine patients on a Sunday afternoon, for example?

Alistair Burt: Let me go back to what I said. To take one piece of this jigsaw in isolation and focus solely on that is not necessarily the right way to do it. I make the case that the general practice in primary care is changing. It is changing in a whole variety of ways. Patient expectation is different. The resources available to practitioners are different. The use of multidisciplinary skills in primary care is changing. All these are happening at the same time as demographics are changing, ageing is changing and all that. At the same time as this is going on, expectations of patients are different from how they were and access is very important. I am not sure you can isolate one from the other. When I said I was not bothered if one part of what we are trying is not as successful as something else, I meant I do not think I will evaluate the whole effort at vanguards, the pilot programme and extended hours on whether or not Sunday opening becomes the norm all over the country overnight. It will work in some areas and it will not work in others, but it does not invalidate the efforts we are making to increase access, extended hours and the like.

Q369 Chair: The point was about use of resources, whether you are confident, given resources are so tight, that this is the best use of resources. That is what goes to the heart of this issue.

Alistair Burt: I am confident at the moment to attempt to meet the challenge of patients' expectation of wider access, which comes through in every survey that we do, by saying "How can this work? How can this work across an extended area? Is this going to be the sort of thing that people are going to use?" It is well worth spending resource to test out whether that is correct or not. If it turns out that it is a complete waste of resource in particular areas, that is a material fact that I would take into consideration.

Q370 Chair: Can I get one further point? Can you give an indication of how long you are estimating that these evaluations will go on before you make that decision?

Alistair Burt: I cannot at present. We want to wait for both wave 1 and wave 2 to be finished.

Rosamond Roughton: We have quite a lot from the wave 1 evaluation and that has shown, as you say, that in parts of the country Sunday uptake is not the priority. We are looking at the scale that you have. Whereas you might have four times the number of slots available on an evening than you have on a Sunday, if that is where the demand is, we want to make sure that, at a local level, people are matching capacity to demand where the demand presents itself.

Chair: Thank you. I know that Dr Whitford wanted to come in and then I will come back to Mr Bradshaw.

Q371 Dr Whitford: You mentioned, Minister, that you did not think the issue of the funding for out-of-hours and these extended GP appointments was an issue, but what about the provision of doctors? Certainly what we heard when we were out on a visit—and we have heard in these evidence sessions—is that because Sunday is quite quiet, a relatively cushy session to do, to go and be run off your feet in an out-of-hours session is unattractive.

Alistair Burt: I have read that too and I understand that there is only a fixed pool of doctors that can be used. That is absolutely right. I can see the difficulty and I have read the evidence, but the question was whether or not this had provoked a crisis in a particular place, and I was not aware of that.

Rosamond Roughton: The issue about out-of-hours and extended access and making this happen across the country so that every patient benefits by 2020 is a key thing that we will be addressing. We started that in October this year by setting out integrated standards for commissioning of GP out-of-hours services and urgent care so that we reduce the overlap there. Now that we know what the funding settlement is for the NHS and we look at how we deliver weekend and evening access to general practice, we want to make sure that we have done so in a way that has delivered best value for money and taken out any duplication of GP out of hours. There is pressure in general practice at the moment in terms of the workforce. You can see signs of that everywhere and I am sure you have heard that in your inquiry. That is why this is about a five-year programme. Certainly, if we were to say overnight we were going to make this happen, there are not the GPs there to do it. We have also learned that to make this happen it is not just about GPs but the

wider workforce, the uptake of technology and working at scale. A key difference here is about how we support practices to work together to deliver a service over a bigger population than just to their individual patients in their practice.

Q372 Dr Whitford: Is the urgent patient who feels unwell, at whatever level of severity, not the priority over someone who thinks, “I will pop down and get that done on a Sunday rather than on a Tuesday evening”?

Alistair Burt: Yes, and I saw your line of questioning on this. Of course, the urgent patient needing treatment is a priority in any circumstances, but I do not think anyone is suggesting that in seeking to accommodate wider access you are putting at risk the urgent and emergency cases.

Dr Whitford: But that is the evidence we got when we were out on our visits in the north of England and certainly is the evidence that we have read—that people are finding it difficult to cover all the shifts because you now have two conflicting demands.

Chair: Unfortunately, there is a Division in the House so we are going to suspend the sitting for a short while and resume.

Sitting suspended for a Division in the House.

On resuming—

Chair: As we are quorate, we will start again. Apologies for the interruption. Because we have quite a lot to get through, I am going to ask that both Committee members’ questions and the responses are short and succinct, if that is possible. Dr Whitford.

Q373 Dr Whitford: We were talking about the difficulty of covering out of hours when there is, if you like, a cushier option available to a GP. I want to move on to using federations, which has been mentioned, so that it is not individual practices. Is it not thought that that is going to create even more confusion, with patients having to work out which practice it is this Saturday, where do they go and how do they get there, when what we read in articles is that people do not know where to start out of hours?

Alistair Burt: There are two things there. The first is the ease of contact and access to a service. The second is the provision of the service and how it is constructed in order to meet demand. The federations are there for a variety of reasons. It is to make sure that practices have available to them, as it were, a critical mass in areas where it is helpful to band together because they can roster, they can share, and they can make sure extended hours do not put too much burden on one rather than another. In places where they are coming together—and, from what I hear, places where they come together quite naturally because people want to work together—they have both that critical mass and the

leadership intent to make something work. By providing services over a wider area they can provide more services.

The second point is to make sure there is easy and good contact. It is a matter for individual practices to make sure that a number that somebody may call out of hours gets through from practice to practice to the people who are going to be available and able to do the job. No, it need not necessarily be a recipe for confusion, but it does need to be handled properly. The evidence that we have at the moment is that people involved in the federations want to make them work for the purpose they are there, to give people the chance to use the service.

Q374 Dr Whitford: How do you envisage providing continuity of care? What kind of access to a detailed shared record would they have if they are seeing a GP whom they have never met, in a building to which they have never been?

Alistair Burt: There are two things. First, the issue of continuity of care is one that is not solely confined to federations and the like. In general practice, which has moved over the years away from the concept of one doctor having responsibility for all their patients to more salaried doctors, locums—

Q375 Dr Whitford: Yet it is talked about that there should be a named GP, which seems to be counterintuitive to the Roland report and a lot of what we have heard,

Alistair Burt: No. It is going back to one of those things that has been one of the mainstays of general practice. The difference for some doctors between being in general practice and being in clinical practice, where a patient is an episode and one to be dealt with and then move on to the next episode, is that continuity of care, getting to know the family, getting to know the history and all that. I believe very firmly there is real room for that in general practice: that is really important. Of course different ways of working have made that more difficult, if you do not have the continuity of individual contact and the summary care record. The ability to access records is absolutely crucial. It is not an issue for the federation; it is an issue in the different ways in which general practice is working now. But you are right: it is essential that notes and information are available, are available electronically, can be easily transferred and that within a federation—

Q376 Dr Whitford: Is that happening?

Alistair Burt: Yes. The determination is in a federation, absolutely. Practice notes have to be shared, so even though you are seeing a different doctor, which now of course can happen in any practice any time, something is known about you. That is very important.

Q377 Dr Whitford: Within a single practice, the electronic record is available to whichever GP in that practice, but it is not normally accessible by a practice that is on the other side of town.

Alistair Burt: It is now and that is growing.

Rosamond Roughton: Interoperability of IT systems in general practice is the critical enabler to making this work. That was one of the key findings from the first wave of these schemes. We have put in about £6 million of support to wave 2 to make sure they are not

wasting money on trying to find solutions that already exist. We are also now working up a detailed technical specification of how to make this work, to talk to suppliers about it, so that, as this becomes a comprehensive offer to the country, we have the IT systems in place to support it.

Q378 Dr Whitford: It is not there yet. You are developing it.

Rosamond Roughton: It is not there yet. We have found some good temporary solutions that I do not think are the perfect end solution that we could arrive at, but to deliver this across the country we need to have that in place.

Q379 Dr Whitford: Do you accept, Minister, the difficulty of creating federations in more rural areas where there may not be anyone to federate with and, if you do, patients are going to have ridiculous and often difficult journeys?

Alistair Burt: Yes, of course. There are obvious logistical difficulties in working in rural areas, but it has been one of the reasons why the pilots, whether they have been the PM's challenge pilots or the vanguards, have been in different parts of the country to try and ensure that there is a provision of service that recognises different demographics, different locations and the like. Of course, it is one thing to move around an urban area but it is quite different to move around the Chair's constituency and doubtless those of some other colleagues, yes.

Q380 Dr Whitford: I assume you saw the John Ford paper in December publishing the GP patient survey data of almost 900,000 patients. It shows that, while 81% were happy with that access, 5% wanted evenings and 14% wanted weekends, and it was only 2.2% of that nearly 900,000 patients who wanted a Sunday. Would you consider that, as a Saturday morning in out of hours is often the quietest session and that seems to be the most popular in the pilots, there is any room for out-of-hours services to offer routine walk-in, "I have a cold. Do I need an antibiotic?"-type appointments?

Alistair Burt: The short answer is at this stage I do not know. I return to how I started in a more casual comment than I should have made. I do not know how every aspect of the extended hours is going to work and none of us yet does. I do know that there are areas where it has been driven, it has been popular and it works, and there are others where it does not. People do get used to different patterns of access over a different period of time. I want general practice to respond to the opportunities that are now available through technology—and that is one of the ways of dealing with the issues of distance in rural areas—and to what works best, both for those who are providing the services and those looking for it. I would not be dogmatic and say, no, we are absolutely fixed on one idea for extended hours and Sundays must only work in terms of routine appointments and things like that. If it is an issue of resource, how best can we resolve it? How best are we treating the patient and what is the best for the resource that is available, both to primary care and to any of the other services that need to be available? It will take time to work that through, but I am very flexible: if something is going to work better than providing for a routine appointment on a Sunday afternoon, if it is not taken up and that is not the demand in the area, what else can we do that will meet that necessity for some?

Q381 Dr Whitford: You described that these are pilots, you do not mind what the result is and you are open to what that result is.

Alistair Burt: Yes.

Q382 Dr Whitford: We know that some of the pilots have stopped doing it because they found it so fruitless, yet what we hear from the Secretary of State and indeed the Prime Minister is that eight till eight, seven days a week is a manifesto commitment that must be done. That implies it is already a rigid commitment, as opposed to, “We are going to look at how we change things and we are open-minded about it.”

Alistair Burt: As we have already mentioned, there was one interpretation of that by friend and foe alike that suggested this was eight to eight every surgery all the time, seven days a week. We all know that is not the case and this Committee knows that is not the case as well. It is the same for extended hours, including Sundays, over a wider geographical area. The determination of the Prime Minister, the Secretary of State and me, as I said right at the beginning, is to respond to that desire for greater access that comes through surveys, through the Patients Association and Healthwatch; it is in the evidence that you have.

Q383 Dr Whitford: I totally understand that, but if in an area a pilot shows no demand or 12% demand for a Sunday, because of that commitment, will that area still be made to provide eight till eight on a Sunday, to meet eight till eight seven days a week?

Alistair Burt: As you yourself said, if we are going to end up paying a doctor to sit in the surgery and read the Sunday papers, none of us can see any sense in that, but we are a long way from working out what the outcome of this will be. Without the pilots, without the efforts that are being made, we would not know. We would not know in Bolton and Bury, for example, that that is what people want. That is the determination.

Q384 Dr Whitford: People welcome the pilots. They just want to know that the evidence will be looked at as opposed to—

Alistair Burt: Perhaps also they would welcome the flexibility that I am showing here because—

Q385 Chair: Minister, if you have an opportunity to reflect on when you think the outcome of those pilots is likely to be evaluated, it would be helpful.

Alistair Burt: Okay.

Chair: I know that Ben Bradshaw wants to come in and then I am coming on to Helen.

Q386 Mr Bradshaw: In the interests of time, I am not going to ask a whole load more questions about the evidence base and the evaluation. We had eight to eight, seven days a week: they were called GP-led walk-in centres and most of them have been closed; they were very popular and they worked. All I would ask you, Minister, as a reasonable and experienced Minister, is not to try and reinvent the wheel. The officials beside you are exactly the same officials, I believe, who served me when I was a Minister in your position trying to do exactly the same and improve access for the public and patients when it came to

GP appointments, which I accept, if not all members of this Committee do, is a very big issue and a huge frustration for a growing number of members of the public. I wish you well, but please look at the evidence and the experience. Do not try to reinvent the wheel and abolish things that worked.

Alistair Burt: Forgive me, Mr Bradshaw, but some things were done before I came into office—the 48-hour target was changed some time ago—but I entirely take your point. There is too much time spent trying to re-do everything. I have come in with a great determination to pick up on what was a good agenda from my predecessor right across my brief and make it work. Also, in terms of general practice, because of a long personal attachment to general practice, I want this to be a success. There are so many great opportunities and I have spoken to so many doctors who are doing good, innovative things and wanting to see a change for the future. I need to balance that with those who feel, as I said in my note, under very great pressure. How do we make this work for everybody? I will of course look at the evidence.

Q387 Helen Whately: I am going to move us on to talking about quality. During this inquiry we have heard from the CQC, who spoke about some very good results from their inspections and a number of practices that were poor, and some, when they were poor, were very poor and had often been known to be poor in their community for some time. We have also heard GPs talking about the CQC regime and quite a level of complaint or concern about the bureaucratic burden and how it affects them. We have heard from patient representatives about the difficulty for patients to be able to tell whether a practice is doing a good job on quality or not; it can be difficult for patients. I would be interested to hear the panel's perspective on the quality of care in primary care at the moment and the direction of travel on quality.

Alistair Burt: One of the most interesting sessions you had was with Professor Steve Field, the BMA and the RCGP. It was a very interesting session from all. I thought Professor Field defended himself extremely well in terms of saying what he was doing and where he was going. There are two things, it seems to me. First is the determination to see what the situation is now, and the QOF regime—the CQC regime—introduced to people who had not been used to it before has in some cases been genuinely quite difficult, but it has uncovered, as Steve Field said, the sort of things that we have known about in medicine for too long, things that were not right that people had not brought into the light and needed to be changed. He gave some good examples. He also said that, as far as he was concerned, the quality regime was going to adapt and change, in that the sort of inspection you would do once for the first time in a good practice would not necessarily be what you would do a second time. You would look at how to compile and use data to make sure you were not reinventing the wheel with a practice that clearly was doing the right thing, earned autonomy and the like. He also said, however, that, on behalf of the public and for reasons we all understand very well, ensuring that that inspection process was there and live, even though it might be uncomfortable for some, was really important. I see it developing under the CQC and what Steve Field is doing, responding to pressures, as we have already done further on QOF—and the previous Government did so in relation to QOF—and it will develop further to try and make the burden as easy as possible. Good practices want to see this done and want it to be easy so they can respond and be confident for the public.

Rosamond Roughton: On quality, we have developed a web tool that has 90 quality indicators that practices can use. We have 23,000 registered users of this web tool. That is a kind of first step. We are working on making that something that the public can use, something that we are looking at over the next three months, so probably in the early summer we will be having something that is public facing that provides much more information than is currently available about the quality of practice. In terms of failing practices, where the CQC has put a practice into special measures, our local teams are straight in there putting a task force around it, an intervention, working with a lot of other partners to stabilise it so that patients are able to continue to access services and then take time to take what is the strategic direction.

Finally, in terms of the burden of data—I will not comment on the CQC inspections—one thing we have heard back is about duplication of reporting from NHS England, the CQC and the General Medical Council, so we are working with both of them to develop a way in which, if one of us asks for information, that can be used for all purposes rather than practices suffering being asked the same thing slightly differently three times.

Alistair Burt: The support for struggling practices is really important here so that it is not seen as a stick or an attempt to criticise and that where weakness is found weakness is altered and supported. Steve's figures were that something like 90% of those that are revisited demonstrate improvement. That, I hope, is the sort of regime that we want to see.

Q388 Helen Whately: In fact, you have pre-empted part of my follow-up question, which is about the action the commissioners are taking when there are quality problems at practices. Are commissioners also taking action when there is an access problem? We have been talking about some of the access problems. Do commissioners have the levers or tools they need to address that?

Rosamond Roughton: Access is one of those indicators that we look at when we are looking at how a practice is doing. The data that we have, the breadth of statistical confidence, around access from the patient survey is quite wide at practice level so you cannot tell as much, but we are working at a local level with Healthwatch England about what they are picking up. Thinking about complaints, some of them at local level have run surveys so that we can put in place working with practices, any particular interventions. The area we need to do more on is where we can see general trends, particularly from an ethnicity basis where we can see that we have lower rates of satisfaction with some parts of the communities than others. That is something we need to do more on over this coming year and particularly in the way in which we implement our wider access amendments.

Q389 Helen Whately: At a regional level, is there enough resource to do the things you are talking about?

Rosamond Roughton: I am always mindful that any money spent on commissioning is money that is not being spent on front-line patient care, so we are always trying to make sure that as much as possible is being spent on the front-line services that people are getting. Our local teams operate on a big geographical spread, and the work we have been doing over the last year with CCGs about moving to joint and delegated commissioning is quite important. CCGs do have a statutory duty to improve the quality of primary medical care. We also know that GPs and the clinical community generally respond better to peer-

to-peer conversations and transparency, which help to drive improvement. Where CCGs have taken on delegated commissioning functions, one of the things certainly that I get is about using some of this data so they can have conversations with the practices about where they can improve. If you have very widespread variation in a CCG area, that in itself is an indicator of probably poorer quality than where you have a narrower band. It is important we do this with CCGs to make the most of the resource and the clinical leadership in the system.

Alistair Burt: I hope it might also help the Committee if I say that, when I spoke about variability earlier on, there is variability in commissioning. Commissioning is really important and it is not always clear that the decision making of commissioners is exactly comparable. I am interested in that. Again, how can we help and how can we improve the quality of commissioning and make sure that it is always doing the right job? That is part of what we do as well.

Helen Whately: I have found those answers very helpful and look forward to the further transparency on the data you mentioned. Some greater transparency into the interventions by commissioners would also be helpful.

Q390 Dr Davies: Could I raise the issue of the number of GPs? We are promised 5,000 additional doctors in primary care, which I believe comprises 4,000 new trainees and 1,000 to include return-to-practice doctors and better retention of those considering retirement. Is the provision of the 5,000 in any way conditional on the delivery of seven-day GP services?

Alistair Burt: No. I do not think it is conditional on that. As the Committee I am sure is aware, work is already under way in order to deliver on this commitment through the 10-point plan, efforts made to recruit more, retain more and bring more returners back. There is quite a comprehensive programme of work by all parts of that process which is already under way. It is there to serve the growing demand there will be for primary care for general practice. We anticipate, as I say, that the evidence of patients wanting greater access is unlikely to go away and so those numbers are going to be needed in any case. I have seen no suggestion that there is a condition attached between the two. We are going to have 5,000 more doctors working in general practice, 10,000 more available altogether in primary care by 2020.

Q391 Dr Davies: Some of the evidence we have taken from the Royal College of GPs and the BMA, for instance, has referred to the retirement crisis, as they put it, and the fact that these 5,000 will in the end be wiped out by those leaving the profession. Do you feel that there will be a net increase, and, if so, by how much?

Alistair Burt: I do. I am going to ask Ben to talk about numbers. The evidence I have is that, year by year, more people join than leave. We do indeed have the figures on that. I read the evidence from the BMA and the RCGP. I would like them to be as encouraging as possible about people staying in general practice, and they have some good initiatives and are working with us very well. They are worried about the retirement aspect, but all the evidence we have is that we can accommodate those who will leave in the methods we have described and we think the figures bear that out. I am happy if Ben wants to quote them.

Ben Dyson: In brief, the objective of having an extra 5,000 doctors working in general practice by 2020 is a net commitment. In order to achieve that commitment, we need to do two things. First, we need to increase even further the numbers undertaking statutory training. Those numbers are already going up. They need to go up faster over the next few years. Secondly, we need to reduce the numbers leaving the profession. The good news, as the Minister says, is that for a number of years now the number of joiners has outstripped the numbers of leavers, but there were some signs in 2013-14 that that was beginning to narrow a little. It has picked up somewhat in 2015, but to achieve that ambition of 5,000 more doctors working in general practice by 2020 we will need to redouble our efforts on both counts.

Q392 Dr Davies: Thank you. The final question at this point from me is that it has been put to us that this additional number of GPs is necessary simply to maintain current levels of access and quality. What would you say to that?

Alistair Burt: No. The anticipation in the Five Year Forward View, looking at the commitments of the NHS for the future, is to prepare a primary care service that will not just maintain the current status quo but will respond to the changes that are taking place, to bring more services from secondary to primary care, to work with the multidisciplinary teams that will be operating in primary care and sharing some of the work and of course over time, we hope, relieving GPs of some of the appointments and the work that they are currently doing that they need to do. The determination to see the workforce increase in the numbers suggested and calculated is designed to cater for the changes that will take place in primary care and general practice up to 2020, not just to stand still from where we are. That is our belief.

Q393 Chair: Can I clarify a point you made, Mr Dyson, when you said you will need to redouble your efforts if you are going to hit the target? If we carry on on our current trajectory, where are you estimating the increase in numbers will be?

Ben Dyson: If we fill all the training places that are now available for each of the years between now—

Q394 Chair: But this is an “if”. If we carry on on our current trajectory was the question.

Ben Dyson: I am not sure I can give you a precise answer to that question. I do know that we have increased in the last year the numbers of doctors undertaking GP specialty training by 100. We need to increase that further so that there are 3,250. Those training places will be available but we would need to fill the great majority of those.

Q395 Chair: It is dependent on filling those training places.

Ben Dyson: If we successfully fill those training places, we would have an extra 4,400 or so doctors working in general practice. It is the balance between that and the 5,000 that would need to be made up through improvements in both retention of the existing workforce and encouraging doctors who may have taken career breaks or may have gone overseas to come back into general practice. There are a number of initiatives under way to improve that return to practice as well.

Q396 Maggie Throup: Minister, in your statement you talk about the struggle to maintain partners and a growing proportion of salaried GPs. I would like to add to that the increasing number of locums. Is this a recognition among doctors that the traditional partnership model has insufficient financial and professional benefits?

Alistair Burt: We could spend more time than you have talking about the changes in structure of general practice and what happens with partners. As I am sure many of you are aware, my dad is a GP. He qualified just after the war and his progress through medicine was very similar to that traditional pattern: he became a partner quite early, brought together a group of practices in Bury, and I have seen general practice develop after that. There is no doubt that the model that he came into and the model probably that we would recognise maybe no less than 20 years ago—where people came in, partnership was associated with responsibility which could be carried, there was extra financial reward for that, but it was a commitment, a way of life—is now different for some doctors. The growth in numbers of salaried partners, you must have seen, is something like fivefold since the early 2000s. It is because doctors are wanting a different sort of life and a different way to carry out their practice.

Being completely non-judgmental about this, we have to respond to that. Some of the old ways of practice were not good. Doctors worked themselves to death: they did the overnights on duty, the things that out-of-hours services were brought in to prevent all those years ago that killed doctors, and there is no going back to that. Working with a different sort of structure seems to me exactly what we have to respond to. We will not go back to saying one model is definitively better than another, but a partnership model in business and clinical terms is still there, is still wanted by some but not by all. It seems to me that our responsibility is, both in the Department of Health and NHS England, to respond to that. What is the best shape of a practice in terms of partners, salaried doctors and locums that give the public necessarily what they are looking for? Some stability is essential. I talk to GPs who want to be partners and it is still important for it to be there, but if the burdens are too great, that is not helping keep that model going. The efforts we have to make are twofold. First, we have to reduce inequitable burdens that are driving people away from a model which is good and yet respond to the changes that people want in order to provide the life and quality of life for doctors that enable them to give their best to their patients and provide a reasonable practice basis for general practice and primary care.

Q397 Maggie Throup: You have answered my question, which was around “Can the current model survive?” I think you are saying that it probably should not survive and we need to adapt.

Alistair Burt: I am tempted again to be rather wide. Nothing survives these days. It is all change. It is a question of, “What is best?” I was struck by one of the comments I got from a colleague in Health Education England to say that a young person going into medical training now, going to university now, is going to be entering general practice fully fledged in about 10 or 11 years’ time. The world will be very different in 10 or 11 years’ time. We have to be preparing a primary care service in general practice not just for today, not just for our spending review period and down to 2020, but for 2030 and beyond. What is the structure going to be? I do not know. I have met doctors who feel burdened by the structure they have now and they have worked very hard. As to the bit that I put in my

paper to say, “In my experience, both attitudes are very real,” there are those who have great excitement about what they are doing, the pilots, the vanguards and different ways of working and working with different teams, those who are in an area where they are all connected and it is on the up, and there are those who—I felt very honestly—said that they are on a treadmill and they cannot get off it. What can we change that will make life different for them?

If there is that traditional business model and clinical model of partnership and the mentoring and the relationships that go with that, I would not like to see that lost because there was anything we did that made it impossible for that to continue. If that is not to be the pattern for everyone, what is to be the pattern for others, and how can we make that work as well for doctors and patients? This whole concept of partnership is an interesting area, which I suspect some of you know much better than I do, but it bodes real in-depth understanding as to how that takes general practice forward.

Q398 Maggie Throup: I am going to move on to questions about under-served areas. Do you feel that offering an additional year of training is a sufficient enough incentive to attract GP trainees to work in under-served areas?

Alistair Burt: It is one of those things; it is not the only one. Offering the extra year and the opportunity to follow another specialty and add that to the skills will be attractive for some, but so also will the exposure as undergraduates to general practice; so will the efforts that have been made with medical schools to try and counter a slight bias sometimes against general practice; and so will be the determination to work with the organisations, the BMA and the RCGP, to make younger doctors feel that general practice is something they want to experience and get into. It is one of those things but it is not the only thing. With the plan from Health Education England and the 10-point plan put together by a collection of people to bring more people back into general practice and sustain them, I was impressed by the enthusiasm to try different things. There is no one silver bullet here and there are so many different things being worked on for returners, for those to be retained towards retirement age—there is flexibility needed there—and to bring people in when they are younger. There is no one single thing but that one extra year may well prove popular.

Rosamond Roughton: I have one point. Over the last 10 years, and over the last five years, we have seen a significant reduction in the gap between areas that were under-served by doctors and areas that had more doctors. The NAO report on access gave crystal clear numbers around it: the gap has narrowed from 19.2 fewer GPs per 100,000 population to 4.9, so we have made quite a lot of progress over the last 10 years on this.

Q399 Maggie Throup: When we heard from Professor Ian Cumming, he was saying that, once post-CTT training has been completed, new GPs would be expected to stay in that area. What is there to keep them in those places?

Alistair Burt: This idea is being worked on for practical incentives that will assist in relation to that. That is a matter under active consideration at the moment.

Q400 Maggie Throup: Moving on again to attracting more undergraduates into general practice, would the Government consider offering financial incentives to follow that pathway?

Alistair Burt: Do you mean to go into general practice as a whole or into difficult areas?

Maggie Throup: For medical graduates to go into general practice as a specialty.

Q401 Chair: I think we are talking about golden hellos. It used to exist within the system.

Alistair Burt: You mean just to go into general practice itself.

Q402 Maggie Throup: Yes, to take that specialty.

Alistair Burt: No, I do not think so. There may be certain areas, as we were discussing, where that might be appropriate, but not just to come into general practice itself. I have not seen that. As I say, on the collective work that has been done to enthuse people, I think Chaand Nagpaul spoke about the magic of general practice. It is recovering that in some way. We are all the same. We will have conversations with doctors where we do not need to explain that and conversations with doctors who will look at us and say, “I had that, and where has it gone?” It is finding and communicating that to those who have the encouragement and enthusiasm to go into medical school in the first place. Medical schools may also have to look at their own intakes and who they are taking in. I saw some interesting discussion about that, about whether they are bringing the right people in. You do not need the scientific qualifications you need to be a Nobel prize-winning scientist to qualify as a doctor and be in general practice. You need a very strong level of science, but you need the human feel as well. Looking at that background and enthusing people who want to work through the generations with people is a part of the encouragement as well.

Q403 Maggie Throup: This is partly connected to James’s question about making sure we get the extra GPs in place. It is about how you make sure they are in the right place as well.

Alistair Burt: Yes. The Government are very conscious of under-doctored areas and looking actively at ways to address that. The Committee will hear more about that in due course.

Q404 Chair: Before we move on to the next group of questions, can I clarify one point? You have ruled out golden hellos as a mechanism, but, perhaps rather topically, there is the issue of premiums to those in training to compensate for the loss of banding supplements. Are you anticipating making those premiums variable so that you withdraw them in areas where there is no problem recruiting and allowing extra payments in under-doctored areas? That has been an area of some controversy.

Alistair Burt: I am not sure we are quite ready to bring this forward yet.

Rosamond Roughton: We are looking at—and we have said it—targeted financial incentives for trainees to work in areas that have found it hardest to recruit GPs.

Q405 Chair: Would that be proposed to be through the premiums mechanism or separately from that?

Rosamond Roughton: We have not finalised that, but I do not think it would be tied up in that.

Chair: Thank you for clarifying that.

Q406 Paula Sherriff: Thank you for joining us this afternoon. Will you bear with me one moment while I set the scene for my next question? We are all aware today that our junior doctors are taking industrial action, with 98% of those balloted feeling that they had no alternative. I joined junior doctors at St Thomas' hospital. A number of them talked to me about unfortunate language used in terms of "Marxism", "militants" and "Moët medics". It is important, in the context of the industrial action, that we acknowledge how unfortunate some of that language being used by the media, and indeed the Government, is. Can you tell us, Minister, how you will ensure that no GP trainee will be disadvantaged by the new junior doctor contract, as promised by Mr Hunt?

Alistair Burt: Junior and GP registrars will be part of the cohort being looked after by the new contract, but let me set that in context and say very clearly what we believe about that. I do not think this session is necessarily about that, but I recognise the point that you make and want to be very clear. I share a common view, I think among all of us, that none of us wishes to see this strike action taking place. We want to see this matter resolved by negotiation and I will join the Secretary of State in what he has continued to say, which is to urge doctors and doctors' leaders to return to negotiation. We believe the contract deals with some of the problems of unduly long hours in order to make the system safer. That is a view held not just by the Government but by a number of other respected organisations. We all share a common desire to see the greatest possible safety for patients and the best opportunities for doctors to practise safely, and we believe, with so many parts of the contract that have been in dispute now at a point where agreement is almost being reached in terms of the 16 areas for discussion, just dealing with the one outstanding issue in terms of strike action does not seem to be the right thing to do. But I am not one for statements likely to make life more difficult for anyone. I cannot think of a doctor who would be doing this without a very heavy heart, as some of the tweets said this morning. I prefer to believe that and all the lines that come out, and I would want doctors to return to work and this to be dealt with by negotiation before there is any further strike action. We want to see GP registrars, a good number of whom I know have been working today, enjoying the opportunities to go into general practice and be supported, but to feel that their colleagues who work in hospitals and are covered by the junior doctors' contract will be in a position where they are working in safer conditions, as so many people who have wanted to change this contract since the year 2000 believe the changes to represent.

Q407 Paula Sherriff: Thank you. Are you satisfied that the induction and refresher scheme is operating as efficiently as possible in enabling GPs who have retired or left the profession, perhaps prematurely, to return to practice?

Alistair Burt: From what I have seen, yes, but I will ask Ros to say a little more about it.

Rosamond Roughton: The new arrangements we have put in place have been an improvement on what was there before and we have seen that in the uptake. In the January

cohort we had last year, we had nine applicants. By July we had had 61, so we are seeing a big improvement. We also know that it is about all the other things that go around it helping people come back to practice. We do not believe yet that that is as slick and as effective as it can be, so over the next eight weeks we are putting in an improvement project, doing process mapping, not just about the induction scheme but things like the checks that need to go on around it. We want to make sure that we get this as good as possible. We have made a big change. We are seeing an increase in numbers, but we still have some real practical issues that we could do better at.

Q408 Paula Sherriff: Thank you. I am really pleased to hear that response. We would be foolish to ignore a cohort of people out there who were potentially available to come back into practice and offer the skills that they have undoubtedly built up potentially over a number of years. Can you tell us what assessment you have made of the financial support available to those participants?

Rosamond Roughton: Under the new arrangements we are offering a bursary of £2,300 while they are in practice for their supervised period. We have not yet made an assessment of whether that is calibrated at the right amount. We have seen this big leap in the number of applicants now to the scheme and it has been going for just under nine months. It is something we will need to review as we look at how we improve all the other bits of the process.

Q409 Paula Sherriff: I would be very interested to see the outcome of that exercise, particularly as bursaries are a very topical issue at the moment. That would be very interesting indeed. Thank you. Changing tack slightly, this is something that really interests me personally. I have some quite significant fears around what the future of general practice will look like. I doubt whether the current model, even with 5,000 extra GPs, is sustainable on a long-term basis. Is it the Government's intention that general practice should continue the model that perhaps we have at the moment, whereby patients almost always see a GP, or should we move to a system whereby GPs are the senior member of a broader team? There is talk about physician associates. Also, we know—statistical evidence shows—that up to 50% of a GP's workload in any given day involves a patient who would not necessarily need to be seen by a GP and could have been adequately seen by direct access to physio, a practice nurse or such like.

Alistair Burt: I would share your concern if there was one model of general practice in 2016 and you were looking ahead and saying, "Will this still be here in 10 or 20 years' time?", and, if not, looking at what there will be. I see flexibility. The model that people have grown up with will be different and I do not think we should be afraid of it. I am extremely interested, as I indicated, in the development of general practice. We have evidence at the moment from vanguards that have looked at different ways of bringing people together, such as multi-specialty groups, where someone may well not see the GP in the first place. There was one in the south-west—I am sure colleagues will know of it—and the connection there is with physios. It is a musculoskeletal practice where people get directed straight to the physio so they need not take up the 10-minute average appointment. There, they have moved on to 20-minute appointments because they have reduced the number of people GPs have to see because they do not need to see them. There are practices where there are pharmacies and physios available. The physio need not necessarily be physically there all the time. I was speaking to practices in Bedford where

they have another form of out-sourced musculoskeletal system where the patient gets offered a variety of different options and a physio can be in a surgery maybe three times a week.

There are different models and I am quite encouraged by the opportunities that this provides. Some of the vanguards are working more closely with the voluntary and independent sectors looking at the caring side, the navigation side, dealing with those patients who come in, not necessarily because the physical problem is the only thing they have but because they have other things they want to talk about which they need not necessarily talk to the GP about but can talk to somebody else about. Yes, absolutely, I see a future where it is much more likely that a practice where a GP will be at the hub of what is going on will know that around her or him there is a variety of different options to be used for the patients and a triage system that enables this to be done. There are all sorts of opportunities.

The thing we have not spoken too much about—but I know Ros is very interested in this—is technology and the opportunities provided there. We think a telephone interview is an advance on the past. Skype is only just coming into things. There will be biometrics. In 20 years' time, we will be wearing things that may be connected to the hospital where we have been treated in secondary care, or to primary care, that will tell someone when we contact them what is going on, us saying we do not feel too good and biometrics are immediately taken—all sorts of things and opportunities, which will reduce immediate pressure on going down the road into the surgery and provide another opportunity. You are right to question whether the model will survive, but your next question is, “What will it be replaced by?”, and, “How exciting is this?”, and talk to some of the doctors who are working on these things now to get that sense of enthusiasm.

Q410 Chair: Can I pick up on one of the barriers we have heard about to creating the multidisciplinary wider team: the issue of regulation, particularly around physician associates? Could you clarify your view, Minister, on the regulation of physician associates and where we are with that?

Alistair Burt: I am aware that this has come up before. There is a whole clutch of regulations around a number of allied health professionals. It is not just physician associates—it is others. The question is whether we seek to submit legislation that would change regulations for all or do it in a piecemeal fashion. My understanding is that the Government's desire to see 1,000 more physician associates, which the Secretary of State announced, is very real. I am not aware at present that there is any legislation fixed on the books in order to deal with this. For instance, there is the prescribing issue with physician associates and whether or not that can be handled in a different way in the practice. I am very conscious of the interest in regulation. It was not something that I had focused on before this inquiry, but I will be going back to look at it again. I do not want to see any barriers to development. I am aware you have had an interest in this for some time and I want to look at it further.

Q411 Chair: We are certainly hearing evidence that it was a barrier to indemnification and for GPs who felt it was a barrier to them being able to expand the role of physician associates. That would be very helpful because, when the Secretary of State came

before the Committee in December 2014, he was committed at that time to introducing primary legislation around the draft Law Commission Bill on regulation, but that now seems to have slipped. The concern we are hearing—and I wonder if you could comment on this—is that you could not do this with secondary legislation; it would require primary legislation. Is that your view, Minister?

Alistair Burt: Some things can be done by secondary legislation, but not all. That is my understanding of it. The connection with indemnity is very important, and again I think Ros wants to say something about this. The indemnity is a serious issue. That is very different from my father's time. It is one of those extra burdens now on doctors. We have brought in some measures to cover winter pressures and some of the emergency issues that were there.

Q412 Chair: Of course, but if you cannot indemnify and these allied health professionals are not regulated but are taking on significant extended roles, surely that is an issue for patient safety.

Alistair Burt: As I have said, Chair, I have been brought into this quite recently. It is a very serious issue and I have undertaken to go back and have a serious look at it.

Q413 Chair: It would be really helpful for this inquiry if you could let us know your thoughts on that in time.

Alistair Burt: I do not think there is any more that I could say beyond what I have said already, to say there are no immediate plans to legislate in relation to this. I want to look at it very hard, but I am not aware of any immediate plans on it.

Q414 Chair: I am sorry to press you on this, but we are going to be training 1,000 people. What assurance would they have that there would be a role for them if they cannot be indemnified and GPs are not willing to take them on?

Alistair Burt: I am not aware that the present situation affecting physician associates prevents them from doing what it is envisaged they do.

Q415 Chair: Ros, do you want to add to that?

Rosamond Roughton: I do not have anything to add to that. It is something we need to take a look at about how we support practices taking on the wider workforce.

Q416 Chair: Can I ask, Ros, whether it is something that has been raised with you as well, as a barrier?

Rosamond Roughton: Not in relation to physician associates, but indemnities costs in general. One of the learnings we have had from the Prime Minister's challenge fund schemes was around indemnity costs for different ways of working and that is something we have been talking to the medical defence organisations about—the kinds of products they offer. I had not encountered lack of regulation before as being one of the contributory factors, so I am sorry—

Ian Dodge: If I could add to that, within the new care models programme, I am not aware of any of the multi-specialty community provider or primary and acute care services,

vanguard or new care models raising with us as an absolutely critical issue for the beginning of their work that we address nationally through legislative change the specific issue that you are raising. They are now keen to develop workforce roles in a variety of different areas and we are working very closely with the Royal Colleges, who issued a supportive statement in the summer about doing that with NHS England. We need to make sure that we have cracked for the longer term the question of the regulation of physician associates, given the ambition of there being around 1,000, as you say, Chair.

Q417 Emma Reynolds: Thank you, Minister, and everyone else for coming to the Committee. I want to ask first about SIFT arrangements. We heard in evidence that there were concerns about the lack of availability for undergraduate placements. If we are to attract medical students into general practice, Professor Ian Cumming very strongly suggested that we need to make sure that they have exposure to general practice and positive experience of it. But there was concern from different organisations about the current set-up. Are the Government looking at reviewing the way in which the GP practices were reimbursed for offering these placements, because we did hear from Professor Cumming that there were a couple of practices that were not able or willing to provide these placements and that this was having an effect also on recruitment?

Alistair Burt: I have been made aware that the funding arrangements for these placements do vary across the country, and, accordingly, we are working to develop a national payment mechanism for primary care with payments that better reflect the costs of the placements. We are conscious of that and we are addressing it.

Q418 Emma Reynolds: That is very encouraging. May I move on to the question about nurses, particularly nurses in primary care as opposed to secondary care? We know that the nursing workforce in GP practices is ageing. What more can be done to make nursing in primary care as attractive, or indeed more attractive, than in secondary care to make sure that we have the nurses we need if we are going to build that wider team? Also, just because you are here, Minister—you are not leading on this in the Department, I think—I would say that there is quite a lot of concern across the House about the change from bursaries to loans, particularly those individuals who are attracted into nursing as mature students, perhaps sometimes as a second career. There is a worry that perhaps the Government have not done a thorough enough impact assessment of making that big change. The question really was about the attractiveness of primary care, but I take the opportunity to make that representation as well in regard to the big change that was announced late last year.

Alistair Burt: There are developments in nursing and nurse training, as we know. I know there has been a concentration on the bursary issue, but at the same time there has been rather less attention paid to the determination to create a new nursing support role—nursing associates—to work alongside healthcare support workers and fully qualified nurses, focusing on patient care. That will also be a route through to nursing, one that will enable people to come into nursing who might not otherwise have done so. One intention of changing the funding scheme is to allow more nurses to be trained. We can train 10,000 more nurses. At the moment, we are turning away from training people who want to be nurses because the funding is not there. The changing of the bursary scheme will enable that to be done. Again, just to fix this in people's minds because people often think that this is a huge debt that they will never be able to repay, it is the same rules on students in that graduates are eligible to pay back their loans after they graduate and then they have to

pay back only 9% of their earnings over £21,000 a year. A graduate on a salary of £21,000 a year would pay back £5.25 per month on their loan.

Sometimes, there can be a great concern about this that turns out not to be justified. Over the years, I have lived through the introduction of student fees in the first place, which was going to decimate the number of students going to universities in the United Kingdom, and it did nothing of the sort. We want to train more nurses; we are creating a new pathway for people to come into nursing in general, to increase the number, and to enable the people who might not have been able to come into nursing to do so. It is all part of a consultation, so, yes, the ideas are out there and people will get a chance to comment. I hope the Committee will recognise that, as well as the change in the bursary scheme, there are other opportunities coming through now that will increase and expand the opportunities for people to become nurses and to train and recruit more nurses from the United Kingdom as well as relying on those who have done such tremendous work for the NHS who have come from overseas.

Q419 Emma Reynolds: I would certainly agree with the objective of increasing the number of nurse placements for training. The worry is the direct comparison between normal undergraduates and those studying nursing. Those studying nursing are working as well and they cannot really get a part-time job to supplement the cost of their studies.

Alistair Burt: That is why a loan is available.

Q420 Emma Reynolds: I understand that the Government want to train more nurses—and that is a good thing—but I do worry about the potential that it is going to have for putting people off.

Alistair Burt: I understand very well and the Committee is right to raise those issues, but, on behalf of colleagues in the Department, I make a plea that there is more to this than just the announcement on bursaries. There is the opportunity of a new route into nursing, which has been looked for for quite some time in medicine and we have not quite found the way to do it up to now, to bring in the nursing associates, which will be warmly welcomed and a good opportunity. Those who may well find that course will find a way through to nursing that might have been closed to them in the past, so that should be evaluated as well.

Chair: We want to keep this discussion more to primary care if that is possible. Is your question related to primary care, Dr Whitford?

Q421 Dr Whitford: It is. This is almost like a return to the enrolled nurse idea, but, when we talk about new primary care teams, we talk about nurses leading and we particularly talk about allied health professionals who are also hit by the bursary change. Is there not a danger that the route people will take will be through a nursing assistant, where they work, they get paid and eventually they end up as a qualified nurse, so why is anyone going to take a degree? Yet we are going to need those nurse leaders and physiotherapist leaders, as my colleague across the table mentioned, in our future primary care team.

Alistair Burt: We have all been around for some time in relation to the health service and all that. Some of us can probably remember when the change in nursing came about to make it an all-graduate profession and the determination of the Royal College of Nursing

and others to say, “We need this step up”, with some of the issues that were raised at that time. The truth is that we are going to continue to need a balance, because, again, we have seen the development of nursing and the opportunities for nurses to carry out more procedures, to be given more responsibilities, commensurate with education and training and all that. I do not see either a primary or secondary care workforce that will not continue to rely on those sorts of skills. Again, it is early stages. I take the point, but I do not think at this stage there is any evidence to suggest that those who want the degree route because they want to achieve something through nursing that will require the graduate background will necessarily not follow that particular route. We are going to need those skills. Widening the opportunity for access is very considerable.

To return to the Chair’s point about primary nursing, if I may, because I missed that point on Ms Reynolds’s comments, Health Education England is working with the NHS on a new career framework in primary care to make sure we can still make primary care attractive for nursing as well because that is going to be very important. As part of the Roland report—and I know you have looked at that and had Professor Roland here as well—that is one of the objectives; it is in the plan; it is in the response from HEE. Nursing is being well considered there.

Q422 Dr Davies: We have already touched on indemnity issues, but I want to ask if the fact that NHS England has found it necessary to provide funding for out-of-hours indemnity cover costs over this winter indicates a fundamental problem with the system or with indemnity, indeed?

Alistair Burt: It is a practical and fundamental problem. This pressure on practice is very real, as the Committee knows, but Ros may wish to add to that.

Rosamond Roughton: We reckon indemnity costs in primary care are rising by about 8% or 10%. That is similar to secondary care. If you like, there are two issues here: one is the general rising costs of indemnity and the second is how that is funded in general practice. The causes of that are the number of claims and then the rising cost of awards. It is interesting that England has a much higher rate than, say, Scotland. The level of claims in Scotland is much lower than in England, and that is true across not just health but other aspects. There is a kind of deep-rooted social issue that we have not got to the bottom of. In terms of making sure we get a good general practice, we have put in place this scheme this winter to make sure that those rising costs are not putting people off from taking on GP out of hours. In the longer term, we are in discussion about the nature of the products and also working with the Department of Health on our overall approach to litigation and how you make sure that we reduce the number of claims that do not lead anywhere. About 80% of claims in general practice do not arrive.

Alistair Burt: We are also working with the medical defence organisations and medical insurers on this. As I say, this not a problem simply associated with winter out-of-hours pressure. It has been growing for some time and there is a longer-term issue to be tackled. We are indeed very aware of it.

Q423 Dr Davies: Essentially, the liabilities faced by the indemnity providers are certainly on the Government’s list of key things that need to be tackled. Can you give any precise ideas as to what might be looked at?

Rosamond Roughton: We have been discussing with them where we are in the kind of extended access, or where you have access to the record, that that is treated as almost like normal “routine” patient care as opposed to out-of-hours care, because, in essence, the conditions that might be regarded as driving up costs do not pertain because you have access to the full patient record. That is why this business about the IT systems is really important because it will help keep down the costs. As we develop the kind of multi-specialty community providers and the different models of care, we are looking to make sure that, in doing that, we mitigate any risk that that drives up indemnity costs because it is novel, because we have actually had the discussions at the outset; so all the insurance and defence organisations can understand how we are limiting risk and ideally improving the kind of clinical governance and arrangements around the new models.

Q424 Dr Davies: I get the impression that there is still quite a lot of work to do to facilitate these new models and multidisciplinary working and so forth being sustainable.

Alistair Burt: This element of it, yes, but it builds on a change in relation to negligence claims, pursuit of claims in medicine in a similar way that we have seen elsewhere in society. It is a problem for the practice of medicine anyway and would have been quite outside what we are planning to do with more multidisciplinary forces and the like. It is an inherent problem that has to be tackled no matter where general practice and primary care go, but the very fact we are doing it means that it brings a sharp incentive to make sure that we are dealing with it as quickly as possible. It is quite a difficult long-term trend. You only have to watch the television in the afternoon to know how encouraged we all are to claim for anything, even the phone calls that tell us we have had an accident when we cannot remember having an accident.

Q425 Dr Davies: Do you have any view as to the pros and cons of the Crown indemnity scheme in place in Wales for out-of-hours cover?

Rosamond Roughton: We have had a look at that. Crown indemnity still does cost. It does not deal with the root problem, which is about the rising costs, so we are trying to make sure we look at the root problem as well as how it is funded within general practice.

Dr Davies: Thank you. Can I put on record my membership of the BMA and the Royal College of GPs before I end those questions? Thank you.

Q426 Chair: Thank you. Can I move on to the issue of funding, perhaps by pointing out, Minister, that I am sure you are aware of the concern that has been expressed to the Committee about the falling overall percentage of the NHS spend that is going into primary care? Could you set out, Minister, where you feel we are now and what your ambition is for that by the end of the decade?

Alistair Burt: In general overall terms, as you know, the funding commitment of the Government through the manifesto is a £10 billion increase for NHS spending. We have now had the spending review and are able to see how much is being allocated to uplift primary care from decisions made in December. Broadly, it is between 4% and 5% annually year on year from 2016 through to 2021. That represents an increase in what has been spent on primary care in recent years. There is acknowledgment all round—I do not think it is a matter for the Government to hide—that the increase in expenditure in primary

care has been lower than that percentage in recent years. It has declined over time. As the recognition of the growing importance of primary care emerges, and as we want to shift more from secondary care, it needs the investment and we are trying to make clear that is where it is. I cannot go beyond that, because I have been discussing with colleagues today, “Is there an overall ambition to set?” It is sensible to say that we have this spending review period; there is the increase in percentages, quite marked from the past, and this takes us through to 2021. It is important that there was new investment, and there is.

Q427 Chair: Right, but can I ask you perhaps to set out for the record where you feel we are now in terms of this percentage of the overall NHS budget that is going into primary care and where you think this investment will take us? There is still a concern that other areas of spending will continue to outstrip this and that we may find ourselves not improving.

Alistair Burt: The figures I have are that spend on general practice was 7.8% of spend on the NHS in 2014-2015, but the growth on that, as I say, will run between 4% and 5% over the next five years, whereas spending in other parts of the NHS will not have the same degree of uplift. I do not know what the percentage will be in 2020.

Rosamond Roughton: I do not, but I can say that, in NHS England’s December board papers, it is very clear that the proportion of spending going on primary medical care is greater than that going on to other services. We have clearly set out each year for the next five years that it is about double, on the whole, what is going into secondary care.

Q428 Chair: But you have not set an ambition for it to reach a certain proportion.

Rosamond Roughton: It would take us a matter of 15 minutes to translate those figures into the answer that you are seeking, but we do not have it written in that way here.

Alistair Burt: As I say, I have the year-by-year figures, if you wish, for 4.2% in 2016-17, 4% in 2017-18, 4.5% in 2018-19, 4.8% in 2019-20 and 5.4% in 2020-21.

Rosamond Roughton: I would add it is a minimum.

Ben Dyson: *It might just be worth adding that that is* before taking into account the further potential shift in resources we hope to see. As CCGs develop these more integrated systems of care that help to reduce avoidable demand on hospital services, you then create a virtuous circle where more and more resources currently locked elsewhere in the system can flow into general practice.

Q429 Chair: That was anticipating my next question, which is whether or not you are confident that the vanguard models will help to drive this process of change, but you have answered that, Mr Dyson.

Alistair Burt: Yes. Again, so much of what we are doing is predicated on the sense that the most expensive care is in secondary and, therefore, what can be achieved at primary level? It is not just a matter of expense: it is the most appropriate care in the most appropriate place. Of course, with the move to greater preventive care provided at community level, the end objective is making sure that as much as possible can be done at primary level rather than secondary, and, if that is the case, and as demands on secondary care change, then with that can go some of the funding into primary care. But it is not an

exact science and it does depend on place to place. As an example, I was talking to Jim O'Donnell in Slough yesterday about the models that they have. He has something like a 20%-odd change in the number of reducing attendances at hospital. That is quite marked in his particular area. I will check the figures in due course and make sure they are right. Some of the vanguards are showing faster change than others. We are going to evaluate very carefully what has been the success of these pilots in the vanguards to see if they translate into that sort of change.

Q430 Chair: How much of this is going to come from the change to more capitated payments and the change in the way that the payment systems work across the NHS, which has traditionally sucked money into secondary care?

Alistair Burt: It is a real issue because of course some people are paid by what they do.

Chair: Exactly.

Alistair Burt: We all have this discussion at local level as well with our own hospitals and everything else because our ambition for the system as a whole often leaves some who have current vested interests. I do not mean that in a pejorative sense, but that is the way they get their funding. That has all changed and I know you have discussed tariff here as well, but I am very pleased to ask Ian to say something about that.

Ian Dodge: Nearly all the new care models are looking at different funding approaches, whether it is the new population health models—and I mentioned two of them earlier—or urgent and emergency care vanguards, trying to reinforce the clinical changes that people are wanting to deliver that create better incentives. Nearly all of those MCPs and PACS are looking to develop some kind of capitated approach or global sum approach. It means that there are not the same incentives, particularly on the acute side, around protecting existing marginal income through activity-based payments. We are seeing within the PACS vanguards that have closer collaboration between the acute sector and primary and community services, and we are looking to try and make it easy for people to do the right thing by way of those changes through developing new contractual models, a new voluntary GP contract, an MCP contract, which is not just about primary medical care but primary care and other community services, wrapped together with some kind of risk share in relation to the wider acute services as well as a contract for the totality of services in the new vertically integrated model. It is an integral part of the support package that NHS England is running with the new care model sites.

Q431 Emma Reynolds: We, as a Committee, went to visit one of the vanguards. What they were doing was really impressive, but outside the vanguards my worry is this—and I totally admire and share your objective, Minister, of trying to shift the emphasis away from secondary and acute care. At the moment it seems to me in a normal set of circumstances, without a vanguard, without an initiative, that the money is being sucked into acute care because hospitals can and are running deficits, although they are not in my area, by the way, one of the very few, and when local government is under pressure and GPs can only spend so much because they cannot run deficits, then the strain on the system is going into acute care. How do we run against the trend of that?

Alistair Burt: Before I ask Ian to say anything again, can I make two comments? It goes back to our variability and also learning lessons. It is variable. Looking at the figures for

unplanned admissions, A&E attendances and the like, they are not uniform; they do vary. It is like discharges and looking at the pressures there. Depending on the local systems in place, you can see a clear spectrum of performance; it depends on local availability and it is not uniform. I am hoping that there will be clear lessons that can be extrapolated from the vanguards and the pilots. You are quite right that, if all the vanguards and pilots prove is that if you put more resource into an area you get a different set of results, it does not help any of us. We want to make sure that there are things that can be learned and if extra resource is going to be put in how it can be most effective.

Let me correct the statistic I used a second ago, but it is pertinent to the question you asked. In Slough, they have reduced unplanned admissions by 5.6% to date over a seven-month period against the 2.5% annual rise in population, and out-of-hours use has fallen by 23% since the additional weekend appointments in wave 1 started. So there is evidence that changing practice has an impact on more expensive services, and if we can demonstrate that and learn from that, and introduce that over time into other areas, that is what we wish to see. I do not know if there are any more figures that Ian can add to that, but I hope that is a reasonable explanation of what we would like to see.

Ian Dodge: Can I add on two specifics? One is around the non-vanguard communities. I was struck by the huge amount of energy and enthusiasm there is right across the NHS for embracing new care models that break down the silos between primary care, community services, social care services and acute services, not just thinking about primary medical services in isolation. Work is happening right across the NHS, so it would be inaccurate to characterise the NHS at the moment as vanguard communities where each and every part of those vanguards is moving at exactly the same pace in driving new models and then the rest of the NHS is not touched. That is not my experience as to how it actually is. There is a lot of learning from different communities, from peers and neighbours through multiple different programmes. Within the planning guidance that we issued just before Christmas, we talked about how we can unlock that right across the NHS for the duration of this Parliament through five-year sustainability and transformation plans. This is something for the totality of the NHS and I have been struck in lots of different places about people, almost the unofficial vanguards, moving just as fast as some of the vanguards.

The second thing is the way in which we have constructed the new care models programme and the way in which we are trying to get replicability from it. Rather than individual systems and sites developing their own unique local solutions that are wholly an expression of the local geographical context leadership enthusiasm, how do we help people connect and avoid that traditional NHS “not invented here” syndrome, help people that are trying to do the same things come together, spot the patterns between them, get them in a room with the national experts so that we are co-designing some common voluntary frameworks that make it much easier for other people to adopt good practice? The success of what we do in the new care models programme is not just about what happens in the individual sites: it is the quality, the degree of enthusiasm that is generated from other sites to adopt those particular models.

Q432 Dr Whitford: My question is around this disincentive of tariffs. Obviously, they served a purpose at a time to try and clear waiting lists and get work done, but I met a clinician who had been involved in an outreach programme to try and reduce admissions of

people with complex needs, which was successful in reducing it by 40%. Then the whole project was pulled because the hospital that was providing her was losing money. Surely, right across the NHS it is time, basically, for tariffs to go.

Ian Dodge: I would say yes, with one caveat, which is that as we create more integrated care, better care co-ordination that may end up reducing local choice and potentially preferences for patients—and we understand that is a likely reality—at the same time we also need to make sure that there is the ability for people who are within integrated systems to be able to go elsewhere if they want. That is common in other international systems of accountable care organisations, and it may well be, if you look at the Alzira system in Valencia, that they have a capitated funding system, but there is a choice. If you want your hip operation somewhere else, you can go there, and then it is the integrated provider that pays the fee for service in that other hospital. We may well look at a similar kind of model in this country so that we can preserve patient choice where that is desirable.

Alistair Burt: As politicians, we have to confront something that has been around for a while, but we have to be honest about it. If we are changing the way in which health is delivered, and if we recognise that there are better pathways for the patients that do not always involve doing the same thing as has been done at a local hospital for a long time because it has to change, then that local hospital may well have to change. This is very difficult for all of us when we are confronted with the usual determination to save bricks and mortar, no matter what has been the circumstance, and we all know the risks and difficulties in that. If we want to make sure that our constituents and people's patients are as safe as possible, have access to the best possible treatment, primary or secondary, and if we recognise we are in a really quite markedly changing medical environment that is going to require some physical change, often to places that have been around for many decades and even longer, we have to be open to that to make sure we are delivering the best for them. The payment system has to end the perverse incentives. That, again, is something that we all know about, coming in from being a representative to a Minister and finding the difficulties that can cause when real change that needs to be made is blocked because of a perverse incentive; and I see that both in adult social care and mental health, as you might imagine. We have to be open to the challenges that that poses in order to make changes, but it will mean some physical changes on the ground and we have to play our part in supporting that.

Q433 Maggie Throup: Can I come back to the settlement announced in December? How can the ambitions of the Primary Care Workforce Commission be achieved within the settlement?

Rosamond Roughton: As you saw as we went through the figures, we have a significant increase in the money that is going into primary medical care, so our expectation is that that level of investment will help to pay for the extra doctors working in general practice and other members of the workforce. Alongside that, we will take some national action to stimulate the use of the wider workforce. Last month, we announced the practices that were successful in bidding against £31 million for extra clinical pharmacists in practice. It is through measures like that where we are piloting the use of medical assistance. We want to try and make sure that we are both making more widespread the use of the wider workforce as well as ensuring that there is investment going into general practice so that practices themselves can spend that money on workforce. I hope that answers that.

Ian Dodge: Could I add that, post the 25 November spending review, there was then the publication of the mandate from the Government to NHS England that set out a set of different ambitions, both for 2016-17 and in the longer term for 2020-21? That mandate is consistent from, I think, the Government's perspective and NHS England's perspective with the spending review and includes higher expectations around improvements in primary care. We have provided a little more detail on that in the planning guidance, which in turn is consistent with the mandate, and that came out just before Christmas. During the course of 2016, there will be further detail inevitably set out on different component parts of that as we work it through.

Alistair Burt: Also, I would say that, in addition to the baseline that I have spoken about, there is a further £1 billion being invested over four years for GP premises and other infrastructures such as IT. That is the primary care transformation fund. There is the £50 million spent on the Prime Minister's GP access fund in 2014-15, and a further £100 million will be spent on the GP access fund 2015-16, £31 million being put in to pump-prime the deployment of clinical pharmacists, £10 million for the primary care transformation fund to kick-start a range of initiatives to expand the GP workforce and a further £10 million for the primary care transformation fund to support struggling practices. So it is not just the baseline. There have been additions on top of that.

Q434 Maggie Throup: You have just answered my next couple of questions all in one between the three of you. My final question for this bit is this. The primary care infrastructure fund has been renamed the transformation fund. Does this indicate that the funding can be used for any purpose—that it is no longer dedicated to investments in buildings and IT?

Rosamond Roughton: This year, in 2015-16, we said that a proportion of it was being used for estates and technology, and we have used some of the funding to support other strategic developments. We anticipate that we will continue to do that over the next three years. It is not completely earmarked just for estates and technology. It is also for other things like the clinical pharmacy scheme: that is funded from that fund.

Q435 Maggie Throup: That has always been the case.

Rosamond Roughton: That has always been the case, and it has also been used for things broader than just general practice, so it has been used to fund enabling community pharmacies to have access to the care records. That is another thing that will help with integration of wider services and making sure that we use the full range of services on offer in the NHS.

Alistair Burt: I like the flexibility, but the determination to have premises and IT at the forefront of that recognises their absolute prime importance in the change and development of primary care. As we have discussed before, it is so important that the IT is as up to date as possible so that information can flow to every clinician who might come in contact with an individual in the different parts of the system. That will be expenditure that will continue to be made necessary.

Q436 Emma Reynolds: I have a specific issue that was raised with us during the inquiry by a specific practice—a number of other practices did as well—about those practices

contracted through the personal medical services contracts, PMS. They are very concerned about the reductions that they may see. One practice that we visited suggested that they are going to be losing 21% of their overall budget. What could you tell us about the change in the equalisation process, the PMS and the effect and impact that is having?

Alistair Burt: As I am sure the Committee is aware, PMS was introduced in order to provide enhanced services in particular areas, but it grew a little bit beyond what was anticipated. The purpose of the review was to examine what services were being delivered, whether they were appropriate and whether they were delivering what was required. The review was put in place—I think it will conclude in March this year—to find where this was not the case, to make the changes, and clear commitments were made to keep the money in general practice, keep the money within the CCG and provide time in order to make the changes. But even above and beyond that—I was involved in an issue in east London—where criteria did not quite cover the situation and there was going to be a problem, it was possible for the CCG to commission enhanced services so that it provided an extra opportunity for a practice not to lose out. Now it is difficult because, within the locality, there have been other ways of producing the services, and in effect some of the practices had over a period of time, not deliberately, gained an advantage that needed to be evened out across the process. Having been into that in some detail with a practice in particular and having these issues brought to me, I work very closely with NHS England to see whether there have been any particular problems or issues, to see if there is a solution that does not threaten the practice but allows it to adjust to the change and make sure the services being provided are still provided in the area. That is my understanding of how the process is being handled.

Q437 Maggie Throup: It was the beginning of November last year that the NHS Choices website indicated that virtually 300 surgeries were not taking on new patients. Just last week, the BBC reported that at least 100 surgeries had applied to stop accepting new patients. Does this indicate that patient demand and workload pressures have now become too much?

Alistair Burt: I have a note on closed lists, but perhaps Ros can start. Broadly, my understanding, of course, is that this has always been an issue. Surgeries and practices have been allowed to close lists for a period of time to enable a settlement if there has been an increase in population and the like, but I think there has been a bit of a spike. It is a matter we are very conscious of.

Rosamond Roughton: In terms of the data we have, practices have to make a formal application to NHS England if they want to close the list. We have not as yet seen an increase, so in 2013-14 there were 99 applications. We had the same number in 2014-15. Of those, roughly about half were approved. I would not want that to be mistaken for us thinking that there are not workload pressures in general practice, because we see that in lots of different ways. We have not yet seen it in the number of increases in applications to close lists. We are talking with the BMA about cases where it might be around temporary suspension of taking on new patients, perhaps for a two-week period. Recently, with the flooding, practices have talked about whether there is a possibility there. They do not want to close their list in the long run. They would like to have a temporary suspension while they address some of the issues they have had to deal with on the flooding. At the moment, our data are not telling us that, but I do not want to sound complacent about the pressures

in general practice because we absolutely believe that general practice is under real pressure at the moment.

Q438 Maggie Throup: Have you made any assessment of how this may impact on patients?

Rosamond Roughton: That is why we go through a formal process. Our No. 1 job is making sure that the public are getting great services. We want to make sure that if a practice does close its list there are arrangements in place, and we want to make sure we understand the impact on neighbouring practices, because they can often be the ones that end up taking the burden. We go through that process in deciding whether or not to agree to the closure of a list.

Alistair Burt: Before we leave, just to set it in context, if I may, applications form a little over 1% of all GP practices and less than 4% of all GP practices close to new patients. So it is important wherever it happens. There is mitigating work being done, but that is the size of the issue.

Chair: Unfortunately, we have another Division. We are very nearly at the end of the session, so I am really sorry, could I trouble you to return for just a couple of brief questions before we finish at the end? Thank you—*[Interruption.]* If we could just deal with the question of conflicts of interest, that would be helpful. We will be quick and then run.

Q439 Dr Whitford: Does the development of large federations and the super-practices mean that you could have GPs who are within that federation and on a CCG having conflicts of interest, and how would that be dealt with?

Ian Dodge: We are acutely aware of the issues around conflict of interest, both in co-commissioning and indeed new care models and the commissioning of primary care at scale. That is why we issued statutory guidance in December 2014 and we have been reviewing those arrangements, including through an NHS England internal audit sample of 10 particular CCGs, 700 delegation arrangements and 300 joint commissioning arrangements. That will be considered by the NHS England board and we are committed to publishing Deloitte's internal audit review. In relation to new care models, we are working out the new commissioning and contracting arrangements and things like the MCP contract; and within that—as part of that work, which is ongoing, so we have not published it yet—we will need to deal with the issues around conflict, particularly if you have either CCGs commissioning and MCP or, indeed, the holders of an MCP contract potentially holding subcontracts with individual practices.

Q440 Dr Whitford: The issue is one that you are aware of.

Ian Dodge: Absolutely, and we need to address the substance of it and indeed the perception of it.

Chair: Thank you very much for bearing with us with the earlier break in the hearing and for coming this afternoon. It is much appreciated.