

Public Accounts Committee

Oral evidence: [Access to General Practice](#), HC 892

Thursday 9 March 2017

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Members present: Meg Hillier (Chair); Chris Evans; Caroline Flint; Anne Marie Morris; John Pugh.

Amyas Morse, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, NAO, Jenny George, Director, NAO, Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Questions 1-167

Witnesses

I: Professor Ian Cumming, Chief Executive, Health Education England, Rosamond Roughton, Director of NHS Commissioning, NHS England, Simon Stevens, Chief Executive, NHS England, and Chris Wormald, Permanent Secretary, Department of Health.

Report by the Comptroller and Auditor General

Improving patient access to general practice (HC 913)

Examination of witnesses

Witnesses: Professor Ian Cumming, Rosamond Roughton, Simon Stevens and Chris Wormald.

Q1 Chair: Good morning, everybody, and welcome to the Public Accounts Committee on Thursday 9 March 2017. We are here today to look at access to general practice. We looked at this last year and raised some concerns then; and some of those have been addressed a bit by NHS England. Today, we want to look at the variations in access around the country. There are very big concerns about the number of GPs—the ability to attract and retain staff in general practice—and clearly there are issues that we have talked about before in relation to the cost-effectiveness of plans for evening and weekend working.

The variations are quite interesting. We were comparing our own constituencies—we will go into that shortly—and some GPs seem to be



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being paid for extended opening hours, but not providing them and closing sometimes during core hours. We want to probe the level of the relationship between NHS England and commissioners and GP practices, to assess how well you are assessing whether patients' needs are being met by your proposals and by what practices are offering. It is quite a mixed picture out there, I think it's fair to say.

I want to introduce our panel. From my left to right, we have Rosamond Roughton, director of NHS commissioning at NHS England. I think we saw you a couple of years ago, Ms Roughton, so welcome back. We have Simon Stevens, chief executive of NHS England; Chris Wormald, permanent secretary at the Department of Health; and Professor Ian Cumming, chief executive of Health Education England, who is not such a frequent visitor to this Committee, but pretty important in terms of recruitment and training, which is obviously a real issue here.

Before I go into all that, I want to touch on a couple of points in the Budget, Mr Stevens or Mr Wormald—whichever of you wants to pick this up. One is the money for triaging at A&E. We were a bit puzzled, because we think quite a lot of that is happening already, so could you just explain what is different and how quickly it will kick in?

Simon Stevens: Yes. We want to use the Chancellor's Budget announcements, which we welcome, as a way of kick-starting a turnaround—

Chair: I think we take it as read you welcome them—they mean more money.

Simon Stevens: We welcome them as a way of kick-starting a turnaround in A&E performance, so that the NHS goes into next winter in a better position than we faced this past winter. In order to do that, we have to help at the front end of hospital A&E departments and at the back end in terms of delayed discharges for frail older patients.

Q2 **Chair:** And this money is for the front end, is it?

Simon Stevens: The Chancellor's announcement is for both. Obviously, the £100 million capital is to help ensure that A&E departments can make the space available to put in place GP streaming on the model that has been successfully adopted in places like Luton and Dunstable hospital, one of our top performing A&E departments in the country, and have that in place by next Christmas. On the back end, with the extra £1 billion for adult social care, as the Chancellor said yesterday, it will be very important that councils use that to help reduce the number of blocked beds.

Q3 **Chair:** I was asking about the capital funding particularly. We do not want to get into the whole debate about the social care bit today. We heard the announcement; that one is well worn. On the A&E end of it, this is a bit of capital money; how many hospitals are going to get money to put a walk-in triage approach into their A&E?



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Simon Stevens: We want all hospitals to have comprehensive front door streaming, with GPs, by next Christmas.

Q4 **Chair:** Have you costed what that will cost?

Simon Stevens: This is a contribution to that. Probably 50 to 100 hospitals need a bit of remedial work or extra capacity creation in order to get that in place.

Q5 **Chair:** So this money will be for 50 to 100 of the hospitals that need it. How much in total will it cost to deliver what you have outlined? What percentage of that was contributed in the Budget yesterday?

Simon Stevens: We are setting a requirement that all hospitals have GP streaming in place by this coming Christmas. Our assessment of the incremental capital required to do that is consistent with the funding we got from the Chancellor yesterday. Obviously, without glossing over it, this is only a part of the solution; there are a set of other things that need to change as well, and possibly the most important will be using the extra social care support to ensure that frail older people are able to leave hospital. If we can free up 2,000 to 3,000 hospital beds that at the moment are out of action, that is the equivalent of opening five new hospitals across England.

Q6 **Chair:** We are really asking about what that bit of money is going to do and how many hospitals it will affect. It meets not the whole cost but the additional costs.

Simon Stevens: It will certainly help. There will be revenue costs associated with this. Different hospital A&E departments have different physical layouts, but this will help.

Chair: So by Christmas, all hospitals will have this facility.

Simon Stevens: That's right.

Q7 **Chair:** Okay. Let's bring in the Comptroller and Auditor General briefly.

Sir Amyas Morse: I just want to check—is that for all hospitals, or all hospitals that have an A&E?

Simon Stevens: All hospitals that have an A&E. That is a key clarification.

Q8 **Chair:** All hospitals with an A&E. Mr Stevens was very clear on that. The other question was about the £300 million set aside for 44 STP areas to put in some capital funding. Do you have well worked up plans for that, or will it be a bidding round for STPs?

Simon Stevens: STPs have already developed their outline proposals, and in a number of cases those are quite well advanced. As the Chancellor explicitly said yesterday, this is a first instalment, with other propositions being considered in the autumn. This is £325 million over three years, so that will enable us to kick-start some of these but is not obviously the whole proposition.

Q9 **Chair:** So it is £325 million over three years. Is there any front-loading or



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back-loading to that, or is it evenly spread?

Simon Stevens: No, it is evenly distributed, which is reasonable given the time to get the—

Q10 **Chair:** So £100 million a year for the next three years.

Simon Stevens: There or thereabouts—slightly more than £100 million.

Q11 **Anne Marie Morris:** It seems to be limited to capital spend. For the transition and the STPs to work, clearly there is capital spend and there is workforce spend. I have made the point before about the need for double-running, which I know has not been accepted by you overall. Why the capital and not the revenue spend on workforce? Why do you think the Chancellor specifically focused on that capital piece? Will that not have implications for demand for workforce funding?

Simon Stevens: There are obviously revenue costs, but in fairness to the Chancellor, we did make the argument that if extra revenue were to be available, social care would have a strong case for it in 2017-18, and there was a need for further capital. In that sense, we have seen the first step of action on both those fronts.

Q12 **Anne Marie Morris:** So you are expecting the revenue piece to come out of the £2 billion—£1 billion in the next year?

Simon Stevens: No, that is social care. The revenue settlement for the NHS has not been altered by the Chancellor's Budget yesterday.

Chair: It is the same pot of money paying for any revenue costs.

Chris Wormald: It is important to understand the process here. STPs were set the task by Simon and his partners of, "How do you live within your revenue settlement?" STPs came back with proposals, some of which involve capital elements that allow them to do so.

Chair: And this is what this is for.

Chris Wormald: And the Chancellor has, even within a very tight fiscal position, contributed money to meeting those plans for STPs. So this is the capital that allows—

Q13 **Chair:** A final question on this point before we move on to the main session. You say he has contributed money, but, Mr Stevens, have you yet analysed the total capital needs of STPs? Obviously some are more developed than others. Have you got a total bill for the capital costs of implementing STPs? How much is this contributing?

Simon Stevens: Well, this is a first instalment, as I think the Chancellor said. And, as the Budget statement said, in the autumn a further round of local proposals will be considered, subject to rigorous value for money tests. We will be bringing those forward for the Chancellor's consideration.

Chair: So it sounds like a lot of money, and then you divide it by 44 and you think of the needs locally. Later I will touch on some of the property



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issues in my area—there are some issues there.

We will move on. Our hashtag today is #generalpractice and I will ask Caroline Flint to kick off.

- Q14 **Caroline Flint:** Good morning. Mr Wormald and Mr Stevens, do you agree that it is important to understand what is happening in GP practices in the core hours before extending them?

Simon Stevens: Both/and. I am not sure about before; I would say we need to do both.

- Q15 **Caroline Flint:** Okay. Are you saying that you are not sure that you should know what is happening in core hours before we extend those hours?

Simon Stevens: No, I am saying we need to do both. We need to ensure that core hours are functioning effectively and we need to ensure that convenient appointments are available outside of those core hours.

- Q16 **Caroline Flint:** So we need to ensure that core hours are functioning effectively. If we look at page 6 of the NAO Report, and paragraph 5 in particular, it says the contract “stipulates that ‘core hours’ are 8 am to 6.30 pm, Monday to Friday”, and that is “equivalent to 52.5 hours per week”. It then says, “Practices do not necessarily have to be open throughout these core hours, but they must provide essential services at times to meet the reasonable needs of their patients.” You will see it also says, “As at October 2015, some 46% of practices closed at some point during core hours. In particular, 18% closed at or before 3 pm on at least one weekday, despite three-quarters—76%—of these practices that closed receiving additional funding in 2015-16 to provide access outside of core hours.” Can you explain that to me, Mr Stevens?

Simon Stevens: Sure. So the reason we have the data is because for the first time NHS England has started collecting that through the e-declarations that began this year and, on the back of that, we are now taking action in two respects to deal with this. First of all, it turns out that about three quarters of the half-day closures are concentrated in about a quarter of the CCGs, so there is geographical targeting that we need to do with individual practices in those areas. The NAO Report talks about Waltham Forest. The same is true of Redbridge and parts of north-east London and other areas as well. We have collected the information and we are now following up with individual practices in those geographies.

The second thing we are doing is that, from October, the GP contract is going to change as a result of the 2017-18 GP contract and practices will no longer be eligible for that enhanced service payment if, on a weekly basis, they have half-day closing.

- Q17 **Caroline Flint:** On that basis, Mr Stevens, you are acknowledging that there was not sufficient data being gathered to understand what was going on in practices, which probably led to payments being paid when they should not have been.



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Simon Stevens: Our view was that it was sensible to collect this data. Throughout the history of the National Health Service, it has not been done. We have now done it, and we are taking action.

- Q18 **Caroline Flint:** Okay. But you are stopping these enhanced payments for extended services during core hours if those practices are not actually meeting their core hours obligation. That is what you just said.

Simon Stevens: That is right.

Chris Wormald: In some cases, there are perfectly sensible reasons why a practice is closed in core hours—

Caroline Flint: Can I come to that?

Chris Wormald: It is relevant to this question.

Caroline Flint: I am going to ask you a question about that—I will come to that.

Chris Wormald: I will answer it later, then.

- Q19 **Caroline Flint:** Mr Wormald, what should patients expect from these practices during core hours?

Chris Wormald: As Simon has said, the history of this is that—the best description of the GP contract is that it has traditionally been a high trust contract, so we have usually left it to GPs to conclude what is in the best interests of their patients. Of course, there is a lot of strength to that system, and it has served us extremely well; people expect their GPs to be able to take decisions. What NHS England has now done, as I say, is collected data on opening for the first time, which allows a conversation on exactly that question.

- Q20 **Caroline Flint:** Can I just stop you there, Mr Wormald? As you said, and as has already been mentioned by Mr Stevens, this data is being provided and we are able to better analyse what the opening hours are and the variabilities that are there, which I think is welcome. I have to say, I did a summary of the 12 MPs representing English constituencies on this Committee and I found quite a huge variation.

For my colleague, Meg Hillier, the percentage of practices closing at some point during core hours was 72%, but it is 80% in my own area. Also, when it comes to the percentage of practices closing by 3pm on at least one weekday, in the Chair's area it was 42% but in my own it was 15%. In Mr Pugh's area, the percentage of practices closing at some point during core hours is 5%, with 0% closing by 3pm on at least one weekday. That is quite a lot of variation.

Can I just draw your attention to paragraph 2.4 on page 17 of the NAO Report? Part of this is what patients need and also what the implications are of not being open for core hours. The evidence seems to be that, where practices are not meeting core hours, there is a higher rate of people therefore attending A&E. Do you accept that data?



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Chris Wormald: Yes. As we have said, NHS England has collected this data for the first time, which allows the NAO to do the analysis it has done. I would like to add some extra points. When we survey patients—

Sir Amyas Morse: There is a point here on accuracy of evidence. As I understand it, you have been operating e-declarations since 2014. Is that not right?

Chris Wormald: Yes, but the numbers we are talking about here is the first run.

Rosamond Roughton: Yes.

Sir Amyas Morse: So when you are saying this is all new, is it? Is it your testimony that this is new?

Rosamond Roughton: This is something that NHS England has done for the first time; it was not done by primary care trusts or the Department of Health previously.

Sir Amyas Morse: Sorry, can you just tie up? You have been doing e-declarations since 2014, but you are presenting this as all new. Can you just tie that together for the Committee please?

Rosamond Roughton: It is new in that NHS England set up this process of an e-declaration in 2014-15; we didn't have any data previously. We have increased the number of questions in that since 2014-15. We had started with a local process, and we have now followed that up with a national process to follow up and make sure that we have a consistent process so that, for every one of the 1,012 practices that are reporting closing before 3 o'clock, we are now chasing up exactly what are the alternative arrangements—

Q21 **Chair:** So you are seeing what you are paying for, and whether you are getting what you are paying for? Or what the taxpayer is paying for.

Rosamond Roughton: And we are seeing what they are doing in terms of meeting the reasonable needs of the population or failing to do so.

Chris Wormald: I will go back to the original question after this important clarification: when we poll patients in the annual patient survey, about 75% of patients are basically happy with their access to their GP, which is quite a high level for a public service. We know that.

Caroline Flint: We know those figures.

Chris Wormald: The point I was going to make a couple of questions ago is that there are valid reasons why an individual practice at a particular time may be closed.

Caroline Flint: Let me put it on the table that I appreciate that there are other things that will be happening in practices, such as training, paperwork and everything, but let me just be clear about this. Nobody is suggesting—I am certainly not suggesting—that a GP should literally have appointments with patients during core hours from 8am to 6.30 pm. I will



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come on to contact time with patients. What we are talking about here, and I think this is the definition that the NAO used, is that when we are talking about “closed”, we are talking about the practice literally being closed. You cannot go to the reception and you cannot necessarily get someone at the end of the phone—you get an answering machine telling you to go somewhere else. That is my understanding, in discussion with the NAO, of the definition of what we are talking about today and the way in which the NAO was looking at it for its Report.

Q22 Chair: Rosamond Roughton, do you agree that that is the definition the NAO uses?

Rosamond Roughton: The e-declaration asks about the core opening hours, so the data in the Report is absolutely correct about that. That is what we have been fed back. We are now going back to all those practices and saying, “Can your patients see a doctor if they have an urgent need? Can they pick up prescriptions?”

Q23 Caroline Flint: Let me stop you there. If the question is, “Can your patients see a doctor if there is an urgent need?” they will turn around and say that there is the out-of-hours service or something else. We are talking about the actual practice being physically closed to people even if they want to come in and book an appointment or collect a prescription. That is my understanding of the definition of what we are discussing today. Are you disagreeing with that?

Rosamond Roughton: We have gone back to follow up with every one of these practices, and some of them have said that they are open for somebody to pick up a prescription or drop off a specimen, but they have registered—

Q24 Chair: We need clarity. Jenny George from the NAO, can you please explain the measurement that the NAO used in clear, plain terms so that we can be absolutely clear?

Jenny George: The e-declaration descriptor, as I understand it, said that the reception was closed and therefore the building was closed at those times. It may be, as I think you are saying, that as you followed up with individual practices they said that in effect they had declared it wrong, but the data collected was that it was closed.

Q25 Caroline Flint: So let us all agree that at the time this data was collected it was made very clear, when the form was filled in, that “closed” meant “reception closed”. They may have changed some of their practices since this data was collected, but that was what was going on at the time it was collected. Can we agree on that?

Rosamond Roughton: That is what the practices reported to us when the data was collected.

Q26 Caroline Flint: That is helpful. Again, we are clear that we are talking not necessarily about appointments throughout this period but about practices physically being closed. Are you concerned, Mr Stevens, about the number of practices that are closing during core hours, the variation



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between practices and, in particular, that not being open during core hours leads to more patients referring to A&E, as the Report seems to suggest?

Simon Stevens: Yes, obviously—

Q27 **Caroline Flint:** Why are there these variations?

Simon Stevens: Precisely because we are tracking this and taking action in the two ways that I described. We do want to address it—while recognising that the clarification you provided is absolutely right. That is not to say that individual GPs should be running their surgeries throughout the day. There are many other pressures and commitments that GPs rightly have in terms of home visits, clinical letters, answering phone calls, discussing patients with hospital specialists and all the rest of it. This is not just about the operation of surgeries throughout the day but about making sure that GP practices are meeting the reasonable needs, as specified in the GMS contract.

Q28 **Caroline Flint:** Why do we not have data on the actual contact time of GPs—or other clinical staff such as nurses, for that matter—with patients?

Simon Stevens: As I am sure Ros will also mention, we are introducing for the first time a GP practice workload tool that is actually going to measure what is happening inside primary care. I would argue, and I think many GPs would argue, that one of the reasons why GP services have lost out, compared with other parts of the NHS, is that there has not been as much transparency about the extra work pressures that have been building in general practice for a decade as there has been about, say, the extra number of patients that hospitals are treating. That has contributed to the fact that the rate of growth in GP funding was half that of hospital funding in recent times until we took a clear decision to begin to reverse that, as we now are.

Q29 **Caroline Flint:** Ms Roughton, can you help me a bit more with how you go about tackling the differences between practices? In particular, can you give some insight into how local clinical commissioning groups are going to do that? One of the interesting bits of information from the Report was that there was a lack of confidence among both GPs and the inspectors that commissioning groups knew what was really going on in practices, even though they are led by GPs, and they were not equipped with the tools or authority to effect change.

Rosamond Roughton: The first thing goes back to what meeting the reasonable needs of the population means. That is the statement in the GP contract, and it is very broad. It is fair to say that local commissioners have not always had a consistent view about how to enforce and interpret it.

Q30 **Caroline Flint:** Can I stop you there? This is about the reasonable needs of the population. Can you explain to me what you feel that definition actually means?



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Rosamond Roughton: I think that definition means that you should be able to phone your practice to book an appointment, pick up a prescription and drop off specimens. If results come into the practice that require urgent attention, there should be somebody there who is able to pick that up, if it is to do with warfarin monitoring or something, and contact the patient. Those are the sorts of thing that ought to be in place, and I think that in the body of GPs there is a reasonable sense of what that is.

Q31 **Caroline Flint:** There obviously isn't, though, because there is quite a lot of variation in the core hours.

Rosamond Roughton: So I think we need to write that down. We agreed in the 2017-18 contract with the BMA that we will work with them and local medical committees to set out what that is. I think that is an important next step.

Q32 **Caroline Flint:** I think everything you just said is absolute common sense. I am finding it hard, given that this contract has been around for many years and "reasonable needs" have been part of it, to understand why, between the Department of Health, you, the BMA and others, they are not well understood. Again, we are talking not necessarily about seeing a doctor, but about just being able to come in and get your results.

Rosamond Roughton: That is why I think we need to absolutely write the definition down now and set it out so everybody can feel confident in applying those rules when talking to practices.

Q33 **Caroline Flint:** So it's not written down at the moment.

Rosamond Roughton: No, it's not written down at the moment.

Q34 **Caroline Flint:** It's just essential needs, vague—

Rosamond Roughton: Yes. We know from the analysis of the location of the practices that report that they close before 3 o'clock that they are concentrated in very particular parts of the country. There doesn't seem to be any obvious reason why some parts of the country have got this pattern of half-day closing and other parts do not. Over half the country has either none or maybe one practice with half-day closing. When we looked at the 1,012 practices, we think this is a cultural—

Q35 **Caroline Flint:** A historical set of circumstances.

Chris Wormald: It is always very difficult for us to answer questions about why something clearly sensible that we are doing now has not happened previously, which is the thrust of your questions. Until quite recently, the system relied on the professionalism of GPs to take all those decisions locally.

Q36 **Caroline Flint:** Have they not been taking them, then?

Chris Wormald: We look at what patients think of GP services. They have traditionally been very—



Q37 Caroline Flint: We can get on to engaging with the public about what they want. It is quite interesting that in all the discussion about needs and what patients want, there seems to be very little evidence of how you have gone out at a local level to ask the public what they actually want.

Chris Wormald: I am not disagreeing with the thrust of your questions—that is why we have been taking action. I am simply trying to explain why I think it may not have been done previously. It is because people have relied on these very popular services and have not specified what they want, in the way that NHS England is now doing. As I say, it is very difficult to explain why something we now think should happen hasn't happened previously, but that is the best explanation I've seen.

Q38 Caroline Flint: I am just trying to get on the record clarity for us and the public about what this core contract means and what it doesn't mean. So much is meant to be based on the reasonable needs of patients, and systems have been set up. A system is being set up that is going to cost money, but the definition of what those needs are has been pretty vague or not well understood. I think that is a fair enough thing to ask before we extend the hours, so that we understand what we are doing, why we are doing it, and what it is going to cost, so we get value for money.

Going back to Ms Roughton—thank you for your answers, which were very helpful and clarifying—if commissioning groups are made up of local GPs, are they independent enough to challenge opening practices in their local areas?

Rosamond Roughton: Yes. We have worked hard over the last two years to be really clear about the management of conflicts of interest in delegating CCGs. We know that people in many parts of the country were taken aback when they saw the data. There is a lot of peer pressure here as well, with people thinking, "Why are some practices closing for a half day when we are not?" In some ways, we know that peer pressure is one of the ways in which change happens, but we will not just leave this to CCGs. We will ensure, in working with CCGs, that this happens. Where we have significant concentrations of practices closing early, we also need to support those practices to be able to address these needs. I know that a couple of areas of the country are struggling with the age profile of GPs. We are not frightened of taking contractual sanctions, if that is where we need to go, but in the first instance, we want to try to support practices in providing the great service that they want—

Q39 Caroline Flint: I know my colleague Mr Pugh wants to come back to this area a little later. You talked about tightening up the system, clarifying the definitions and so on. What other support are you providing to commissioners to support that in general practice, and how are GPs responding to that?

Rosamond Roughton: We have an extensive development programme now, since I last gave evidence to the Committee, to support those providers and commissioners in stabilising and changing general practice. We have a whole series of events, webinars and guidance to support



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providers of the service and the commissioners of the service in tackling these issues. We have done some very detailed work looking at how practices manage their work. We have clearly identified opportunities for practices to re-design their services within their funding envelope to provide a better service and reduce the workload, which is probably one of the key issues. Just this week, on Tuesday we had about 400 people, with two thirds from practices, looking at how they could learn from each other and build support to start making improvements.

- Q40 **Caroline Flint:** Mr Stevens, it is very welcome that more information is being collected to have a better idea about what is happening and the variations. Is there a case for making the information more public and accessible to patients?

Simon Stevens: Yes, absolutely.

- Q41 **Caroline Flint:** You have got the data, could you put it—

Chair: We discussed this last time.

Simon Stevens: I would go further than that; we want to have more information on the availability of GP appointments for routine conditions. We will start collecting those data during the course of this year, and then we want to publish those so that people can see what the different waiting times are. I think that will be good for patients and for GPs, because it will illustrate the opportunities that Ros has talked about. This is all in the context of a general practice system that is under great pressure, but into which we are putting investment. It is therefore reasonable to expect, on the back of that, improved access alongside the extra GPs, practice nurses, pharmacists and mental health therapists that we will put into general practice over the next several years.

- Q42 **Caroline Flint:** Can I move on to the proposals for the extension of hours to 8 pm during the week and to weekends? Given our previous discussion about the core hours and the variations there, what do you expect from general practice in providing these additional hours? What should be happening during those additional hours?

Simon Stevens: We will get to a situation by next March where half the country is covered by GPs who are able to offer evening and weekend bookable appointments, and it will be the whole of the country by the following March, in 2019.

- Q43 **Caroline Flint:** How many bookable appointments should be available in those additional hours? At the moment the core hours are to 6.30, so it is another hour and a half. How much of that extra hour and a half per day in weekdays should be appointments, for example?

Rosamond Roughton: We have specified to local commissioners that we are expecting at least an additional 30 minutes per 1,000 of population. That is about face-to-face appointments—

- Q44 **Caroline Flint:** Roughly, a practice is what? They vary, but about 7,000?



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Rosamond Roughton: Yes, 7,500 or 8,000, on average. How that is organised—in terms of do you put three GP clinics on a Friday night versus six on a Sunday, or is it one on a Friday night and six on a Saturday—is something that local commissioners will make a decision on. On the length of the appointment, one thing that we have found in the access schemes that we have done already is that by offering some additional extended-hours capacity, practices have been able to create longer appointments for some of their patients whom they are seeing during the week. So we are not specifying the number of appointments because we do not specify the length of time.

Q45 **Caroline Flint:** So we could get quite a lot of variation still.

Rosamond Roughton: Yes, but you will not get variation in the amount of additional capacity. You will get variation in, or you will be looking at things like group consultation. We have had schemes in which we have had group consultations, a really helpful device to improve compliance.

Q46 **Caroline Flint:** How are you and the CCGs assessing the evidence for the demand for these services in the evening and at weekends?

Rosamond Roughton: As Simon said, we have commissioned this GP workload tool, which every practice will be getting during the course of this year—

Q47 **Caroline Flint:** When will they be getting it? Do you have a more specific date?

Rosamond Roughton: From April this year.

Q48 **Caroline Flint:** Will they all be trained to use it? Will it be operational?

Rosamond Roughton: We will be following it up. The idea is that at the click of a button they can produce a monthly report which shows how their utilisation of their current appointments is going. So that provides a foundation to see what we are doing in the current system. In addition, with the current schemes, we have been doing patient surveys about where people want additional appointments. We are also getting feedback from patients about—

Q49 **Caroline Flint:** This is a big change. Paragraph 4 on page 6 of the NAO Report talks about cost. It suggests: "If the additional funding is only used to meet the minimum additional capacity required by the new commitment, this would equate to £230 per appointment hour per 1,000 registered patients. In core contract hours the cost is an estimated £154" equivalent. How are you assessing the need and the demand for this? It seems important to be able to justify quite a huge uplift in terms of the cost per appointment hour.

Simon Stevens: We say three things. First, we agree with the sentence construction that the NAO has used: it begins the sentence with the word "if"—

Caroline Flint: Oh. You're not serious?



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Simon Stevens: I am serious. This was a very constructive discussion that we had with the NAO during the course of the production of this excellent Report, and the point it makes is that “if” the additional funding is “only” being used to meet the minimum additional capacity, that would be £230 per appointment hour. The reason the “if” is there is that the funding is not only being used for that. Some of it is being used to lever in far wider changes, including the ability to operate as practices across a town, sharing access to medical records, so you can go to one practice in the evening and they can still see your own records from your own surgery. Those are one-time costs. The costs are coming down.

Q50 **Caroline Flint:** I appreciate that clarification. On the costing and the £230, of the additional amount over the £154 per appointment hour that it is at the moment, how much do you think will be going into the GP practice to pay for the “per appointment hour” rather than to some of the other things you described?

Simon Stevens: Ros can correct me on this, but I think that the first wave of schemes were in the zone of £11 or £12 a head—something like that—the roll-out is now taking place at half that, at £6 a head, and the in-year cost is going to be closer to £3 to £4 a head.

Chris Wormald: You would expect, as we do in all sections of the economy, to see some uplift for paying for out of hours rather than core hours. On the NAO’s figures it is about 50% uplift, which is about time and a half. As Simon says, you would expect it to pay for more than that, and to come down.

On your question about evaluation, the policy has been rolled out quite slowly and iteratively. The first pilots were £50 million and there was an evaluation of that. We learnt quite a lot, particularly that things like weekend and Saturday morning appointments were considerably more popular than Sunday ones in that evaluation. We learnt a lot about the effects of how you advertise the services as on demand. That was then built into the wave 2 pilots, and then into the actual roll-out. The way this policy has been done has been to try it out on a small scale, learn from that and then build to the next stages, and we expect that to go on. We are not claiming we have got all the answers about how exactly this will work.¹

Q51 **Caroline Flint:** Just remind me in case I have missed something, Mr Wormald. That is all very helpful: all the information that you have pulled together and the other information looking at what is currently happening and learning from concerns about how, under the core hours contract, enhanced payments were made when they were not open. Can that all be pulled together as a body of information that underpins the rationale for

¹ The witness later clarified that ‘When describing what we have learnt from the evaluation of the first wave of the GP Access Fund I misspoke when describing ‘weekend and Saturday morning appointments’ as more popular than Sunday appointments. I meant that ‘weekday evening and Saturday morning appointments’ were, according to the evaluation, more popular than Sunday appointments.’



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moving to extended hours?

Chris Wormald: Yes, with one proviso. The way this policy has been developed, which is one of its strengths, has been a continuous iteration. There will not be a point when we say, "Here is the definitive answer." First, we want to iterate it, and secondly, we want some local flexibility.

Q52 **Caroline Flint:** The more information that is available would be really helpful to understand the processes and what therefore underpins the strategy, and of course the costings at the end of the day about any extended service.

Rosamond Roughton: I would add that we have got from the national GP patients survey really consistent results for many years now. If you are in work and aged between 18 and 50, you will have a worse experience of general practice. The older you are, the better your experience of general practice is. In terms of convenience of appointments, working age people find it much harder to get an appointment. That is what we get from the feedback in the local schemes.

Q53 **Caroline Flint:** I understand that. I have raised it myself. As a working person myself, perhaps if they were open from 8 am to 6.30 pm, and if there were appointments at 8 am or at 6 pm, that would certainly help me and a lot of other working people. But is it the case that appointments do not start until 9 and they finish by 5? I don't know because we do not have any information on that pattern of appointments that are provided within the core hours. It is really important to understand not only what happens during the core hours beyond the reception.

Q54 **Chair:** Do you agree?

Chris Wormald: Yes. Some of the things Simon described will help with that.

Chair: But you agree with Ms Flint that we don't really have the figures?

Q55 **Caroline Flint:** If we had appointments at 8 am, they might not need to stay open until late.

Chris Wormald: We do know quite a lot about what the public want. If we take the 25% of patients who were not satisfied with opening hours, 72% of those people think Saturday opening would help; 69% think evening; and 40% think Sunday. So we do know—

Chair: Those are national figures.

Q56 **Caroline Flint:** Mr Wormald, is it fair for me to say that you do not know, when you look across the 1,012 practices, how many of them offer actual contact time GP appointments before 9am or after 5.30 pm, within the core hours as things currently stand?

Rosamond Roughton: I would need to go back and check what our dataset that we have collected tells us about precisely what happens in those hours.



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Q57 **Caroline Flint:** It is a fair point. It will not suit all working people, because some people work shifts and therefore weekend or 8 o'clock might not help, but if you do not know whether there are offers for working people before 9 am or after 5.30 pm, on what basis are we assuming that extending the hours will be value for money in terms of that suiting their needs? If we were more prescriptive about what should be provided during the core hours in terms of contact time, we might meet the need of some of those working people. Is that a fair comment?

Chris Wormald: No.

Q58 **Caroline Flint:** It seemed completely logical to me, but maybe not.

Chris Wormald: I will clarify my answer. I don't completely agree.

Q59 **Caroline Flint:** So you do sort of agree?

Chris Wormald: The first thing to say is that we are of course implementing a manifesto commitment here, so we start from that as a baseline. We know, from patient surveys and our evaluations of wave 1 and wave 2, a lot more than we did previously about this. Would the kinds of information that you are describing help? Undoubtedly, yes. But I don't think that that undermines the case for extended opening overall, although I think it is a perfectly valid point about—it has been worked into how Ros and others have been rolling this out—how you roll it out in particular places in order to meet—²

Q60 **Caroline Flint:** It is interesting that we really haven't got much data about the application or the provision of appointments at those points that might help working people. But let's move on—

Chris Wormald: I think that is a good point—

Caroline Flint: Let's move on.

Simon Stevens: The patient survey—

Caroline Flint: No, I'm sorry.

Chair: We are going to move on.

Simon Stevens: It is practice-specific, so we do have that. It is practice-specific data on what the patients of that practice themselves say about the availability of appointments.

Caroline Flint: No, I'm sorry, Mr Stevens. What you haven't got is data that we can talk about today that explains how many appointments are available before 9 o'clock and after 5.30 pm, which might be in the interests of working people. So let me move on. I am sorry, Mr Stevens. I asked a question.

Chair: We are not going to go back to the 2008 data collection.

² The witness later clarified that 'I referred to our evaluations of waves 1 and 2 of the GP Access Fund, I should have said the 1st and 2nd evaluations of wave 1.'



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- Q61 Caroline Flint:** We are trying to determine the basis of the strategy for the extended hours. There is some concern about how extending the hours sits with what is already available in terms of out-of-hours services. Can you tell me what assessment you have done of that and how you are going to avoid overlay and end up paying twice for services that are maybe not being used effectively? We have out-of-hours care and we have other things being developed, and that is a welcome strand of activity. It seems to me there is a danger that by extending the GP hours, those services will not be used—they are contracted to do that for a period, and therefore we are paying money and they will not be used—or that the GPs won't be used because we are doing a marketing exercise as we speak to try to get people to use those other out-of-hours services. Who is doing the joined-up thinking about that?

Rosamond Roughton: This is definitely a risk and the NAO Report is right to pull that out. That is one of the main reasons why we ended up with the strategy being about devolving money at a local level to local commissioners to draw up plans, because they understand the range of services that this extended access needs to be connected with. It is also why—as we have set out—some of the flexibilities are there. What we have found from some of the pilot schemes is that in parts of the country with quite dispersed populations—take the East Riding of Yorkshire, for example—it would not be cost-effective to have the same concentration of extended access hubs as you might have in the middle of London. You might be better off using the GP out-of-hours service that is already there to provide bookable appointments on top of the urgent care service that they provide. What is really important for us at the moment is getting all the plans back from CCGs and scrutinising how they have made sure that there isn't a duplication of cost and service.

- Q62 Caroline Flint:** Will you very clearly follow activity and take-up and match that against what you are paying for these services? First, we want to avoid overlapping, but we also want to clearly see, down the road, whether we are paying over the odds for a service that is now being underused, because other parts of the local health community are providing a very similar offer.

Rosamond Roughton: Yes. What we have done with the schemes already is get detailed reporting about the scale of appointments being offered and what the utilisation is on Saturdays and Sundays and evenings. That is why we want to get this tool in place from April available across the country—

- Q63 Caroline Flint:** Therefore, if in the local health community they have used the tool for assessing needs, and are able to look more clearly than before at who is accessing the service, the price against that, and whether a service is being underutilised because the patients' needs are being provided elsewhere, how quickly could you move to change services so we weren't paying them too much?

Rosamond Roughton: That would depend on how the contract has been set. We need to do some work on collecting the data not from the



extended access provision, but from the GP out of hours. That is the area where we still have a data gap about the utilisation of GP out of hours across the country. Locally, in order to make sure you are using this money properly, you are going to need to understand both those things. It is no good just understanding one.

Q64 **Chair:** Are you planning to do a survey of out-of-hours access?

Rosamond Roughton: Not at national level, no, but that has been part of when we have gone to talk about the guidance we have issued to CCGs; that is, demonstrating and making sure we have got these connections right. That is one of the areas that we need to come back to.

Q65 **Chair:** To be clear, CCGs will be assessing how the out-of-hours service in their area is used, for example, whether someone has been to a GP in the day and then gone to the out-of-hours service, or are using the out-of-hours service instead of a GP.

Rosamond Roughton: We have not specified that precisely. We have asked them to tell us how they would be confident that they are not duplicating resource. One of the bits of data that they will need for that is about utilisation of GP out of hours. I couldn't say to you here that we—

Chair: So it is national broad guidance but not the detail.

Q66 **Caroline Flint:** I have another question about the impact of extended service. It was interesting that the Report seems to suggest that, where currently practices offer extended hours, there is a danger that the continuity of care for patients is lost within that. What work have you been doing to bear down on that particular problem?

Rosamond Roughton: Again, working with some of the pilot schemes, we have been looking at how they have designed their flow so that, in essence, by providing additional capacity at these other times of day, whether they have been able to create longer appointments or group consultations for patients they might see on a routine basis or who are more complex patients.

In some parts of the country they have been more successful at that. The GPs are saying, "This has helped us create space to have longer consultation times with those 100 patients who are on my personal worry list at the moment." That is a really important element for the implementation, because we know the continuity of care for certain groups of patients at certain points of life is critical to the outcomes.

Q67 **Caroline Flint:** They want to see a named GP.

Rosamond Roughton: Yes, and the utilisation of resources in the system.

Q68 **Caroline Flint:** I understand that part of the negotiation about the extended hours is that a practice may not have to do this if another practice is offering it. They are obviously going to look at others. Earlier one of you mentioned patients' notes. I understand that currently it is quite difficult if someone wants to go and see another GP in this situation



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for there to be sharing of patient notes. How is that going to change? Will that have to be in place before you allow that flexibility to happen?

Rosamond Roughton: This is really important to have in place. Otherwise, you end up getting people bouncing around the system because they see an unknown bit of the system and then they go back to their normal practice.

When we have looked back over the past 20 years, that is one of the things that has meant we have not delivered better access. This is what we are doing. The schemes we have got already have devices that go on top of their systems to connect to another system with all the relevant information governance controls.

That means that they can access that patient's notes with their permission, even though they are not coming to their practice. We are trying to get a national solution. We are testing in Leeds and Cornwall a way to do that that would mean that, from September this year, there would be a much simpler national solution, instead of some of these workarounds.

Caroline Flint: Thanks very much, Ms Roughton, you have been very clear and helpful in your answers.

Q69 **Chair:** I want to follow up on that. Is that something you would consider rolling out to community pharmacies?

Rosamond Roughton: We have nearly completed investment for all community pharmacies to have access to the summary care record. I think the figures were that about 85% had taken up that investment.

Q70 **Caroline Flint:** My final question is about funding. Obviously, there has been a long discussion about making the funding formula fairer, Mr Wormald; and it has been going on since 2007, I understand. As of last year, my understanding is that, in terms of the new formula, that is being applied to, if you like, the areas—but the criterion for the new formula is not coming into being at practice level until 2018. Is not there a worry with that, in that the amount of money that is going to areas is meant to be based on a fairer funding formula, based on need of the community; but we are not going to be able to have that same methodology applied to practice level for another year and a half?

Simon Stevens: That is conflating two separate things. The area-based funding shares for primary care are based on relative need, whereas the payment formula for individual practices—the Carr-Hill formula—was essentially based on expected workload. So we have made dramatic strides in improving the equity of the allocation of primary care funding across the country, and it is probably fairer now than at any point since 1948. You can see from figure 9 the fact that for this coming year we will have ensured that no CCG is below 5% under its weighted cap, and from 2018-19 that will be true as well for the primary medical care component of CCG allocations. So in terms of ensuring that the people of Hackney or Doncaster or wherever it might be have got their fair share, not just for



the NHS money in the round but also for the primary medical care component of that, I think it is dramatic progress.

The second part of this is: what about the individual GP contract? As you may recall, this Carr-Hill thing was a source of great controversy and consternation and was almost enough to topple the new GP contract that came in in 2004, in the first place. I think everybody wants to tread with care when they are messing with things that actually would produce big swings in the resourcing for individual practices. As you will recall, we are moving to a fairer system around the minimum practice income guarantee, MPIG, but that has had to be phased in over seven years so as not to have that big dislocating effect at practice level, and the reviews we have been doing of the PMS funding, again phased, over four years—

Q71 Chair: Just explain PMS, please.

Simon Stevens: Personal medical services. Two different flavours of GP contract, the PMS reviews are phased in over four years, and so forth. We have committed in principle to phasing out the quality and outcomes framework bit of the GMS contract, which in my view and the view of many others now has run its course. So as part of the discussion about the replacement for the QOF element we have also got to take a look at what this Carr-Hill piece would be. I do not think we should throw all the cards in the air so it would be a big bang that would destabilise individual practices for 2018.

Q72 Caroline Flint: With, obviously, potentially quite a lot of variation in terms of GP practices moving towards extended opening hours, have you considered whether—obviously part of this is about patient choice as well, and we want more of that, I think, because it pushes up standards, hopefully—it might be more attractive for patients to want to be registered with those GP practices that are offering more of what you have identified as meeting their needs as working people, or for whatever reason? If there is a move and a desire for people to go to longer opening hours of these practices, will they be accepted, and, if they are accepted, how will that affect the planning for funding at a local level?

Simon Stevens: Part of GP income relates to the number of patients it is looking after under capitation. So, to the extent lists grow at a particular practice, because they are attracting more patients, obviously that gives them the resourcing to expand their services. But for a lot of these evenings and weekends, as Ros says, we are expecting that this will be done on a shared basis between practices in a town or a locality. So if you think about what is going to be happening in London, by March 2018 we expect to have 8-to-8 bookable access to GP appointments right across London. Obviously, that is not going to be every practice, but if you look at what is happening in south-west London right now, you will see they have figured this out. They have got the record-sharing, three or four practice hubs across those boroughs—

Q73 Caroline Flint: I know there's a brave new world, where there will be shared information—



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Simon Stevens: It's happening—it's already happening for 17 million people.

- Q74 **Caroline Flint:** So, if I see a GP practice that is steaming ahead, providing a lot of different services based on need and providing me with options for when I have my appointments, if I choose to, can I go and say, "I like that place. I want to change and register with them"? First, will they accept me, and how will it be managed if people like me choose to do that? Secondly, will the funding move from my existing practice to support that practice?

Rosamond Roughton: Yes. We changed the regulations—I think it was last year—to make it possible for people to register with practices that might be near where they work, rather than where they live. Practices need to say that they are happy to do that, because you wouldn't then be eligible for a home visit from that practice. So we have legally made that more possible.

We assess the registrations at regular intervals during the year. As Simon said, the funding that goes to practices is determined by the number of people on the list. If a practice's list grows astronomically during the year, it would see funding for it catching up during the year.

The issue about whether a practice would accept you on the list is that practices can apply to have closed lists. So, they can say to commissioners, "We feel we are saturated. We can't take on any more patients." There is a policy about the circumstances in which we would accept a closed list from our point of view, and at what point would it mean, "Sorry, practices are obliged to take you on"? It is only if they have got a closed list that they couldn't take you on.

- Q75 **John Pugh:** May I move on to performance management of GPs? The performance managers par excellence are the clinical commissioning groups in this framework. You accept that there will be problems or issues connected with conflicts of interests there because you don't normally get people being performance-managed by their colleagues and collaborators—if I can put it like that—do you?

Simon Stevens: We have very clear guidance on conflicts of interest—

- Q76 **John Pugh:** I'm just saying that there could be a problem and therefore you have clear guidance. That's all I wanted to say; it's the preliminary point I wanted to make. It is fairly straightforward and discussed under the—

Simon Stevens: There is a trade-off here. We can either try to manage every town, village and hamlet from Leeds, or we have to recognise we need a more localised system.

- Q77 **John Pugh:** Initially, Mr Stevens, I think that was the intention of the legislation. Then NHS England found it could not do that and therefore aggravated the potentiality for conflicts of interest.

Would you also accept that, as a performance management system, if



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you have a look at it, you see there are an awful lot of carrots in this system and practically no sticks?

Rosamond Roughton: As Chris said, traditionally this has been a high-trust kind of contract—

Q78 **John Pugh:** That is another way of saying it, isn't it, really?

Rosamond Roughton: So the process that our local teams have taken is looking at the range of data sources that exist, so that primary care—

Q79 **John Pugh:** I accept your assurance that it is a trust system. It is a system based on carrots and not on sticks. There is no equivalent to the fines you can impose when you performance-manage acute hospitals. I think they paid out £600 million in fines last year. Is that right?

Simon Stevens: We dropped fines from the standing contract for 2016-17, as you may recall.

Let's take a step back. If one accepts, as I do, that GPs are under very considerable pressure—no doubt we will come on to discuss the importance of retaining GPs and persuading people to come into general practice in the first place or to come back to it—

Chair: We will.

Simon Stevens: Then we've got to do two things. We've got to ensure value for money for taxpayers' resources, but we've also got to recognise that this is a really tough job and the vast majority of GPs, according to their own patients, are doing a brilliant job.

Chris Wormald: You are clearly correct that we do not manage, and have not historically managed, the GP system in the way that we have managed other public services. However, if you put the point you made to the BMA—I was talking to them yesterday—they would not accept your starting proposition.

Q80 **John Pugh:** I wouldn't expect them to. As a performance management system, I think you would accept—but possibly not in these candid terms—that it is a pretty rubbish system.

Simon Stevens: No, it is not a performance management system; it is a contractual system. That was the original deal in 1911 that Nye Bevan agreed to in 1946. We have a contract and we have to manage to those contracts.

Q81 **John Pugh:** If I could refer you back to page 23, there are two bits of evidence there that say that this is a performance system that is ripe for serious review. First, the GPs themselves, no matter how benign the system might be, are clearly not happy with its capacity to produce the changes that they think should happen. Page 23 states: "Two-thirds (66%) of CQC inspectors...thought that commissioners did not take effective action to deal with concerns about access at individual practices". The CQC is saying it is not an effective management system.



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Simon Stevens: Let us not over-interpret these rather skimpy data. The GP survey is n=124 out of 42,000 GPs. It is a sum total of 49 CQC inspectors responding to the first of the responses.

Q82 **Chair:** Sorry, we might get the NAO to clarify, but figure 7 says it is "Based on 839 responses from GPs".

Simon Stevens: Yes, but the ones that are red—that is, the 15.1%—add up to a tiny fraction. It adds up to 124 GPs. So, 14.8% of 839 is 124 GPs out of 42,000.

Q83 **John Pugh:** Okay. Let me move on to something less contentious. When you put it to GPs that the performance management system is not perfect, they will say that none the less it is wholly beneficial for GPs to share data with one another. They can look at what colleagues do and ask themselves why they do not do better than some of their colleagues. You have developed a web tool, and I think NHS Digital is committed to transparency. Could you give me your understanding of how well that is working? In other words, are these sorts of soft incentives—looking at your colleagues and seeing how they're doing—working any better than fines and stuff like that?

Rosamond Roughton: We have developed this primary care web tool, which I think has more than 20,000 users. It has more than 60 indicators of different measures that are either absolute health outcomes or proxies for good-quality care. Tracking it can give us a picture of how things are changing at a national level, and what we can see is that, on the whole, more practices are getting better than worse.

I know, from talking to people at a local level—this is more anecdotal—is that there are places where this has been really useful and the practices have used it as a peer-to-peer tool. They can also look at it relative to practices that have the same kind of demographic population as them, so they can group themselves with similar practices to make sure they are comparing themselves to—

Q84 **John Pugh:** I am not saying that peer-to-peer doesn't work; I am asking you how well you think it is working.

Simon Stevens: May I add a factual addendum? Let's also understand that this is not just peer-to-peer. GPs are the one group of the clinical professions whose personal income is strongly tied towards performance against a set of clinical quality indicators—the quality and outcomes framework. Some £700 million of their practice income is tied to the world's largest pay-for-performance incentive structure for any clinical professional, so they are much more exposed.

There is a question as to whether that is any longer doing the heavy lifting we want of it. As I said earlier, I don't think it is, but it is not the case that it is just some soft, peer-to-peer review process; they have £700 million of their income at stake, based on their clinical quality performance.

Q85 **John Pugh:** But the vast majority of them are maxing or nearly maxing out on their QOF measures one way or another.

Simon Stevens: They've done well.

- Q86 **John Pugh:** You've raised the question of whether you need to sophisticate that, because you may actually be indirectly incentivising futile but none the less rewarded activity. People may go in to have their ankle looked at because it is strained, but find that their blood pressure is taken from some strange reason that they suspect is something to do with GP remuneration.

Simon Stevens: The move will be away from those kinds of approaches, towards a more professionally based quality improvement process, recognising that GPs are professionals and that this is probably a time-expired tick-box scheme.

- Q87 **John Pugh:** How, therefore, will you be measuring the efficiency of a GP's service? If they are not going to use QOF, which we accept is probably a time-expired scheme, are you going to use output measures? *The Lancet* showed that QOF improvements did not tally with mortality improvements.

Simon Stevens: Obviously Martin Roland and colleagues have done extensive work, not just in *The Lancet*, but in *The New England Journal*, the *BMJ* and elsewhere. Their advice is that we have now got as far as we are going to get with using QOF as a quality improvement tool.

- Q88 **Chair:** QOF is over.

Simon Stevens: QOF is over, and that is a negotiation we will be having with the profession. We set a reimbursement rate that corresponds to an efficient delivery of primary care. An individual practice that then incurs higher costs to do so is obviously incentivised to bring its costs down.

- Q89 **John Pugh:** May I just pick you up on your wording? Efficient delivery of primary care is not necessarily the same as what we have been talking about for most of this session, which is basically access. Obviously if primary care is working well, one of the benefits you would expect is that people would be much better at managing chronic diseases and would therefore need to access their GP less, or—as IPPR research showed—would see some other experienced professional, maybe not a GP. How are you going to catch that in the performance measures?

Simon Stevens: It goes back to a point Ros made earlier: we have about 300 million consultations a year in GP surgeries, and we have a differentiated group of reasons why patients are consulting their GP. It has tended to be seen as a one-size approach when looked at nationally, but we have to differentiate a person with multiple chronic conditions, who might require a more intense follow-up and for whom continuity of care will make a difference—there is good data on that—from the 85 million same-day urgent GP appointments that are happening each year, a lot of which are for things that just need sorting out there and then or one-off episodic improvement.

The reason it is so important that the GP system functions well is not just the long-term conditions management, but the availability of same-day



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urgent care. If you think about 23 million A&E attendances versus 85 million same-day urgent GP appointments, it is obvious that if you under-resource or under-support the primary care urgent care system, that spills into other parts of the NHS. It is worth reminding ourselves of the fantastic efficiency that primary care represents—over 90% of patient contact is in primary care, and a year's worth of GP care costs less than two A&E attendances.

- Q90 **John Pugh:** I was trying to make the point that it is about how you measure the efficiency of GP care. It is not just how many people you divert, or not, to A&E; it is how few people actually turn up at the GP, because the first consultation has put them on a successful path of self-management.

Rosamond Roughton: May I add something? Maybe we are not doing it at national level, but that is part of what we are doing in our national general practice development programme. We are taking practices through a process that helps them to really look at and analyse the demand that they are seeing in their practices and, based on what we have learned from those pilots, find a better and more productive way of helping to manage GP workload, such as using other members of the workforce, as you mentioned, or the voluntary sector.

Where we have done that work, it has been really fantastic for patients and practices. We are giving them a tool so they can measure it and so that, as Simon says, there is a really good incentive already built into the system for practices to be more productive. What we are trying to do is support them doing it for themselves, so that we build a bit more hope and confidence in general practice about being sustainable and long-term.

- Q91 **John Pugh:** I suppose there is an issue about how well the CCG can lead that process locally, but we will move on. Just one last question, which may trespass over some territory that I think the Chair is likely to visit. In my patch, I have a very, very large medical centre opened under the LIFT programme, which is wholly underutilised. I also have the local CCG investing significant amounts of money in GP practices. The sensible thing for the health economy would be to persuade the GPs who have poor accommodation to go into the surplus accommodation that the NHS currently holds and pays for. Am I right in thinking that there is neither the leverage in the CCG nor the incentive to the GP to do that?

Rosamond Roughton: Cases like that involve a really difficult set of value-for-money considerations, because if they are GP-owned premises, buying out those GP-owned premises sometimes ends up being more expensive than the costs currently in the system.

- Q92 **John Pugh:** The GPs are awfully keen on doing up their premises.

Rosamond Roughton: I don't know what price they are expecting to get for them, but—

Simon Stevens: Also, in fairness—look, when the NHS was set up, we didn't nationalise GPs and therefore GPs own many of their buildings and



they have to invest in them to produce an environment where they can look after their patients. Is this changing as a result of a whole range of factors—the move towards larger practices, salaried staff as well as partners, upgrades in the scope of services such that you can't now operate out of a semi-detached house, even though that is a lot of the real estate that people are in? We are in a much better position than we were in 10 years ago, but frankly we need to be in a dramatically different position in 10 years' time from where we are now.

Chair: We will come to that later. Anne Marie Morris.

- Q93 Anne Marie Morris:** It is clear that if we are to ensure that there is access to GPs, we have to ensure that we have enough of them, they are doing what we need them to do and the other parts of primary care are functioning properly, so what you actually need is a workforce plan that is an umbrella plan and takes into account the GP bit, but that flexes, given what you do in-house with your MCPs, your physiotherapists, your mental health practitioners, your pharmacists and your practice nurses. Is there, within NHS England, a plan for looking at that workforce in a holistic way, because if you have not looked at that, you cannot work out what you need specifically from GPs?

Simon Stevens: There is, and it's the GP forward view. We talk about needing an extra 5,000 doctors in general practice by 2020, but also supplementing that, as you know, with another 1,500 clinical pharmacists, another 3,000 mental health therapists embedded in general practice, practice nurses, physician associates and so on—at which point I think it is time for Ian to shine.

Professor Cumming: Thank you, Simon.

- Q94 Anne Marie Morris:** In which case, Professor Cumming, although I understand what Sir Simon has said, we have had three reports from the King's Fund and the Nuffield Trust in the last two years, and we have had the Health Select Committee's report on primary care. What Sir Simon seems to be saying is that we are going to have 5,000 of these and 5,000 of those, divided up, chop-chop-chop. That is not the same thing as saying, "What is the plan and how are we going to get these different specialists working together?"

Also, how are we going to get the general man in the street to be willing to go and see some of those others, rather than feeling fobbed off? A lot of the King's Fund and Nuffield Trust research shows that people want to go and see a GP—a doctor—not a nurse. Nurse practitioners are incredibly skilled individuals, but we have undersold them. So how are we looking at this plan driven by need, not just "Let's have 5,000 here and 5,000 there"?

Professor Cumming: Absolutely. This is definitely about the team environment that we actually create and about ensuring that people see the person who is best able to address their needs at that particular time. We have talked about many of the professions. It is physician associates, pharmacists, paramedics, nurses in a range of guises, health visitors,



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community midwives, psychological therapists—there is a wide range of people who can help deliver these services.

- Q95 **Anne Marie Morris:** I am aware of that, Professor Cumming. What I want to know is: when you are looking at your targets for recruitment, where is the need-driven push that will help us decide whether you have actually got that right, and how are you going to make sure that the incentives are in place? At the moment, if a GP wants to have a physiotherapist or if he wants to train a nurse, he has to take the money out of his budget, whereas if he wants a trainee GP, the Government pay.

Professor Cumming: I will let Simon and NHS England talk about the funding of people working in the practices, but from our perspective, we are seeking to train enough GPs to help meet the 5,000 additional doctors working in general practice component, but we are also training the additional workforce to meet the 5,000 others that Simon referred to. For example, yesterday, coincidentally, we published a report on the general practice nursing workforce and how we want to expand, revitalise, re-enthuse and redevelop that workforce across the whole country to make sure that we meet the additional 5,000 component there. So it is not just targeting doctors.

- Q96 **Anne Marie Morris:** Understood, but you are still not giving me any basis upon which to then evaluate how many of these different groups I need. Secondly, from all that I have seen in these reports about communication across these different bodies—the colleges of X, Y and Z, including nurses, GPs and so on—they have not come together and looked at this holistically, to say, “This is together what we’re going to do and what we need.” The disparity in incentives means, in a sense, that you are defeating yourselves before you have started.

Rosamond Roughton: Perhaps I can say a little bit about what we are doing to try to stimulate use of the wider workforce in general practice and about patients. In terms of the incentives, one of the big things we are doing is offering co-funding to practices to recruit clinical pharmacists into general practice. In some parts of general practice, that has met with scepticism about whether it will be a useful addition to the team and whether the business case is there. But as we have been able to demonstrate the value in practice and give people hard evidence about how this is saving GP time and improving use of medicines, and how that is therefore helping with patient outcomes, we are winning over practices on this model.

- Q97 **Anne Marie Morris:** Good, but that is one example. There are a number of different professions involved. What are you doing in the others and how are you joining up the dots? It’s no good doing this in a piecemeal way.

Rosamond Roughton: In terms of joining up the dots, general practice as a sector has been less connected to the NHS planning sector in terms of workforce. One of the things we have been doing with Health Education England is creating community training hubs so that general practice as a provider is part of a wider group, saying, “This is how many nurses we

think we're going to need in the future. This is where we can do some of the training together." That is a step we have taken in the last 12 months.

Q98 Anne Marie Morris: Is that rolled out generally, or is it just a pilot?

Rosamond Roughton: We have hubs in every part of the country—I cannot recall if it has happened or if it is this year, but delivery is imminent in every part of the country. In terms of patients, there is work to do. We have found that in some of the sites where we have introduced this, they have almost started and then taken a step back and had a different conversation with the public. Once people experience it, they have a different view of whether it is something they would like, but if they haven't experienced it, they tend to be more anxious, as anybody would be about it.

Anne Marie Morris: Which is understandable; that's a human reaction.

Rosamond Roughton: I think we need to do more—it is not just about workforce; it is about technology as well.

Simon Stevens: I just want to put some numbers around this, because I think we might be talking ourselves into believing there is a problem where there isn't one. We have about 300 million patient visits to GP practices each year. Of those, about 80 million-plus are already to nurses, therapists or others working in general practice. The 1990 GP contract gave co-funding for the first time—we could go back to 1966 actually, but let's start with 1990.

Chair: Let's not have a history lesson. We don't have time for that.

Simon Stevens: The 1990 GP contract led to a big expansion in practice nursing. That has continued. The 2004 contract—which meant that the contract was with the practice, not the individual partner—made it easier to expand the skill mix. So actually, British general practice, compared with primary care doctors in many other countries, is more multidisciplinary already, and patients are clearly accepting of that. What we are doing now is using our national funding to support individual practices working together at the 30,000 to 50,000 population basis, which is why the clinical pharmacists won't just be in each individual practice; they will be working across several practices. The 3,000 mental health therapists is not just a number plucked out of the air; it is very precisely designed to get the workforce needed to do the expansion in talking therapies that our mental health taskforce—

Q99 Anne Marie Morris: How did you get to the figure of 3,000?

Simon Stevens: We got to the 3,000 figure by saying that we need to expand the number of patients being looked after in primary care talking therapies from a 15% IAPT uptake rate to 25%. That corresponds to another 600,000 or so patient treatments a year. The workforce to do that constitutes these 3,000 mental health therapists.

Q100 Anne Marie Morris: How will you ensure that you incentivise practices? I



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hear about the hubs—I have one in my constituency. The constituents don't know about it or think it is a complete waste of money, because they think it's just a centre where admin put numbers into computers. There is something that is not yet working to get the consumer involved. While I understand, Mr Stevens, that we may be better than lots of other countries, there is still a problem, in that the consumer does not understand or value it and will still say, "I will not see a nurse." That is what a very recent report from the Nuffield Trust came out and said.

There is still a problem, which in your honesty I think you should accept. Tell me a little bit more not just about how wonderful we are compared with everything else, but about what we are actually going to do about it, and how we are going to ensure that the cost incentive for the GPs for all these different pieces actually ensures they will buy into it, rather than just the ones that the Government will pay for centrally.

Simon Stevens: Unusually, I have a difference of view on this point. I think patients do understand when they need to see a doctor, what the practice nurse can do and, increasingly, what the pharmacist can do for their medication review. If you are having a blood pressure check or vaccinations and all the rest of it, of course that is a practice nursing role. I think over 20 years or so, people have really understood that.

Q101 **Chair:** I think the Report is quite clear; it is perhaps somewhere between the two of you. What Ms Morris is asking is how you are making sure that you will be able to measure use of them and recruit the right people, because of the disincentive that she has highlighted about the funding. It is cheaper for GP practices to employ people funded by the centre—

Simon Stevens: Hang on again. We are calibrating this quite carefully. For the clinical pharmacists, we are part-funding them. For the mental health therapists, we are deliberately fully funding them as part of our expansion of mental health services over the next several years. I must admit that one of the very few places in this Report where I think we had a difference of view was where the NAO suggested that somehow we were wrong to have a financial incentive for practices to take on GP trainees. Actually, at a time when we want to substantially expand the number of GPs in training, some positive financial incentives there make a lot of sense.

Q102 **Chair:** I am not sure the NAO had an opinion; I think it was more of a statement of fact that it is cheaper for you to take—

Simon Stevens: Okay, as long as it is not a criticism, because we want to expand the GP trainees.

Chair: Let's not go back down that squirrel hole.

Rosamond Roughton: I think we can see in the way that general practice has developed over the last 10 years that, as a proportion of the income they get, they are spending more and more on other staff. We can see that that ratio is changing, so it is in their interests, if it works for their patients, for them to be employing staff that do not cost as much as a doctor. There is a very direct incentive there.



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Q103 **Anne Marie Morris:** I hear what you say and what Mr Stevens said. I just refer you to the Nuffield Trust's report and the primary care report that came out last year from the Select Committee, which do not agree with you.

Chair: That is the Health Committee.

Q104 **Anne Marie Morris:** Yes. Let us move on. It seems to me that one of the things you are looking to do is put in place new structures to, if you like, ensure integration, which we all applaud. The MSPs are very well conceived—I do not have a problem with that—but one of my challenges, to go back to the debate we had earlier about need, is that those are predicated on footfall, so you can only have that consolidation and these different specialists coming together in these hubs within a population area that will give enough demand for the service.

I have a rural constituency, and there is no way we could have an MSP. In a sense, that leaves us high and dry. If you applied the current structural arrangements as they are now, you would see a number of our district hospitals closing because we do not get the footfall. You would have a challenge because our GP surgeries, due to the challenge you talked about earlier, couldn't manage. We cannot go further than the MSPs. I have a real sense that while the intention is right, you have got a one-size-fits-all approach, and you have not looked at the diverse needs across the country in rural, deprived and urban areas.

Simon Stevens: We completely recognise what you say. The model for the branch surgery—the practice in a village serving rural areas—is going to have to be different from the model in Hackney, but the horses for courses approach is implicit in the way that general practice will continue to evolve, just as it has been one of the great strengths of British general practice hitherto. It is adaptable and it is diverse.

Q105 **Anne Marie Morris:** Diversity is absolutely right, but the challenge is that these are small practices in rural areas. There is no pot of money to help them innovate and move forward. Often, they do not even have broadband. There is a real challenge. While I applaud the desire for flexibility, I cannot see any help in all the noise I hear for that particular rural challenge.

Rosamond Roughton: I think what I would point those practices to is, first, that we have asked CCGs to set aside about £171 million to support practices in their areas over the next two years. That is about improving access, supporting at-scale working and securing sustainability. Secondly, every practice in the country has got the chance to take up our development offer. We have already got about 600 practices signed up to doing productive work. We have got about half of CCGs across the country going into practices. That is where you can get things that I think help smaller practices, because working at scale might offer them the opportunity to get things like payroll, HR and career development functions without losing that village community sense. They can still be small practices, but they are able to get some of the at-scale provisions where that makes a difference to them.



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Q106 Anne Marie Morris: At one level you are right. The challenge is that some places are particularly rural. In Devon we have more roads than Denmark, and therefore we have to look at different ways of working—the way we use hours, access, telephones, etc. I don't see the GPs getting support for that innovation. Mr Stevens, you referred to the GP five-year plan—I have read it and it is good. When we looked at the STP issue last time we all met, it was clear that the GPs were not as involved in the STP process as they should be, and that not enough attention was paid to the GP five-year plan. I have a concern that, for all you have both said, we are still not really engaging the GPs, given the diversity of need across the country, in this new journey forward. Do you agree?

Simon Stevens: I accept that you are concerned.

Q107 Anne Marie Morris: Do I have reason to be concerned?

Simon Stevens: Are you talking specifically about Devon?

Anne Marie Morris: Rural areas.

Chair: Sparsely populated areas.

Simon Stevens: There were particular issues in the south-west, which we are collectively having to approach. As it happens, in Devon there is a good process now that is bringing together the GPs and the CCGs. Some controversial decisions are under discussion and are progressing there, but there is no reason why GPs across Devon ought not to be able to engage with the process that Angela Pedder as the STP leader is convening on behalf of you all.

Q108 Anne Marie Morris: Indeed. Mr Stevens, Angela is an exemplar, but she has also got her hands tied behind her back. She can tell them only indirectly, rather than directly. What we ought to do now is move on, focus specifically on GPs and look at how on earth we are going to find these 5,000. It is predicated on the ones we have got staying. As we look at the statistics now, as evidenced in the Report, we have got the same number leaving as staying.

Chair: The same number joining as leaving.

Anne Marie Morris: Thank you, Chair. We also have a challenge increasing our part-timers. We have also got more locums. We have got people more attracted by a salaried option. Realistically, what are we going to do to ensure we get these GPs? At the moment, the current scheme, while expected to increase—to get to 97% isn't bad—is still not where we need it to be.

Professor Cumming: You are absolutely right that this is about flows in and flows out. It is not just about training the new workforce. It is also about the number of hours an individual chooses to work in delivering patient care, which has gone down over the years as people choose to work fewer hours. We have been successful in recruiting an increased number of people into GP training. This year we had 3,019, which is the highest ever number of doctors choosing to train in general practice, and



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is about 10% up on the year before. Our target is 3,250, which we are aiming to hit for this year's intake. Round one has just closed, in terms of applications for GP training this year. That is 4.7% up on the same time last year, so we are seeing continued progression in the number of people wanting to train as GPs. In part, I think that is in recognition of some of the work that is going on elsewhere, in terms of seeing the additional funding coming through. Going back to your earlier question, other professionals support and work with the GPs in that team environment.

Q109 Anne Marie Morris: That's all lovely. I don't disagree with what you are saying and I am pleased it is more attractive, but I have talked to an awful lot of GPs and the Royal College, and there is still a sense that GPs are the last choice if you are an ambitious doctor. Something about that has to change. What used to be the attraction was the lifestyle. What are you going to do about the part-timers and couples to help them work in a sensible way? During training, are you going to advise them about what they might train in so they can work together? What are you going to do? You have to realise and accept that you can't change it; there will be more part-timers and people who will stay in for only 10 years. What are you going to do to change your offer and the attractiveness to get them to stay?

Professor Cumming: We need to embrace that rather than see it as a bad thing. Professor Val Wass from Keele University did a report for us, looking at what happens at medical school and what the perception is of general practice by new doctors as they are coming out of medical school and why some are put off. You are right that in some parts of the country—in some places—there is a perception that being a GP is not as good a career choice as going to train to be a cardiologist or a neurosurgeon. To my mind, that is fundamentally flawed. It is a different role, but it is just as challenging and just as rewarding. Being a specialist across the whole of general practice is a very challenging career.

What we do know is that there is a direct correlation between how much time medical students spend in the community when they are learning and how likely they are to choose general practice as a career further on.

Q110 Anne Marie Morris: That is absolutely right. One of the things we clearly need is more training in different parts of the country and GPs circulating around. Are you doing anything about that?

Professor Cumming: One thing we have done over the last two years is offer a financial enhancement to people wishing to train as GPs to go into training slots that have not had a GP train in them in the last three years.

Q111 Anne Marie Morris: Can I stop you there? It is a good initiative, but in rural areas we have found that that is not the point. It is not about the money; it is about lifestyle. They will not come and work in rural areas. What else are you doing to help these people attract the resource they need?

Professor Cumming: If I may disagree slightly with that, on that initiative this last year 105 out of 122 slots in predominantly rural areas



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that have either never had a GP training in them or not had a GP training in them in the last three years have been filled. So we are finding that some financial incentive at the start of training, which in some cases is allowing people to pay for a deposit on a house—of course that has the added benefit of meaning that they are more likely to stay there once they have trained—is beneficial.

Q112 Anne Marie Morris: That is good. What about couples—how are you going to help them? Otherwise, you are going to lose one or other or both out of the system.

Professor Cumming: We have been working with the BMA, looking particularly in training at what happens if a couple want to train together and one of them gets a place in Newcastle and one gets a place in Exeter. The concept of being more flexible in terms of how we can allow people to move to be able to train together is something that we are about to agree with the BMA as the next step for the next recruitment round.

Q113 Anne Marie Morris: When you say “about”, when is that?

Professor Cumming: In the next few weeks. We will be publishing it in the next two weeks.

Q114 Anne Marie Morris: That is good news. What about the use of resource overseas? Maybe this is a question for Mr Wormald. As I understand it, there was an attempt to try to ensure that GPs coming in from overseas were a priority to get them in, and that was rejected. Are we going to change that policy?

Chris Wormald: We recruit quite a lot from overseas. Health Education England leads that. Do you want to say a bit more, Ian?

Professor Cumming: We lead the recruitment into training. One of the things we have been looking at quite closely is the potential impact of Brexit on international applications or EEA applications for our training programme. This year—bear in mind that the applications for training opened after the referendum—was exactly the same as last year. So we have seen 18% of applications—this is not just for general practice; this is all specialties—being from EEA nationals this year and it was 18% last year. So seemingly the attractiveness of postgraduate training in this country, which is widely considered to be among the very best in the world, has not been impacted by Brexit so far.

Q115 Anne Marie Morris: Okay. That is good. What about the people who are fully trained and we want to bring in as fully trained? They are not coming here for training. As I understand it, they do not have any priority in the visa system, with their ability to work.

Rosamond Roughton: Part of the other end around GPs—Ian has talked about training—is attracting people back into practice. We are doing three things. One is about international recruitment of doctors already working in general practice in other places. We started piloting that in Lincolnshire, looking at a rural area, and in that, we are not coming up against those



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difficulties. We have got a plan to roll that out for other parts of the country over the next two years.

Q116 **Anne Marie Morris:** But they are not a priority sector, are they? Because the way the system works is that in some areas the UK says, "We need these people" and they are a priority.

Rosamond Roughton: It is not a shortage occupation, no. General practice is not on the shortage occupation list.

Q117 **Anne Marie Morris:** Do you not think it should be? I believe there had been an application to put it on that list, which was rejected.

Rosamond Roughton: Yes, I understand that was rejected.

Q118 **Anne Marie Morris:** In your view, should that be changed if we are to have any hope of meeting the numbers of GPs that we need in our system?

Rosamond Roughton: At the moment we are not finding that it is the inhibiting factor, but obviously we collectively put that application in and it was turned down.

Q119 **Chair:** We have got a shortage of people. On that and more widely on Brexit, Mr Wormald, in the discussions with Government are you shouting loudly that we may need to keep people coming in from the European Union to be doctors given that we have already got 18% applying for training places?

Chris Wormald: Yes. What we look at is the overall supply of doctors. Actually, when you look at the GP—

Q120 **Chair:** I am asking specifically about what conversations you are having across Whitehall to put the case for European nationals to continue to be able to work to the NHS. There is going to be a new regime—we do not know what it is yet—for people who are currently here and those who may want to come. Have you but in a bid or a viewpoint?

Chris Wormald: You will be unsurprised by my answer, but I am not going to discuss the exact conversations we are having.

Q121 **Chair:** I am just asking, have you had a conversation about this? I think that is a reasonably simple question.

Chris Wormald: Workforce in general, as I said to this Committee—

Q122 **Chair:** I am asking specifically about the workforce from the EU. Have you made representations within Government—to the Home Office or whoever—about the number of people working in the health service from the EU and what the impact would be if they were no longer allowed to come here?

Chris Wormald: Yes, we discuss that with our colleagues all the time and it is top of our issues around Brexit.

Chair: Good. Thank you.



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Chris Wormald: I will say specifically on GPs, we do not have good data on the nationality of GPs; we have data on where they first trained. People who trained within the EEA are a comparatively small amount of the GP workforce.

Simon Stevens: Yes, 4%.

Chris Wormald: Yes—the rest of the world is about 16%. We tend to look at what our needs are from the whole world, as opposed to the specific Brexit questions, but of course it comes up in our Brexit discussions—

Chair: If we turn the tap off suddenly, there is going to be a big problem, as Anne Marie Morris highlighted.

Chris Wormald: The Government announced their intention that they wish to be self-sufficient in doctors—

Chair: That is all very well. I am going to come to some of the figures from colleagues, but let us go back to Anne Marie Morris.

Q123 **Anne Marie Morris:** In part, Ms Roughton, you have already begun to tackle retention. When we looked at renegotiating the various medical contracts one of the things the Secretary of State said was that he would look at working conditions, which was one thing that it was clear was still a problem. Clearly retention and working conditions go together. What progress has been made on that front?

The second thing the Secretary of State said was that he was going to look at requiring those who trained here to give four years post-qualification to the UK public sector. Have we got anywhere with either of those? Clearly in terms of retention, ensuring that once the taxpayer has paid for someone to be trained, giving four years back does not seem particularly controversial—actually, in Australia they have to pay for themselves. On trying to look at working conditions—part of which is clearly the couple piece—what are you doing?

Rosamond Roughton: On retention, we have done work with a number of groups and have also looked at all the research around it to see why people are leaving. We have found that the No. 1 issue is workload. That is one of the main reasons—GPs feel they have got an uncontrollable workload and that it is unmanageable. When we published the general practice forward view last year, all the things in it were designed to contribute to making the climate in which GPs are working more favourable—what we are doing about investment, about bringing in other parts of the workforce and about offering support to redesign how you offer your service are all about tackling workload.

In addition, we have just started trying out a scheme for doctors who are thinking about leaving and do not want to locum, because they feel they are very experienced. We have identified 11 sites around the country where there will be a host employer that will employ those doctors to provide clinical as well as leadership and mentoring support to practices and to have their own peer network. We are trying to calibrate it so that it



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is more attractive than leaving altogether, while making sure we do not poach people from—

Q124 **Anne Marie Morris:** How far rolled out is that? It is a nice idea, but how far has it got?

Rosamond Roughton: We announced the sites in January and had all the detailed submissions on 28 February, and the funding to support it will be from 1 April.

Q125 **Caroline Flint:** General medical practice is probably the last closed shop in the UK. There is only one way in, via a medical degree. Practitioner nurses have a lot of skills, but there does not seem to be any opportunity for them to broaden their skills, through access courses or whatever, to be able to provide an opportunity to fill this gap.

Why aren't we looking at ways in which we can bring on other health practitioners to advance and progress their careers in a way that could help to fill this gap, particularly as most doctors come from socio-economic groups A and B.

Professor Cumming: There is a huge number of initiatives for healthcare professionals to take on enhanced skills. Part of what we are trying to achieve is—to use an American term—allowing everybody to operate at the top of their licence. That means allowing GPs to spend the majority of their time doing things that only GPs can do. It's the same with physios, pharmacists, nurses across the spectrum.

You raise a point that we are very keen to see come out of the expansion of medical student places that has recently been announced. We are looking for opportunities for people to consider part-time medical degrees, to allow people who may be working as a pharmacist, a physio or a nurse who wish to become a doctor, the opportunity to continue to work and practise but study medicine on a part-time basis.

That is not dissimilar in some ways to the concept that we have at the moment of healthcare support workers being able to study for a nursing degree on a part-time basis while working, to allow them to further their skills.

That is a key part of our strategy of social mobility and widening participation: to allow people to come in, demonstrating values and the right behaviours that we want to see. Then, through committing to the NHS and patient care, we will help them gain the academic qualifications and allow them to move into a variety of different professions.

Chair: Thank you. We'd love to talk more about that; perhaps another time. Anne Marie Morris.

Q126 **Anne Marie Morris:** Time presses, so let me put a final question to Mr Stevens. Do you accept that, with the change—not just in medicine but other professions—in what people want to do with their lives, in wanting the flexibility of part time and a portfolio of more than one career, the NHS is going to have to look at a different structure and at recruiting



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more? Because people are not going to stay for life like they used to.

Assuming you accept that change is there and whatever we do we can't change it, what steps are you going to take? I still have not had an answer about the four-year commitment from Jeremy, our Secretary of State, to ensure that, if you do train, you have to give at least four years.

I'd like your response on what you are going to do to this whole approach to workforce planning, specifically on GPs, given the change in how they look at this.

Simon Stevens: The implication is that, for any given number of full-time equivalent posts, we need more individuals, given part-time working and that people take time out mid-career and hopefully come back. That is one reason why it is right that we have got this 25% increase in medical school intake, which is obviously not going to be an overnight answer for us.

With those extra 1,500 places, it is crucial that, when decisions are being made about which universities and medical schools those places are layered into, people take account of the curriculum and the extent to which new doctors coming out of those medical schools have been well acquainted with general practice and, I might also say, with psychiatry.

We see big differences in the likelihood that new medical graduates will want to choose general practice or psychiatry between medical schools across the country. It would be a very desirable incentive to ensure that a disproportionate number of those extra 1,500 places go to medical schools that are capable of producing doctors of the future in the kind of disciplines that the health service is going to need.

Q127 **Anne Marie Morris:** So you accept there is change that we have to meet, rather than ignore.

Simon Stevens: Yes.

Q128 **Anne Marie Morris:** You still haven't answered the four-year question.

Simon Stevens: That's a question for Ian.

Professor Cumming: We are working with colleagues in the Higher Education Funding Council on allocating places for the 1,500, as Simon said.

Q129 **Anne Marie Morris:** This is the retention.

Professor Cumming: But it is linked. We want to create those 1,500 places. As part of that, we are starting to explore the Secretary of State's desire to lock people into the NHS in return for the commitment that has been made to their training.

I have to say that almost all doctors who train in this country currently give a lot more than four years to the NHS. From my perspective, this is more about making sure we do not see a change in that trend, rather than to correct a problem that is not there at the moment. The vast majority of people who train as doctors in this country fully commit to working as



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doctors in the NHS in this country already. That is not the same situation in Germany, for example, where a number of people would study for a medical degree and then not practise medicine afterwards. They would use that as a route into other areas. So we have not yet started any work looking at any potential lock-in or any mechanism behind it, but it is something that we have said we would take forward, in conversations with the Department of Health and the Secretary of State, on the back of the 1,500 new medical students who will not be starting medical school till 2018.

Q130 Anne Marie Morris: Just to back that up, can you give us some figures, for the Committee, so we can see how many are retained and work more than that four-year period? Is that something you can do?

Professor Cumming: I would have to come back to the Committee with those figures. I do not have those with me.

Chris Wormald: The key point is that the two announcements were linked together, as it were, so as we expanded the number of places, we put in an extra requirement, and said this was about dealing with an issue for the future, as opposed to now; so the two go together in a patient—

Chair: It does not stop the early retirement issue, though. Have you made any representations to the Treasury about the size of the pension pot, Mr Wormald? This is causing early retirement among GPs and other senior doctors.

Chris Wormald: This affects doctors in exactly the same way as anybody else in that—

Q131 Chair: I do not think it was intended, was it, that doctors would all be retiring early because of it?

Chris Wormald: The information we have, which goes with the surveys that Ros mentioned, is that that is a factor but by no means the factor. When I discussed this with GPs before the hearing, the general thought was that quite frequently that was an issue that triggered the conversation about when you might leave, but actually it was other underlying issues around workload, and the issues that Ros was describing that are the driver. We are not doing anything specific on doctors around that, because, as I say, it is an issue that affects anyone whose pension pot reaches that size. Of course, it has to be said, that is quite a large pension pot by normal standards.

Q132 Chair: I want to move on a bit just to cover a bit more on skill mix and on premises, which we have not really covered. On the premises issue, our colleague Joan Ryan, MP for Enfield North, has been doing quite an interesting bit of work in her constituency. One of the problems there is that they have lost 12 doctors' surgeries, and only one has opened. You might remember—some of you were here for the hearing on 11 January when Sarah Thompson and Rob Whiteford from Enfield clinical commissioning group were here; they talked then about opening the new hubs, which we have heard a bit about. We don't need to go into that.



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They were going to have four. They have managed to open three, but the problem is that last month the MP was informed that the fourth cannot be opened because the CCG has been unable to find a suitable accessible surgery. In my constituency and borough there are very big issues around premises, still. PropCo comes into this picture as well. Who is, overall, responsible for making sure that premises are up to scratch, and that there is enough money in each local CCG area to do that? Because there are quite big variations around the country.

Rosamond Roughton: I think we recognise that there needs to be more capital investment in general practice premises and the supporting infrastructure, and that is why we started this programme of work and investment. It is a multi-year programme, so we have already done about 500 schemes. We have done that not based at local CCG level but we have done it at a bigger geographical footprint than that, to try to make best use of the money; so the needs vary.

Q133 **Chair:** So by segments—not quite STP area.

Rosamond Roughton: Yes.

Q134 **Chair:** Not STP areas, though—we are talking about different segments.

Rosamond Roughton: Yes, this was based on NHS England's local team footprints. That has been the currency in which we have operated in terms of prioritising bids that have come from general practice.

Q135 **Chair:** Just to be clear, if you are in Enfield and your practice has closed because it was not in good condition, you are saying that it is okay if it is opened in Barnet—I am sure you are not quite saying this; I don't want to mischaracterise you. Would that be acceptable?

Rosamond Roughton: No, that wouldn't be.

Q136 **Chair:** Are you going to make sure that one area is not denuded?

Rosamond Roughton: Yes, fundamentally our job is to secure general practice services for people in a convenient, accessible way, and we are doing that directly through local CCGs. This is more about how we prioritise extra investment in estates; we are doing it on a bigger geographical footprint. I do not know any of the details.

Q137 **Chair:** I am not expecting that. I am only raising it because the other thing about this is that, in the survey that the MP did—it had 250 responses, so not a bad or a little survey—at least 39% of constituents surveyed had to visit an out-of-hours service or A&E because they were unable to get a GP appointment. Although there is the wider drive by Mr Stevens and NHS England to reduce attendance at A&E, the lack of premises and GPs is very stark in some areas. That is just one example out of a number that have come across my desk this week. How much do you prioritise areas where there is a real increase? Do you measure increase in demand for A&E and correlate it back to a lack of provision in GP services?



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Rosamond Roughton: In terms of prioritising where we put investment in estates, we will be looking at the expected growth in new populations; we know that is an area where we may need to look at the estate. We will also look at the calibre of the estate—certainly, where we have had CQC inspections of practices that aren't up to scratch.

We are limited to a certain extent, in terms of beyond the CCG. Half of GP premises are GP-owned and so, in a way, in terms of the investment that is made into that bit of the estate, that is more of a dialogue. We don't have a visible map of that. Obviously, NHS Property Services, which is running a lot of the estate, and Community Health Partnerships, which is the other organisation that is involved, in terms of lift schemes and the like, will be doing the day-to-day work in assessing what investment is needed.

Q138 **Chair:** How big would you estimate the problem is, in terms of actual physical property across England? Do you have a figure for what it would cost to get the estate up to scratch?

Simon Stevens: It begins with a b.

Chair: Billions. We've got a little bit; we have £300 million. That is all right for STP capital funding.

Simon Stevens: Well, no, we've got more than that.

Chair: That's the new bit, anyway.

Simon Stevens: We have actually got a billion over four years for GP premises, technology and other related infrastructure investments, so I think progress can be made there.

Q139 **Chair:** Do you have any idea about the timescale? We all remember how bad it was; my borough has moved on enormously but there are still problems. Have you got a timeframe for when every patient will be able to go to a modern, up-to-date health facility to see a GP or primary care practitioner?

Rosamond Roughton: No. We have a timescale for delivering the pipeline of investments in estates in general practice that we announced last October.

Q140 **Chair:** I love that jargon. Perhaps you could just unpick it? How long will patients in an area like Enfield, where there is a problem, have to wait?

Simon Stevens: Over four years, we have several hundred million to spend on this. The initial bids we got back were a multiple of that, so there has to be the prioritisation process that Ros had described to you.

Q141 **Chair:** But you are expecting that people will be able to see a significant difference?

Rosamond Roughton: Yes. I could show you photographs today of the impact of that investment already, of extensions that have been built or remodelling that enables more clinical rooms to be provided. You can

touch and feel that. It is not an aspiration, it is something that is happening there now.

- Q142 **Chair:** Going into the whole multidisciplinary issue, comments from some of my local GPs include, "Our premises is limited as to the number of GPs we can recruit, so we have to manage our list size to match that." Another said, "We can only have one nurse or one healthcare assistant working at a time due to space constraints." Do you prioritise an area where there is a particular demand on A&E or where there is a shortage? Are you looking at those data as well when the bids come in?

Rosamond Roughton: We published a set of criteria last year that basically guided the prioritisation process of which projects we would fund first and the speed of that. There is a published list on our website of where all of those schemes are going to happen. In addition, there are likely to be local investments as well; that will be a decision that local places will make. In terms of our national investment, I think we set that out clearly, and as I say, it includes a number of things that are about population. If people can't meet the needs of a rising population, the ability to have other services to be provided from that practice—

- Q143 **Chair:** That is numbers. What about healthcare outcomes? Is there a particular prevalence?

Simon Stevens: I will take the context of Hackney and London, where we have a particular concentration of smaller, older, inappropriate practice premises, although that is by no means just London. On the initial devolution arrangements that the NHS, the GLA and the Mayor have entered into—with Sadiq Khan in the next several days, I am going to be re-upping with colleagues for the next phase—part of that has been looking at capital investment in infrastructure across London, including primary care. In particular, we have been looking at how we free up some of the surplus assets, estates and unused buildings that the NHS has got around London and then reinvest that back into primary care. Historically, that has been quite a slow process. A lot of those assets have been sitting with individual trusts, but they need reinvesting across a local area, including in primary care. The health partnership that we are going to set out with the Mayor and the GLA will cover some of that territory as well.

- Q144 **Chair:** You might be aware that I have had a long beef with PropCo, which has taken local assets, not just in my area but across the country. It takes them and controls them. There is a mayoral devolution plan. My own borough has a devolution plan. The Liverpool and Manchester mayoral elections are coming up, and there is devolution there. Jon Rouse has gone from the Department to be involved in that. Is there going to be an approach that allows PropCo assets to be returned to their local community for better asset management, or will that damage your books? Is that not possible, given that your budget is so tight?

Chris Wormald: I will need to go and check the exact position, but I think that is for discussion.

- Q145 **Chair:** That is for discussion. As I say, it is confusing things locally when



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you have local priorities and you have to go through a bureaucratic procedure. Ros Roughton has talked a lot about local needs underpinning the changes, and then we have got PropCo, which is like a spaceship up in Whitehall that stops things happening.

Chris Wormald: I appreciate the point. I will go and check the exact position and give you an exact answer.

Q146 **Chair:** If you could write to us, that would be helpful and welcomed by people across the country. We talked about the skills mix, but we did not get into community pharmacies much. I am not asking you to talk about the policy, but there has been a change in the approach to the funding of community pharmacies. The understanding is that it will particularly affect pharmacies where there might be several of them in a cluster. There may be a bit of competition between them when the base funding is removed. I met Councillor Peter Bales from Moorclose in Allerdale, and he told me that the GP practice there has gone down from five GPs to one. He said that three quarters of people in the area do not have cars, yet the community pharmacy there is under threat. If you are trying to balance not having people go to A&E, the role of a good community pharmacist in an area—particularly one like that, which is way out of the town centre—is an issue. I do not want you to talk about that particular case, but we know that it is happening around the country. Have you factored in the changes to community pharmacies to the overall access that patients have to primary and pharmacy care?

Rosamond Roughton: With the community pharmacy contract and those changes, part of that includes the pharmacy access scheme for particular pharmacies where access for patients would be compromised if that pharmacy did not exist. I think the Department published a list of those, and we have been running an appeals process. A number of community pharmacies have written to us to set out exceptional circumstances by which they believe that they are—

Q147 **Chair:** The last resource.

Rosamond Roughton: Yes. So at the moment we have got a process under way that is reviewing each one of those cases.

Q148 **Chair:** Do you know how many you have had write in?

Rosamond Roughton: I don't know.

Q149 **Chair:** Could you write to us with that?

Rosamond Roughton: Yes, I can.

Q150 **Chair:** It would be very helpful if you could. Are you promoting the idea of independent prescribers, so that pharmacies can be an integral part and keep people away from GP practices when they are already pressured? Is that part of the plan?

Rosamond Roughton: Yes. One of the things—I realise I keep harking back to it—is the pilots we have been running on access, which were about improving access in the round. They were not just about extended hours.



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We have had places that have taken on pharmacists and supported them on independent prescribing. Part of what we will be investing in with our scheme to bring clinical pharmacists into general practice is the training and education of those individuals so that we can maximise their skills. I think we have built up a good lot of case studies and evidence about the difference that can make, working alongside general practice.

- Q151 **Chair:** My local pharmacy group tells me that a practice-based pharmacist may cost upwards of £60,000 to the GP practice. They say that for that sort of money you would be able to get a lot more patients managed for long-term conditions using medicines optimisation by community pharmacists who have been trained as independent pharmacists. Do you agree with that statement?

Rosamond Roughton: Yes.

- Q152 **Chair:** So that is something you are looking at.

Rosamond Roughton: Yes. We know we have got a good supply of pharmacists coming out of training. As a profession it has not been really utilised by patients or by other staff in the NHS. We are really keen to try and shift that.

- Q153 **Chair:** How do you monitor flows going through community pharmacists? Do you do any analysis, or do you require CCGs to do that to see who is going through to their community pharmacists and therefore not going to their GPs?

Rosamond Roughton: We have done some evaluation of the diversion rate where we have been funding it nationally. We have put some investment in, so we have been able to monitor flows. That is part of what has built up our—

- Q154 **Caroline Flint:** You can look at the number of prescriptions that go through for a start.

Rosamond Roughton: Yes, particularly where they have been set up like local minor ailment services. Also, we talk to patients and say, “If you hadn’t come here, where would you have gone?” We found that in one scheme—I can write to you with the details—some 80% of patients said, “We would have gone to the general practice instead.” So we know there is a role here that we could make more of. It goes hand in hand with the business of how we make best use of the GP as a trained doctor.

- Q155 **Chair:** How do you manage the tension? Whether it is QOF or not, there is a payment for certain things. What if someone goes to a pharmacist with a long-term condition or they are in a place where the pharmacist thinks, “At this point I could also give them a vaccination for something”? The GP would get paid for that. There is no incentive for the GP to provide data or permission for data sharing. I know there are data-sharing issues for individual GPs as well. But if you have someone in the right place at the right time, it would be quicker, cheaper and more efficient with less pressure on the GP service if they could get it all in one place. Are you looking at any of those flows and the competitive and, I suppose,



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commercial tensions?

Rosamond Roughton: I think that, particularly when we have introduced payment to community pharmacies for flu vaccinations, we have seen in some parts of the country tension between practices and pharmacies.

Q156 **Chair:** Exactly. How have you dealt with that?

Rosamond Roughton: In terms of volume, we want to increase the number of people that get flu. *[Interruption.]* Flu vaccinations.

Chair: That is a headline you don't want.

Rosamond Roughton: Our starting point is whether we are getting the health benefit that we need. We think that community pharmacies offering vaccinations has helped us. We are letting that tension exist.

Q157 **Chair:** But the flu vaccination is straightforward. I think you can be vaccinated for arthritis or something.

Caroline Flint: Anti-inflammatory.

Chair: There are anti-inflammatory ones out there. They are things that probably need to be on your medical record. You can't have everyone shopping around. Does that get fed back to the GP?

Rosamond Roughton: Yes, it does. Absolutely. We would not do it if we could not have information back. Otherwise there is a risk of somebody being vaccinated twice.

Q158 **Caroline Flint:** What you say is very interesting. On the earlier discussions about whether clinical commissioning groups are aware of what is really going on in GP practices, what is your understanding of how in touch they are with what is going on in pharmacies in their area? What about the buildings that pharmacies are in, if you want to provide other services? What is going on with the CCGs? They seem to be best placed to be out there looking at what is going on, what is being provided and who does what. Are they doing that?

Rosamond Roughton: I know that a lot of CCGs are working with community pharmacies to set up particular schemes that they want to see in their local area.

Q159 **Caroline Flint:** Do they physically go out and have a look? Do these people go out and see what is going on, rather than doing a paper exercise?

Simon Stevens: To some extent they do, but let us remember that CCGs are relatively small organisations.

Caroline Flint: I understand that.

Simon Stevens: As part of our ongoing effort to cut administrative costs in the system, we do not actually have a vast army of people who can go out and visit thousands and thousands of private businesses.



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Q160 **Caroline Flint:** I think you could get patients to be a standing group of people in the community who would be very willing to go out and do things such as checking. Give them a tick list and say, "Go in the pharmacies and tell us what you think is there." There is surely a way of involving the public in this.

Simon Stevens: Yes, that is a great idea.

Caroline Flint: There could be an army of people going to see what is happening, as in the hospitals that have lay people who come in and check hygiene on wards.

Chair: There is an idea for you, Mr Stevens, to add to your otherwise empty in-tray.

Caroline Flint: I am not saying it is your job—CCGs could do it. They could involve the public a lot more in some of this work.

Q161 **Chair:** Healthwatch England is there very much to do that. I hope that they are listening, too. You might want to take that up—Mr Stevens meets them regularly.

My final question is about the 111 out-of-hours service. I am picking up that CCG clusters are being asked to commission a new, beefed-up 111 service rather than their existing out-of-hours services. Is this correct, Mr Stevens?

Simon Stevens: It most certainly is.

Q162 **Chair:** Are you mandating CCGs to do this?

Simon Stevens: Yes.

Q163 **Chair:** What is the rationale behind that?

Simon Stevens: If we think back to a previous deliberation of this Committee on an NAO Report on out-of-hours and 111 services, we will remember that you made a set of recommendations to us that we should do just that, and of course we take that as a very important instruction set. So many of the—

Chair: Okay, we have got the point. Flattery gets you nowhere, but carry on.

Simon Stevens: The actual point of this is that, as we were talking about with the extended access thing, 111 is a highly valued service, but frankly we need 111 to answer a higher proportion of calls that are being dealt with by a doctor, nurse or paramedic. We want to increase that proportion from 22% of calls right now to north of 30% by this coming winter. In order to do that, one of the things we want to make sure is that we have got proper integration with the GP out-of-hours service. Many of the out-of-hours services are already using 111 as their front-end call handling, but it really makes no sense to have two parallel offers. So that integration—integrated out-of-hours urgent care with the ability also to book people into an urgent treatment centre or to connect with the GP



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streaming and the front-end of A&E—is part of the 10-point plan we need to improve the performance of the NHS on urgent and emergency care over the course of the next year.

Q164 **Chair:** Will it have targets to reduce admissions to A&E?

Simon Stevens: The targets in the first place will be around the proportion of calls that are being handled by a clinician, and then the clinicians will be able to use their clinical judgment. We have got a very important pilot working across the north-east of England that has been able to link the data from 111, out-of-hours, the ambulance service and the A&Es to show what effect a higher proportion of clinical call handling has on the so-called dispositions: where patients end up being treated.

But it is also worth saying that 111, despite all of that, and as recorded by patients, is doing an important job. Indeed, at times of maximum pressure, the proportion of calls that are referred on to A&E actually goes down. Perhaps to trade with Anne Marie Morris on the Nuffield Trust reports, I draw your attention to their winter insight on 111, which, contrary to some of the myths that have been propounded about 111, says, “NHS 111 has occasionally been blamed for contributing to the pressures experienced by A&E departments in winter. The figures, however, suggest the exact opposite: the call line actually soaks up extra need by referring a lower proportion of callers to A&E and ambulances in the winter months”.

Anne Marie Morris: Touché.

Q165 **Chair:** Thank you very much for that. People are always concerned about change. We will keep an eye on it. No doubt we will come back to out-of-hours services at some point, but I cannot tell you when. Thank you very much for your time. Sorry we ran a bit over what we intended.

Our transcript will be up, as usual, in the next couple of days, if you want to check it. On the checking of it, Mr Wormald, when Mr Williams appeared before us, he sent in a correction that he misspoke, but he misspoke on something that I thought was more substantial than a misspeak. We asked if he was monitoring whether trusts were paying late in order to make sure that the budget was balanced. At the time, he said, “Yes, this is being watched closely”, and then he wrote to us to say that it was not being watched closely, which was quite a big change, and an odd thing to say. It is not good enough really to come to a Select Committee and misspeak on something so substantial. Usually, a correction is a tiny thing and we thought that was quite substantial. We will be exchanging correspondence. I do not know if you have anything to add to that.

Chris Wormald: Obviously, we are very sorry about that. As I am sure you know, Mr Williams is a highly diligent civil servant and I am sure that would not have been his intention.

Q166 **Chair:** Will you now be watching closely to see if payments to suppliers are being delayed?

Chris Wormald: I will not give you a definitive answer without checking—



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Chair: Having been bitten once—

Chris Wormald: I will learn. But as I say, I am sure Mr Williams will be mortified—

Q167 **Chair:** If the NHS is balancing its books but not paying its suppliers as part of the way to do that, that is really not good enough.

Chris Wormald: I will check the exact position and come back to you.

Chair: Thank you. We will be exchanging correspondence.