



House of Commons
Health Committee

Primary care

Fourth Report of Session 2015–16



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*Report, together with formal minutes
relating to the report*

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The Health Committee

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Committee staff

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Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is healthcom@parliament.uk.

Contents

Summary	3
1 The experience of primary care	5
Meeting patient expectations	5
Patient satisfaction	6
Improving access to primary care	7
Weekend appointments	9
Utilising information technology	16
Struggling workforce	19
Workload	19
Funding	21
Variable quality	23
2 The new models of care	26
Changing how we care	26
Findings of the Primary Care Workforce Commission	26
The blueprint for a new model of care	27
Specialists in primary care	33
The role of federations	35
3 Building the new team	39
Primary care workforce	39
Workforce planning	39
Tackling local shortages	44
Nursing	46
Training and education	48
SIFT payments	48
Workforce and federations	50
Regulation	50
GP leadership	52
4 Funding	54
Changing incentives in the system	54
Investing in primary care	56
Proportion of NHS spending on primary care	56
Future funding	57

Conclusions and recommendations	62
Annex: Visit to Halifax and Sheffield	69
Formal Minutes	74
Witnesses	75
Published written evidence	76
List of Reports from the Committee during the current Parliament	82

Summary

Primary care is the bedrock of the National Health Service and the setting for ninety percent of all NHS patient contacts. It is highly valued by the public but is under unprecedented strain and struggling to keep pace with relentlessly rising demand. The traditional model of ten minute appointments with general practitioners no longer allows them to provide the best possible care for patients living with increasingly complex long term conditions.

The difficulty in accessing primary care is a serious concern for many patients, especially for those who work during the week. We believe that it is vital that patients have timely access to primary care services. This includes both access to urgent appointments and the ability to book routine appointments in advance.

During the course of this inquiry we heard many examples of innovative practice which give cause for optimism that patients' access to and experience of primary care can be improved. The priority for government should be to train, develop and retain not only more GPs but wider multi-disciplinary teams working within a more integrated system of care. Patients would also benefit from the better use of technology to assist communication with and between their clinicians. There is a pressing need to improve continuity and safety through the use of electronic patient records which can be shared, with their consent, wherever people access their care.

In line with the recommendations of the Primary Care Workforce Commission, multi-disciplinary teams can harness the skills not only of GPs but physiotherapists, practice nurses, pharmacists, mental health workers and physician associates. We support the Commission's vision of teams of professionals using their skills to meet the needs of patients much earlier in their journey through the NHS. This would allow GPs to concentrate on those aspects of care that only they can provide. We expect GP leaders to be at the forefront of the development of multi-disciplinary teams.

Patients need more health professionals from a range of disciplines to choose careers in primary care. Existing medical education does not encourage graduates to do so and greater attention must be paid to the needs of patients in designing training pathways and incentives across the entire NHS workforce. It is far from certain that sufficient numbers of GPs and nurses will be available to build new teams and improve patient access. Much greater efforts to recruit, train and retain the primary care workforce will be necessary if the vision of the Primary Care Workforce Commission is to be achieved.

The government made a manifesto commitment to seven day access to services but further clarification is needed about how this commitment is to be implemented and resourced, especially in light of the workforce shortfall.

Improving access to primary care is a welcome goal, but practical application of the seven day policy should be locally designed, led by the evidence and take account of local recruitment challenges. The policy must also focus on the continuity of patient care and avoid reducing the capacity of weekday services as well as urgent out of hours primary care cover.

Although difficulty in accessing general practice continues to frustrate patients, GPs consistently receive highly positive patient satisfaction ratings. Healthwatch England pointed out that service users are reluctant to criticise their doctors and caution that the figures may mask deep-seated concerns about quality and standards.

We heard worrying evidence about the longstanding variation in quality across primary care. The Care Quality Commission has highlighted very poor standards of care among a small proportion of practices and has developed a mechanism to close those which put their patients at risk and follow up necessary improvements in others.

We welcome the benefits which CQC inspection has brought for patients and we urge the Royal College of General Practitioners and the British Medical Association to work constructively with the CQC to protect the public from failing practices and to help to turn around underperforming practices. At the same time, NHS England, the CQC, the General Medical Council and Local Education and Training Boards must work together to reduce bureaucracy and unnecessary duplication, so that time which should be devoted to patient care is not eroded by an excessive bureaucratic burden.

Despite the rising demand for services and a consensus on the value of primary care, its funding has fallen behind as a share of the overall NHS budget. The five year funding settlement provides only a very limited uplift in expenditure on primary care. We believe that it should receive a larger proportion of overall NHS spending in order to improve access and services for patients.

1 The experience of primary care

Meeting patient expectations

1. Primary care is the bedrock of Britain's National Health Service, accounting for nine out of ten patient contacts within the NHS.¹ Our system is admired around the world for the quality and continuity of care it provides, and for its role in preventing ill health and reducing the pressure on more expensive acute and secondary care.
2. Primary care has, however, come under unprecedented pressure. In many areas patients are finding it increasingly difficult to access services and we heard evidence of an unacceptable level of variation in the care provided.
3. Healthcare professionals report growing and unsustainable pressure, exacerbated by a lack of resources. In spite of Government recognition of the importance of primary care and the need to move more care from acute settings into the community, the service has received a falling proportion of overall NHS funding since 2006.²
4. Primary care will need to adapt if it is to meet the rapidly rising and changing demands of patients living with increasingly complex health problems. In the course of this inquiry we have heard many examples of innovative practice which give cause for optimism that this change can be achieved. Our report does not seek to replicate other more detailed inquiries such as the Primary Care Workforce Commission (PCWC), which described a new model of care based on practices collaborating via networks and federations and primary care health professionals working in multi-disciplinary teams. Instead, we seek to address the barriers which may stand in the way of developing new models of care and to encourage the provision of the best primary care services for patients now and in the future.
5. Don Redding, Policy Director at National Voices, a coalition of national health and social care organisations including charities which support patients, succinctly set out why a new model of care is required:

Two thirds of consultations are for people with long-term conditions and a third of consultations are for people with multiple conditions. The core customer has changed but the model has not. The model remains reactive, in that it waits for people to turn up with an exacerbation or a symptom. It is episodic. Although GPs try their best to provide continuity, the way that they work is not geared to providing continuous support. It deals with one issue or symptom per consultation.³

Candace Imison of the Nuffield Trust starkly explained the challenge that this presents to the NHS:

We want and need general practice to do things it has not historically done, so there is a need to think very strongly about population health management, proactively manage chronic disease, support people to do selfcare and relate

1 Royal College of General Practitioners ([PRI 174](#)) para 1

2 The King's Fund ([PRI 191](#)) para 16

3 Q185

very differently to patients and local communities. Those are all things that move general practice away from its traditional model, and that is going to require significant investment and change.⁴

Patient satisfaction

6. Despite the pressures facing general practice, feedback from many patient groups remains resolutely positive. A number of local organisations endorsed the overall quality of care available to patients in their areas. Healthwatch Brighton and Hove noted that “Doctors (85%) and nurses (87%) were rated positively with regards to listening to patients properly and making them feel heard.”⁵ Healthwatch Richmond described “a relatively high level of overall patient satisfaction with the quality and standards of care in the borough”⁶ and, similarly, Healthwatch Suffolk reported the outcome of their GP survey which found that “of 604 survey respondents, 486 (82%) said that they were happy with the overall service provided by their GP Surgery.”⁷ In Cambridgeshire, Healthwatch found that “89% of people are positive about their surgery and their Doctors.”⁸

7. From the national perspective, Healthwatch England said they “found that, overall, people spoke positively about their interactions with their GP.”⁹ This perspective supported the argument made by the Government in its evidence. The Government emphasised the outcomes of the GP Patient Survey:

The latest results, published in July 2015, show that 85.2% of patients reported a good overall experience of their GP surgery.

In addition to the GP Patient Survey from December 2014 it became a contractual requirement for GP practices to offer the “Friends and Family test” (FFT). [...] The latest publication of results for May 2015 shows that 88% of patients would recommend their GP practice to their friends and family.¹⁰

8. Anna Bradley, Chair of Healthwatch England, told us that high levels of reported patient satisfaction can mask wider concerns:

You will be very well aware that, if you ask patients [and] the public about the quality of primary care, you get very high levels of satisfaction. That is undoubtedly the way most people talk about primary care. It has been our experience very clearly that, if you scratch the surface and have a bit more of a conversation with people about perhaps their latest episode of care or their experience most recently, it is very varied.

Ms Bradley said that, in part, this is because patients value services provided by the NHS and are reluctant to voice complaints, however informal:

people are ultimately truly grateful for the national health service and see it as a treasure that they want to protect, and throwing brickbats at it for not doing

4 Q151

5 Healthwatch Brighton and Hove ([PRI 41](#)) para 2

6 Healthwatch Richmond ([PRI 77](#)) p 2

7 Healthwatch Suffolk ([PRI 167](#)) p 4

8 Healthwatch Cambridgeshire ([PRI 74](#)) p 4

9 Healthwatch England ([PRI 228](#)) para 21

10 Department of Health, NHS England and Health Education England ([PRI 200](#)) paras 21–22

quite what they want is not, in their view, necessarily the right way to behave. There is something about the quality of conversation that you have with people and the fact that people feel safe to have that conversation.

One thing that has emerged in all the research we have done is that people feel quite vulnerable when they are using health and care services and are quite fearful to say if their experience has not been that good because they think it may have ramifications for their future service, and there have been occasions where indeed it has. Although that is not the general picture, it is something that makes people quite fearful and perhaps slightly less than honest.¹¹

9. Anna Bradley's insight is vital to understanding the real experience of patients. It would be easy for policy makers to become complacent by relying on the headline figures and ignore serious underlying concerns. General practice does manage to provide good quality care that is highly valued by patients, but sometimes in spite of the system rather than because of it and due to the skill and dedication of the health professionals in primary care. Sir Bruce Keogh, Medical Director of NHS England, outlined the challenge of providing care as a member of a general practice team and paid tribute to the skills of the workforce—a tribute which we endorse:

Both general practitioners and their associated staff are having to deal with tricky issues of increasing demand and rising expectations, and in particular in the face of increasing complexity of the patient workload that they have to see. In my view, it is a really hard job. They have to be clinically, intellectually and emotionally strong. I can say this as a cardiac surgeon, where all our patients come to us kind of worked up. [...] But day in, day out, general practitioners are having to sort out the wheat from the chaff, to identify major clinical problems masquerading as minor ailments, and it is utterly relentless. It requires quite a lot of intellectual flexibility and people have to be very tolerant individuals. It is one of the hardest jobs in medicine. It is important to say that at a time when general practice is going through quite a lot of turmoil.¹²

Improving access to primary care

10. Difficulty in accessing general practice is a core concern and one which can determine the extent to which patients are satisfied with the service they receive. Much of the evidence from the patient organisations that submitted evidence to this inquiry examined questions of access, both in terms of the availability of appointments when requested and wider concerns related to extended hours and routine weekend appointments. The Patients Association summarised their overarching national view in their evidence:

Through our National Helpline and our research we have received consistently poor reports from patients about the ease and time it takes to book a GP appointment. Issues of waiting times, inability to obtain same day appointments or appointments in advance remain an ongoing problem. Callers to our Helpline constantly tell us of waiting long periods simply to get through by phone to their GP surgery. Often when they eventually get through there are

11 Q186 (Ms Bradley)

12 Q267

no appointments available and are asked to call the following morning [...] These recent results are also largely consistent with our larger report, *Access Denied*, published in 2013, which revealed that:

- more than a third of working age people have had to take time off work to attend a GP appointment.
- a third of respondents were unable to book a GP appointment at least 48 hours in advance.
- over half of respondents felt that booking a GP appointment was either “very difficult” or “could have been easier”.
- over half of respondents were not satisfied with the service they received from an NHS out-of-hours provider in the last 2 years.¹³

11. The headline finding from the National Audit Office’s (NAO) stocktake of access to primary care, published in November 2015, appeared to contradict the evidence supplied by the Patients Association:

Overall, the vast majority of patients report a positive experience of access to general practice, with 89% reporting in 2014–15 that they could get an appointment. Three-quarters of patients got an appointment within the timeframe they wanted. Only 12% of patients reported a poor experience of making the appointment.¹⁴

12. Behind this figure, however, the NAO reported significant variation between practices, which can shape the widely differing experiences of patients:

The availability of appointments varies significantly between different practices—the proportion of patients unable to get an appointment ranged from 0% to 52% in 2014–15. We found that much of this variation could not be explained by demographic factors, practice characteristics or supply of general practice staff.

Significantly the NAO found that variation in access means that some groups are less able to access care:

- Older patients were more likely than younger patients to be able to get an appointment, more likely to rate the appointment as convenient, and more likely to receive continuity of care if they wanted it. This is likely to reflect that a higher proportion of younger patients are in employment so may find it difficult to attend appointments during working hours. We also found that younger patients have different expectations: they are more likely to expect same-day or next-day access to general practice than older patients (paragraphs 4.8, 5.11 and 6.5).

13 The Patients Association ([PRI 196](#)), p 4

14 [C&AG’s Report, Stocktake of access to general practice England, Session 2015–16, HC 605, 27 November 2015](#), para 12

- Patients of a white ethnic background reported the best access to general practice, with 11% saying in 2014–15 they had been unable to get an appointment compared with 19% of Asian patients. And 62% of white patients who wanted continuity of care received it, compared with 47% of black patients and 47% of Asian patients.¹⁵

13. The public has consistently rated the service provided by general practice even more highly than the NHS as a whole.¹⁶ Trust in doctors is higher than for any other profession and faith in GPs exceeds that of other medical professionals.^{17,18} However, high patient satisfaction rates have recently fallen, declining by 3 points from 2013 to 2014 according to the British Social Attitudes Survey.¹⁹ The public and patients' groups report increasing dissatisfaction with their ability to get to see a GP, either when they need to or at a time that is convenient for them. In response to these concerns the Government made a commitment to deliver a seven day service by enabling the provision of routine GP appointments at weekends.

Weekend appointments

14. The Government's 2015 general election manifesto contained a commitment to "ensure you can see a GP and receive the hospital care you need, 7 days a week by 2020, with a guarantee that everyone over 75 will get a same-day appointment if they need one".²⁰ The introduction of weekend primary care services, however, pre-dated the 2015 manifesto commitment and by April 2014 twenty pilot sites had already been selected to test the provision of weekend appointments in general practice.

15. In January, the Secretary of State for Health, Rt Hon Jeremy Hunt MP, reiterated the Government's position regarding the delivery of seven day services:

As part of our commitment to a seven-day NHS, we want all patients to be able to make routine appointments at their GP surgeries in the evenings and at weekends.²¹

16. When asked to set out how the Government will evaluate evidence emanating from seven day primary care pilot schemes, Alistair Burt reflected that the evidence from the pilots was not yet clear but said that he "would look at the evidence individually from each area and make a decision based upon that."²² Mr Burt added that if the operation of routine seven day services represented "a complete waste of resource"²³ then that would be "a material fact I would take into consideration."²⁴

17. There has been some confusion about the intention of the Government's policy. When Simon Stevens, Chief Executive of NHS England was asked at a meeting of the Committee of Public Accounts whether he was "wedded to the idea of every general practice providing

15 [C&AG's Report, paras](#), para 12

16 National Centre for Social Research, [British Social Attitudes 32 - Health](#) (2015)

17 General Pharmaceutical Council, [Public perceptions of pharmacy](#) (January 2015)

18 Ipsos Mori Social Research Institute, [Veracity Index 2015](#) (January 2016)

19 National Centre for Social Research, [British Social Attitudes 32 - Health](#) (2015)

20 The Conservative Party, [The Conservative Party Manifesto 2015](#) (April 2015), p 37

21 HC Deb, 5 January 2016, [col 4](#) [Commons Chamber]

22 Q360

23 Q369

24 Q369

an 8-till-8, seven-day-a-week service”²⁵ Mr Stevens simply answered “No”.²⁶ Mr Stevens explained that he does not believe that this is what the Government wants and, in any case, workforce constraints would not allow for this type of service.²⁷

18. Dr Maureen Baker, Chair of the Royal College of General Practitioners Council, outlined concerns that there is insufficient capacity within the existing general practice workforce to provide seven day services and extended weekday hours:

We are struggling with medical, nursing and other workforce in general practice to provide the service Mondays to Fridays, and to provide extended access in the evenings, which we do know that patients want, and Saturday mornings as well.²⁸

Demand for weekend appointments

19. The NAO reported that the “percentage of patients reporting that opening times are not convenient increased from 17% in 2011–12 to 20% in 2014–15.”²⁹ The report noted, however, that the majority of the evidence gathered from analysis of the Prime Minister’s GP Access Fund called into question demand for services at weekends, especially on Sundays:

A survey commissioned by Monitor in 2014 found that 14% of respondents said evening and weekend opening was one of the top 5 things they look for in a general practice.

Research in 2015 found that weekend opening is much less important than evening opening during the week when people are choosing a GP practice. However, respondents to our survey in September 2015 said it was just as important to be able to see or consult with someone on a Saturday or Sunday as it was to consult with someone after 6.30 in the evening.

The Prime Minister’s GP Access Fund evaluation, also in 2015, found high take-up of extended hours appointments in the week and on Saturday mornings, but very low take-up on Sundays.³⁰

The independent evaluation of the GP Access Fund (also known as the Prime Minister’s Challenge Fund) concluded that additional hours are necessary but the case has not yet been made for seven day routine services:

Given reported low utilisation on Sundays in most locations, additional hours are most likely to be well utilised if provided during the week or on Saturdays (particularly Saturday mornings). Furthermore, where pilots do choose to

25 Oral evidence taken before the Committee of Public Accounts on [11 December 2015](#), HC (2015–16) 673, Q 46 [Ms Flint]

26 [Ibid](#), Q46

27 [Ibid](#), Qq47–48

28 RCGP ([PRI 174](#)) para 23

29 [C&AG’s Report](#), para 14

30 [C&AG’s Report](#), para 5.6

make some appointment hours available at the weekend, evidence to date suggests that these might best be reserved for urgent care rather than pre-bookable slots.³¹

We note that the first independent evaluation of the Prime Minister's Challenge Fund pilot schemes reported that a number of the pilots reduced or discontinued their weekend services. Whilst in some cases this was due to low attendance this was not exclusively the case.³²

20. These findings are in line with evidence produced by organisations which have examined the take up of weekend primary care services in local areas. The Centre for Health Innovation Leadership and Learning, Nottingham University Business School evaluated the take-up of Prime Minister's Challenge Fund (PMC) supported additional hours projects in the East Midlands. They found that there was little demand for weekend services:

Patient preferences are revealed by the take-up of weekend appointments in PMCF initiatives. Utilisation rates for the weekend hub pilot in Rushcliffe CCG for the period 1st January to 31st June 2015 is 38% on Saturday mornings and 29% on Sunday mornings. A similar weekend hub located in Ilkeston (Erewash CCG) had utilisation rates of 31% on both Saturday and Sunday mornings during the period 1st January to 31st July 2015.

We know that in other weekend PMCF initiatives around the country, that Sunday utilisation rates can be as low as 10%.³³

The researchers who undertook the evaluation concluded that:

If evidence such as this had been available, ex ante, to local practices and CCGs, it is very unlikely they would have undertaken initiatives to offer additional weekend appointments.³⁴

21. It is notable that criticism of the Government's policy extended to local commissioners of health services. Sheffield CCG said in their evidence that:

7 day access always has been available when out of hours is considered. The question is should 7 day a week 'routine' care be available? We do not see much evidence to support the view that patients want, let alone need, access to routine GP services seven days a week.³⁵

22. Chris Ham, Chief Executive of the King's Fund, was enthusiastic about the concept of 7 day services, but he argued that it would require significant additional resource to deliver.³⁶ This argument is reinforced by analysis undertaken by the RCGP that attempted to cost the delivery of routine care on Saturdays and Sundays. They reported:

31 NHS England, [Prime Minister's Challenge Fund: Improving Access to General Practice First Evaluation Report](#) (October 2015)

32 [Ibid](#), [GP seven-day pilot schemes](#), Pulse, 7 May 2015

33 Centre for Health Innovation Leadership and Learning, Nottingham University Business School ([PRI 122](#)) para 21–22

34 [Ibid](#), para 20

35 Sheffield Clinical Commissioning Group ([PRI 127](#)) para 3.2

36 Q152

That extending GP hours so that one in four surgeries open late and at weekends would cost at least £749m per year—rising to £1.2bn if one in two practices were to take part.³⁷

23. The Patients Association is a keen advocate of seven day services and said that routine care should be provided across the working week and weekends. Their Chief Executive, Katherine Murphy, argued that lack of demand in the pilot schemes was attributable to poor public awareness, telling us “[the] public are quite used to having a primary care service from Monday to Friday. If they do not know that the services are available, it is difficult for them to access them.”³⁸

24. It should, of course, be acknowledged that any patient registered with a practice offering weekend services who seeks an appointment will be made aware of weekend availability once they contact their surgery. This point was partly addressed by the first evaluation of PMCF projects which questioned the relationship between advertising and demand:

there is general agreement that the lack of success with certain weekend extended hours slots is not necessarily attributable to the delivery and design of projects or an ineffective communications strategy; rather it is a result of entrenched patient behaviours.³⁹

The implication of Katherine Murphy’s statement is that there is a population of patients that do not ever seek to make routine appointments as they assume that they could only be seen between Monday and Friday during working hours. This is the group of patients that needs to be reached.

Improving access to primary care: conclusions

25. We believe that it is vital that patients have timely access to primary care services. This includes both access to urgent appointments and the ability to book routine appointments in advance.

26. Evidence from the National Audit Office shows that people who work during the week would like to make use of extended hours at weekends.⁴⁰ We welcome the principle of improving access for people whose working lives make it very difficult to obtain appointments during the week and recognise that this was one of the Government’s manifesto commitments. The Government should, however, bear in mind evidence that there may be more demand for access to GPs in the evenings or on Saturdays than on Sundays.

27. There should be a full evaluation of the pilot programmes testing the provision of routine weekend appointments before any new system is rolled out around the country.

37 RCGP, [Royal College of General Practitioners Seven day access to routine general practice – position paper](#) (2015), para 7

38 Q220

39 NHS England, [Prime Minister’s Challenge Fund: Improving Access to General Practice First Evaluation Report](#) (October 2015)

40 [C&AG’s Report](#), para 12

The Government's approach should be evidence based, learn from best practice and avoid unintended consequences such as damaging weekday services, continuity of care or existing urgent out-of-hours primary care services.

28. Patient understanding of the services available to them would be enhanced by the Government and NHS England providing more detail as to the type of service the Government would like primary care to offer. The Secretary of State and the Prime Minister have stated that patients can expect to have 7 day access to a GP surgery for routine appointments, but comments from Alistair Burt and Simon Stevens suggest a more nuanced approach.⁴¹ A more consistent message which clarifies the type of service that patients can expect would help the public to better understand how primary care is evolving. We note that virtually all practices involved in PMCF initiatives have also taken the opportunity to remodel their workforce.⁴² In promoting improved access the Government should also emphasise that patients will not only be able to consult a GP but can have access to a broader multi-disciplinary team. It would be helpful for the Government to provide more clarity about how certain aspects of the policy will function, for example:

- whether out-of-hours providers will be permitted to provide routine weekend appointments
- how Ministers expect the provision of appointments via hubs or federations to interact with the commitment to allocate a named GP to all patients aged over 75
- how the challenge of providing accessible services in rural areas will be met
- whether all localities will be expected to provide a Saturday and Sunday service or if local areas will have the freedom to tailor weekend services around trends in patient demand.

29. We are concerned that insufficient advertising and promotion of routine weekend appointments may have artificially limited latent demand for weekend appointments by failing to reach those who would benefit the most from these services. **An essential component of extending primary care services to weekends should be making those patients currently disenfranchised by the existing model of care aware of improved access. Ongoing evaluation of Prime Minister's Challenge Fund backed projects should, at a local level, incorporate an analysis of patient awareness of weekend services.**

Continuity of care

30. The RCGP has cautioned that seven day services would disrupt the continuity of care that patients with multiple long-term conditions require:

We are concerned that the proposal to provide seven day GP access to routine care could jeopardise continuity of care, which is of key importance to tackling the problems currently facing the NHS, especially in the management of long-term conditions.⁴³

41 "PM on plans for a seven-day NHS", Prime Minister's Office, 10 Downing Street, 18 May 2015

42 Q 248

43 The Royal College of General Practitioners ([PRI 174](#)) para 24

Without additional workforce numbers the requirement to provide weekend services could diminish the availability of extended weekday appointments and diminish continuity of care, which we know is valued by patients.⁴⁴

31. An inability to communicate patient information also risks compromising continuity of care. The Government and NHS England told us that investment is in place to ensure that interoperability of IT systems allows for the transfer of electronic patient records between practices that are parts of federations.⁴⁵ At present, however, systems are not in place to make this standard practice and, for the time being, practices are using “temporary solutions.”⁴⁶

32. Continuity of care demands continuity of record keeping. Patient safety is compromised by inadequate access to patient records. There is greater risk of medical errors as well as the unnecessary costs of increased bureaucracy where patient records cannot be accessed and electronically updated at every point of contact. Routine appointments, especially for complex patients, without access to patient records give rise to an avoidable risk.

33. It is essential, both for patient safety and to reduce bureaucracy, for patient records, accessed with their consent, to be directly accessible by all the health professionals seeing patients registered with any practice within a federation, network or out-of-hours provider. The response to this report should lay out a clear timetable for these arrangements to be in place including for shared access between primary and secondary care. Efforts should be made to ensure that such arrangements apply UK wide.

Interaction with out-of-hours care

34. In oral evidence Dr Maureen Baker argued that operating weekend services could make existing out-of-hours provision untenable:

One concern we have is that by focusing on provision of routine services seven days a week we could be running down the essential out-of-hours service. Even if you did provide routine general practice eight to eight, Monday to Friday, 12 hours a day still need to be covered by an out-of-hours service. At the moment, where schemes are providing extended access in the evenings and weekends, the doctors that they bring in to do those are doctors who would otherwise work in the out-of-hours service. So some out-of-hours services are finding they are becoming extremely unstable in being able to provide doctors for that service.⁴⁷

35. Dr Baker observed that extended hours can be more attractive to GPs because such a system is better remunerated and carries less risk,⁴⁸ a point reinforced by evidence from the Medical & Dental Defence Union of Scotland.⁴⁹ During our visit to Sheffield the GPs

44 The Nuffield Trust ([PRI 175](#)) para 2.2

45 Q377

46 Q378

47 Q310

48 Q311

49 Medical and Dental Defence Union of Scotland ([PRI 185](#)) para 2.1

working at Page Hall Medical Centre said that the extended hours hubs they work through offered GPs better remuneration but were not meeting patient demand.⁵⁰ The net result of these concerns was illustrated by the Lancashire Cumbria Consortium of LMCs:

There are only so many GPs to go round and we are already seeing the impact of initiatives such as the Prime Minister's Challenge Fund where locum GPs are attracted to do shifts for these services at the expense of being available to man out of hours services or fill sickness and holiday absences in practices. Furthermore the market is being distorted as GPs see the advantages of doing shifts to suit their personal circumstances at attractive payment rates without any ongoing worries or commitments to their practice.⁵¹

36. The RCGP has called for the policy emphasis to be on locating GP out-of-hours services where patients can physically access them. Dr Baker said the RCGP had:

recently produced a joint statement with the Royal College of Emergency Medicine to say that co-location of GP out-of-hours services with A&E services, where there is suitable opportunity to do so—it does not work everywhere—is, in general, helpful, useful for patients and leads to better use of resource.⁵²

37. The relationship with out-of-hours services is particularly pertinent in the context of providing weekend appointments in rural areas. Giving evidence to us in September 2015, the Secretary of State said that weekend GP services could be offered by one practice as part of a network or federation.⁵³ During our visit to Sheffield this concept was addressed by one GP who said that offering services through federations in rural areas (such as his) would not be satisfactory as patients would not be willing to travel ten miles or more for a routine appointment if only one practice in a federation was offering the weekend services.⁵⁴ Analysis by the NAO found that “only 1% of people in urban areas do not have a GP surgery within 2 kilometres, compared with 37% in rural areas.”⁵⁵ Where rural federations operate across even wider areas, the distances patients need to travel will be even greater.

38. There is a risk that an unsophisticated approach to the introduction of 7 day GP services in rural areas delivered by federations or networks may not achieve the ambition of facilitating better patient access. The availability of primary care services will not be improved if patients are expected to travel to inaccessible locations. Weekend urgent primary care is already available via out of hours providers and this should be taken into account when assessing the most effective method of delivering weekend services, especially in rural areas. **We recommend that clinical commissioning groups, federations and networks be given the flexibility to develop local solutions for weekend access to meet the needs of those who cannot attend routine services between Monday and Friday. Clear and consistent statements affirming the Government's commitment to local flexibility are required to assist both implementation and public comprehension of the policy. Implementation of new weekend routine services must also take account of the impact on local provision of existing out of hours services for urgent primary**

50 Note of Committee visit to Halifax and Sheffield

51 PRI 87, p 3

52 Q312

53 Oral evidence taken on [15 September 2016](#) HC (2015–16) 446, Qq 24–27

54 Note of Committee visit to Halifax and Sheffield

55 [C&AG's Report](#), para 18

care. We recommend that locally led design underpinned by adequate funding and resource from the centre should form the basis of the Government's implementation of its manifesto commitment to 7-day primary care services.

39. In 2013 our predecessor committee recommended in its report on urgent and emergency services that urgent care centres providing out of hours GP services should be co-located on hospital sites where appropriate for the local population.⁵⁶ The future location of extended primary care provision should take this recommendation into account as part of a process of simplifying and concentrating the confusing array of urgent primary care services.⁵⁷ Local demographics and the location of hospitals will not always make this possible, therefore local input is vital to determine the optimum locations for patient access.

Utilising information technology

40. A key conclusion of the Primary Care Workforce Commission emphasised the importance of better applying technology in primary care. The Commission said they:

anticipate that video-conferencing consultations will become a common extension of the telephone consultations that are already widespread in general practice.⁵⁸

The number and profile of patients who will want to take up online consultations or other services has not been established, and trends relating to patient demand are not well understood. Patient expectations regarding the use of IT can, however, range from a desire to use new technology to access consultations or advice to far more prosaic concerns such as being able to easily communicate with their practices. Causes of frustration for patients can include being unable to speak to practice staff when necessary and it not being possible or straightforward to book appointments online.⁵⁹

Contacting practices

41. The views of many local Healthwatch bodies focused on improving the use of IT to improve and simplify basic elements of general practice such as booking appointments. Healthwatch Brighton reported that the majority of patients they surveyed had never attempted to book appointments online.⁶⁰ Healthwatch Worcestershire identified that existing call-back booking services are difficult to use for teenagers in school or at college and that this group would prefer to book online or by text message.⁶¹

42. NHS England data from January 2015 showed that 91 per cent of patients are registered with practices "that offer the ability to book or cancel appointments online."⁶² The GP Patient survey reported that patient awareness of online services is improving with 29.3% of patients now aware that appointments can be booked online, but only 6.3% of patients

56 Health Committee, Second Report of Session 2013–14, [Urgent and Emergency Services](#), HC 171, para 114

57 *Ibid*, para 112 – 113

58 [Primary Care Workforce Commission](#), July 2015, p 26

59 The Patients Association ([PRI 196](#)) p 4

60 Healthwatch Brighton and Hove ([PRI 41](#)) para 2

61 Healthwatch Worcestershire ([PRI 194](#)) p 4

62 NHS England, [Board Paper](#) (January 2015)

actually book appointments this way.⁶³ Healthwatch Gloucestershire’s evidence, however, highlighted the problems of local variation—27% of practice websites they examined still did not offer online appointments.⁶⁴ Overall they found a lack of consistency in the information available from practice websites in their area and almost half those reviewed contained out of date information.⁶⁵

43. The GP patient survey has reported that the proportion of patients who find it easy to contact their practice by telephone is in consistent decline from 76.6% in December 2012 to 70.4% in January 2016.⁶⁶ Over a quarter of patients now report that it is not easy to speak to someone in their practice by telephone.⁶⁷ Katherine Murphy described the experience of many patients when they attempt to contact their practice by telephone:

very often people are on the phone at half past eight in the morning, phoning for an hour, only to be told that there are no appointments left for that day or to phone back in the afternoon, and when they phone back in the afternoon the appointment has gone. This occurs day after day.⁶⁸

Remote consultations

44. Examining alternative ways for patients to consult health professionals, Healthwatch England called for the use of email to replace posted letters “as a bare minimum”. Facilitating direct communication between clinicians and patients by email was explored by the PCWC. The Commission suggested that this idea should be progressed with some caution:

Email correspondence between primary care clinicians and their patients should be piloted prior to becoming a routine part of NHS care. The impact of introducing emails from patients on the primary care workload should be evaluated, bearing in mind its potential to reduce face-to-face consultations.⁶⁹

45. Healthwatch Sutton reported findings from a survey that said:

Respondents were asked to identify which methods they would be happy to use to hold a consultation with a GP. If commonly available methods are removed from the equation (i.e. face-to-face appointments), 58% of respondents advised that they would be happy to hold a consultation over the phone, 16% by email and 12% via video call (Skype).⁷⁰

46. Healthwatch Coventry identified a reluctance on the part of patients to engage with remote consultations. In circumstances where a face to face consultation was not available most patients “would prefer to have a phone consultation with their GP; or alternatively

63 Ipsos Mori Social Research Institute, [The GP Patient Survey](#) (January 2016) p 7

64 Ibid, p 5

65 Healthwatch Gloucestershire (PRI 14), p 6

66 Ipsos Mori Social Research Institute, [The GP Patient Survey](#) (January 2016) p 6

67 Ibid

68 Q207

69 [Primary Care Workforce Commission](#), July 2015, p 27

70 Healthwatch Sutton, [GP Access Report](#) (December 2014), p 4

see a practice nurse.”⁷¹ We found no sense in any of the evidence from patient groups that telephone consultations or various methods of consulting online were regarded as preferable to face-to-face consultations.

47. Understanding patient willingness to use online and remote services is a particularly complex problem. Professor Steve Field, Chief Inspector of General Practice at the Care Quality Commission (CQC), said that he expected young people to be enthusiastic about utilising new technology:

Younger people—the millennial generation—have a different idea of access to general practice from my parents. It is not going to be just in a surgery seeing somebody. It will be via mobile phone and Skype.⁷²

But Anna Bradley warned that Healthwatch England’s research shows that this may not necessarily be the case:

The work we have done gave us a very interesting finding—slightly counterintuitive, on the first take—which was that younger people were, on the whole, less content to use Skype and other means to engage with GPs than older people. [...] It emerged when we explored that a bit further that that was because these young people did not think that GPs were going to listen to them because they were young. Their experience of GPs was that they were dismissed. There was a lack of trust and confidence for these young people in their GP service. They felt that they had to sit and look at the whites of their eyes to get an honest response from their doctor. There is an important lesson in there, which is that technology can do great things for us, but unless the fundamentals of the relationships are right and the trust and confidence is there it won’t help.

48. Healthwatch England noted that older people may not be concerned about this aspect of the patient / doctor relationship because they were “more familiar with dealing with the Health Service”.⁷³ Nevertheless, they observed that there is demand for services such as consultations by Skype,⁷⁴ and Katherine Murphy said there are patients who “find it really useful and very reassuring, especially mothers of young children who use Skype and telephone consultations a lot”.⁷⁵

Improving access with IT: conclusions

49. The frustration of not being able see a GP quickly or at a convenient time is exacerbated by difficulty in contacting practices to make an appointment or a routine query. Some patients have no difficulty in communicating with their GP practice, including making appointments online and communicating with practice staff by e-mail. This should be the norm. The primary care system should enable all patients to get to see a GP urgently when they need to and to book a non-urgent appointment ahead with ease.

71 Healthwatch Coventry ([PRI 71](#)) para 1.2.2

72 Q344

73 Healthwatch England ([PRI 228](#)) para 41

74 *Ibid*, para 22

75 Q225

50. Enabling direct email contact between GPs and patients would inevitably add to the clinical and administrative workload faced by primary care staff. Piloting and evaluation needs to produce a clear understanding of the patient benefits and avoid creating an additional burden which detracts from clinical care. There should not be an assumption that email contact will reduce demand.

51. We firmly believe that harnessing the opportunities presented by IT could improve access and quality of care. Patients expect to be able to book appointments online and practice websites should facilitate that. Whilst many patients will prefer or require a face to face consultation, for those who do not, primary care providers should facilitate telephone and eventually online consultations.

52. NHS England must offer support by sharing and promoting best practice on the use of IT to facilitate remote consultations. Practice partners and managers would benefit from clear guidance and support in helping them to understand how technology can be harnessed to improve access and clinical standards of care in the most cost effective manner. We recommend that NHS England undertake research to support this objective with the aim of formally assessing demand, risk and potential benefits.

Struggling workforce

53. General practice has been forced to contend with increased demand without a consequential growth in resources. The Centre for Workforce Intelligence reported “a slowly growing GP workforce unable to keep up with increasing patient demand”⁷⁶ and added that “Demand pressures have been compounded by a decline in real funding levels and in the number of GPs per capita in recent years.”⁷⁷ Their written evidence highlighted Health Education England data which showed that “NHS England estimated demand for GP services equivalent to around 35,500 FTE for 2014—almost 3,000 FTE more than the recorded level.”⁷⁸

Workload

54. It was evident from the submissions sent to us by individual GPs that much of the general practice workforce regards their workload as unmanageable. This concern was best expressed by the NHS Alliance, who described an “undoable workload” as being the “underlying problem” facing general practice.⁷⁹ The Local Government Association and ADASS submission looked specifically at the clinical workload that primary care is required to deal with and reported that “Between 1995 and 2009 the number of general practice consultations has risen by 75 per cent, resulting in an increased clinical workload of over 40 per cent.”⁸⁰

55. More detailed analysis was provided by the Nuffield Trust, but they emphasised the difficulty in accurately measuring the work undertaken by GPs and questioned the extent

76 Centre for Workforce Intelligence ([PRI 183](#)) p 1

77 [Ibid](#), p 1

78 [Ibid](#), p 1

79 NHS Alliance ([PRI 90](#)) para 3.2

80 Local Government Association and Association of Directors of Adult Social Services ([PRI 70](#)) para 5.1

to which it is an increased clinical workload that has created the difficult circumstances within general practice. Their analysis pointed to the complexity of patient conditions and lack of overall care coordination for patients as being central problems:

To try and address the lack of reliable evidence on GP workloads, the Nuffield Trust last year acquired data held on a private basis by the Clinical Practice Research Datalink, which recorded consultation trends across a sample of 337 practices (Curry, 2015). [...]

From 2010/11 to 2013/14, consultations in total rose around 11 per cent. The number of consultations per person per year registered on a practice list also rose—from 7.6 to 8.3. However, it is noteworthy that consultations with GPs themselves only rose by around 2%, in the context of a workforce which also grew by around 2% in the same period. We speculate that if pressure on GPs has sharply increased, it might be more related to an increase in other tasks. Anecdotally, GPs may be spending more time than they used to co-ordinating the care their patients receive with hospitals and local authorities.⁸¹

56. This strikes at the heart of the challenge faced by GPs in particular and the problem with the existing model of care. Anna Bradley told us that people with long-term conditions often understand what services they require and “they do not want to have to keep going back to their GP”⁸² to manage every single element of their care. Ms Bradley said that patients do not want their GP to be the sole coordinator of care and “they wanted someone whom they described as a care navigator, someone who could help them to find their way through the system.”⁸³ The problem faced by GPs is that without professionals in place to undertake this role the GP will inevitably become the de-facto care navigator.

57. The feeling that the provision of general practice has become unsustainable is a consequence of caring for so many more patients with complex needs and long term conditions. As the BMA observed:

The factors increasing GPs’ workloads include a growing population of older people with more complex health needs and the movement of care out of hospitals into the community. The number and complexity of patients in residential and nursing homes has added to the increase in doctors’ workloads.⁸⁴

Giving oral evidence on behalf of the BMA, Dr Chaand Nagpaul said that the challenge GPs face is that demand for their services is unlimited.⁸⁵ The King’s Fund also agreed that the overall workload has become more complex.⁸⁶ Don Redding said that patients with multiple long-term conditions “will likely have 10 or 12 GP appointments in the year, see eight specialists, and have 11 or 12 medications to manage, three episodes of urgent care, and so on.”⁸⁷

81 The Nuffield Trust ([PRI 175](#)) pp 9–10

82 Q205 (Ms Bradley)

83 Q219 (Ms Bradley)

84 British Medical Association ([PRI 49](#)) para 37

85 Q288

86 The King’s Fund ([PRI 191](#)) para 15

87 Q217

58. We heard that this pressured environment has created a “haemorrhage”⁸⁸ of GPs and that a retirement crisis is looming. Dr Nagpaul said that of GPs aged 50–54:

the University of Manchester says that 38% of GPs are likely to retire in the next five years. [...] Our own statistic in the BMA was 36%, so it is even worse through independent analysis. We know that is happening. We see it in front of our own eyes when we meet colleagues who are retiring early.⁸⁹

We heard anecdotal evidence from GPs that changes to pension arrangements and seniority payments were also encouraging GPs to leave the profession.⁹⁰

59. Beyond the risk posed by GPs planning to retire, we also heard warnings that as a consequence of what is felt to be an unmanageable workload in general practice, young GPs are planning for careers away from the NHS and outside England:

younger GPs are more amenable to considering working abroad in places like Dubai, Australia, and New Zealand where working conditions are perceived to offer a more attractive work life balance.⁹¹

60. A survey of 1,001 GPs working across the UK published by the Health Foundation in February 2016 underlined just how fragile morale is amongst GPs:

GPs in the UK report higher levels of stress and lower satisfaction with practising medicine compared to primary care doctors in other countries. 67% of UK GPs report being satisfied, compared to an average of 79% across the other 10 countries featured in the survey. 59% of GPs in the UK describe their job as extremely or very stressful, higher than anywhere else.⁹²

61. The findings reported by the Health Foundation are consistent with the general tone of discussion around general practice. Professor Martin Roland, Chair of the Primary Care Workforce Commission, said that at present “morale is poor”⁹³ and this was reflected in the comments from the GPs we met in Sheffield.⁹⁴ It was evident that whilst their commitment to providing the best possible patient care had not wavered, their genuine concern for the future of general practice and their own profession had contributed to low morale.⁹⁵

Funding

62. The challenges facing primary care are compounded by particularly constrained funding for primary care. Even the Department of Health’s evidence conceded that “there has been a decrease in investment in general practice of around 0.8% per cent in real terms since 2008/09”⁹⁶. The King’s Fund added that:

88 Q326

89 Q325

90 Note of Committee visit to Halifax & Sheffield

91 Londonwide LMCs (PRI 172) para 23

92 Health Foundation, *Under pressure*, [What the Commonwealth Fund’s 2015 international survey of general practitioners means for the UK](#) (February 2015), p 2

93 Q73

94 Note of Committee visit to Halifax & Sheffield

95 Note of Committee visit to Halifax & Sheffield

96 Department of Health, NHS England and Health Education England (PRI 200) para 45

Relative to other health services (eg, the acute hospital sector), general practice's share of NHS funding has been declining: between 2005/6 and 2013/14, total investment in general practice fell by 6 per cent—equivalent to nearly £560 million. This is in contrast to a real rise in total NHS spending of 4.4 per cent since 2010/11.⁹⁷

63. The RCGP acknowledged that this pattern is the unintended consequence of the overall NHS funding system:

real terms spending on general practice fell by 3.0% between 2009/10 and 2013/14. This drop seems to have not been the result of a deliberate policy, but reflects the fact that NHS funding mechanisms tend to channel money towards secondary care.⁹⁸

64. As real terms spending on primary care has declined so have practice incomes. The Government's evidence showed that “between 2004/05 and 2012/13 there has been an annual average percentage decrease of 2.1 per cent per year” in practice income.⁹⁹ The BMA summarised some of the additional financial burdens that practices have had to manage which, they argued, have compounded the problem of constrained funding. The BMA said that rising national insurance contributions, a 9% increase in Care Quality Commission (CQC) fees for 2015–16 and growing indemnity costs were particularly pressing concerns for GP partners.¹⁰⁰

65. Beyond these challenges, practices have had to contend with the phasing out of minimum practice income guarantee (MPIG) payments and the equalisation process stemming from the review of Personal Medical Services (PMS) contracts. Practices contracted through PMS contracts can expect a reduction in the premium received as NHS England seeks to equalise core general practice funding across all types of contracts.¹⁰¹ Dr Kate Bellingham, a partner at Page Hall Medical Centre in Sheffield, which serves a population with high levels of need, outlined the impact of the equalisation process for her practice:

We will be losing £258,000 in income (21% of our total budget) over the next 3 years through the equalisation process, and will not be viable unless extra resources are found.¹⁰²

66. Pulse, the magazine for general practitioners, highlighted the relationship between funding changes and practice closures:

Shrinking funding is a major factor in rising numbers of practices nearing closure. Figures obtained by Pulse show more than 160,000 patients across the UK having to register with another practice as a result of their practice closing over the past two years. There has been a 500% jump in the number of practices seeking advice from NHS managers about closure or merging.¹⁰³

97 The King's Fund (PRI 191) para 16

98 RCGP (PRI 174) para 5

99 Department of Health, NHS England and Health Education England (PRI 200) para 53–54

100 British Medical Association (PRI 232) para 19

101 NHS England, *Reviews of Personal Medical Services*, (February 2014)

102 Dr Kate Bellingham (PRI 152) para 2b

103 Pulse (PRI 165) p 4

Variable quality

67. A lack of consistency in the quality of primary care was highlighted by local Healthwatch organisations. The essence of their concern related to the variation in standards that they have observed across relatively small local areas. The organisations that have highlighted this concern are located in different regions of England, which indicates that problems are not exclusive to any one part of the country.

68. Healthwatch Cambridgeshire’s evidence noted that whilst the majority of the complaints they hear relate to primary care they too “hear many stories of excellent care and staff going way beyond their job to help patients”.¹⁰⁴ Nevertheless they remain concerned at the level of ‘inconsistency’¹⁰⁵ in the quality of primary care. Healthwatch in Coventry described variation not only in quality but also in access and linked this variation to the health inequalities experienced in an inner city area:

For a number of years in Coventry there has been an issue regarding variation in quality of service/care from different GP practices, evidenced by different health and patient experience outcomes depending on where people live and which GP practice they are registered with. Pressure on inner city practices serving ethnically diverse and deprived populations is apparent within Coventry. Coventry also experiences a number of health inequalities which may contribute to the variation issues regarding GP services.¹⁰⁶

In addition, Healthwatch Coventry’s observation that “Patients find it confusing when they hear from friends or relatives who seem to be getting a more comprehensive service from another GP practice”¹⁰⁷ captured the fundamental frustration experienced by patients.

69. From the national perspective, variation in the quality of care was a key theme identified by Professor Steve Field from the CQC’s inspection of general practice services. He said that “85% of practices are good or outstanding”¹⁰⁸ but the worst 4% rated inadequate were “generally worse than I thought they would be before I started.”¹⁰⁹

70. The BMA and the RCGP vociferously argued that the CQC inspection regime is not effective and that the data measured by the CQC does not allow for an accurate assessment of quality.¹¹⁰ Dr Nagpaul questioned the value of attaching ratings to individual providers:

Practices vary at the moment in funding per head by twofold. You cannot compare two and say one is great and one is not without understanding that. Practices that are being inspected may have, as I said earlier, recruitment problems; they may be trying to run a practice three partners down and no one is there to fill those spaces. Ranking them without understanding the context does not help.¹¹¹

104 Healthwatch Cambridgeshire ([PRI 74](#)) para 2.1

105 [Ibid](#)

106 Healthwatch Coventry ([PRI 71](#)) para 1.2

107 [Ibid](#), para 1.2.2

108 Q268

109 Q270

110 Q280

111 Q280, Dr Nagpaul

71. Dr Maureen Baker said that GPs should not be burdened with “a very heavy bureaucratic, onerous process with many areas that people do not feel are valid in terms of quality and safety” simply because a small minority of practices have provided unsafe care.¹¹² Professor Field, however, said that many failing practices had been known about for years and there has been “a failure of my colleagues and the systems that have been in place to identify and do things about it”¹¹³ Professor Field added that he is “doing this job on behalf of patients and the public”¹¹⁴ and the practices that were of greatest concern were those with “poor or absent leadership, no vision, [and] poor systems”.¹¹⁵ The CQC’s evidence outlined the overall figures for practices that had been rated following inspection:¹¹⁶

Measure	Outstanding	Good	Requires improvement	Inadequate
Number of locations	122	2443	311	112
% of locations	4%	82%	10%	4%

72. The CQC’s written evidence provided examples of the type of poor care which would attract enforcement action against a practice once they had been rated as inadequate. In one case, the CQC described a practice which had its registration removed after it was discovered that:

During the inspection CQC identified one locum staff member who had treated patients but could not provide evidence that they were medically qualified to do so. The management of medicines was found to be unsafe and placed patients at serious risk of harm. Medicines were found to be out-of-date which rendered them unsafe, and requests for prescriptions had not been processed in a timely manner to ensure patients had access to their medicines.¹¹⁷

In addition, the CQC has reported other cases where emergency medicines have been inaccessible or unavailable and where no employment checks have been undertaken to ensure that staff can practice safely.¹¹⁸

Variable quality: conclusions

73. We welcome Care Quality Commission (CQC) inspection of GP practices and the benefit which it has brought for patients. Independent regulation supported by robust inspection is a useful tool in driving improvement, ensuring quality and giving the public confidence in the services they pay for. Since the CQC’s remit was extended to primary care it has played an important role in identifying failing and underperforming practices, closing some down and ensuring others improve.

74. We reject the calls from the British Medical Association and the Royal College of General Practitioners to scrap the current regulatory regime. We urge them to work

112 Q282

113 Q275

114 Q284

115 Q272

116 Care Quality Commission ([PRI 244](#))

117 Care Quality Commission ([PRI 202](#)) para 27

118 [Ibid](#), para 29

constructively with the Care Quality Commission to protect the public from the small minority of dangerous practitioners and to help to turn around underperforming practices.

75. Professor Field told us that the CQC is starting to collaborate with NHS England and the GMC “to try and reduce the data load, the workload, for general practice so that we collect data once and it is used for many different reasons.”¹¹⁹

76. We heard evidence of duplication of data requests resulting from the Care Quality Commission’s (CQC) primary care inspection methodology. Like all good regulators the CQC should constantly examine its procedures and methods to avoid or minimise unnecessary burdens or duplication. NHS England, the CQC, the General Medical Council and Local Education and Training Boards must work together to agree a common framework and data set to reduce bureaucracy and unnecessary duplication. It is essential that time which should be devoted to patient care is not eroded by an excessive bureaucratic burden.

77. We were encouraged by Professor Field’s evidence that the CQC’s “role is to encourage improvement”¹²⁰ and that “93% of the 100-plus practices we have re-inspected have improved.”¹²¹ He added that once the CQC can:

sort out the very poor practices, that means we can all focus on how we improve care and move to a much more efficient integrated health and social care system.¹²²

We believe that this is the correct approach. To build faith amongst both the public and clinicians and the CQC’s inspection regime must be seen to be relevant for improving patient care as well as identifying poor practice.

The experience of primary care: conclusion

78. Primary care has been described as the “jewel in the crown” of NHS services¹²³ but it is under unprecedented strain after several years of funding decline relative to other services. There are growing concerns from patients about access to primary care services, quality varies from the excellent to the dangerously bad and the system of care is unsustainable. These circumstances have undermined the morale of the workforce and disenchanted GPs and other primary care professionals. Patient satisfaction remains high but patient concerns are growing: good headline figures can mask the poor experience some patients can have of primary care. The difficulties experienced by patients underline just how important it has become to develop a new model of care.

119 Q273

120 Q276

121 Q278

122 Q278

123 Marshall M, [A precious jewel: the role of general practice in the English NHS](#) (March 2015)

2 The new models of care

Changing how we care

Findings of the Primary Care Workforce Commission

Background

79. Comprised of six commissioners and chaired by Professor Martin Roland, the Primary Care Workforce Commission (PCWC) was tasked by Health Education England in 2015 to “identify models of primary care that will meet the needs of the future NHS”.¹²⁴ The PCWC’s final report described networks and federations of practices built on multi-disciplinary teams working collaboratively. The vision of the Commission was one of teams of professionals utilising their individual skills to meet the needs of patients much earlier in their journey through the NHS. They said primary care will be:

based around the GP practice holding responsibility for the care of its registered patients, but practices will have a stronger population focus and an expanded workforce. Many existing healthcare professionals will develop new roles, and patients will be seen more often by new types of healthcare professional such as physician associates. Clinical staff will have better administrative support and, when needed, healthcare professionals will be able to spend more time with their patients to discuss and plan their care. They will also be able to communicate with patients and with other health professionals by phone, email, electronic messaging and video-conference.

Individual general practices and community pharmacies will work more closely together through networks and federations in order to provide a wider range of services, and IT systems will become joined up across providers of primary care. Primary and community care staff will also work closely with secondary care and social services through some of the models outlined in the NHS Five Year Forward View. Premises will be upgraded, making better use of existing community facilities in order to support closer working with hospitals and with social services, and to provide a wider range of diagnostic facilities.¹²⁵

Improving the patient experience

80. Improving the quality of care and the patient experience is central to the PCWC’s conclusions. National Voices, a coalition of national health and social care charities, is campaigning for fully integrated health and social care teams. In relation to general practice they argued that a multi-disciplinary team is necessary to achieve this aim:

Practices should recognise the role of nurses and administrative staff in supporting more person centred care. Primary care should be capable of collaborating with external teams, working closely with other health and care professionals, including specialists.¹²⁶

¹²⁴ Primary Care Workforce Commission, [The future of primary care, Creating teams for tomorrow](#) (July 2015), p 57

¹²⁵ *Ibid*, p 7

¹²⁶ National Voices ([PRI 144](#)) para 18

Anna Bradley told us that patients do not want to be reliant on their GP and would like to be able to self-refer to other health professionals. Ms Bradley said that patients “would rather see someone who can help them with their problem than necessarily always see the same person.”¹²⁷

81. The PCWC acknowledged that general practice built around 10 minute appointments where only one problem is addressed is insufficient for today’s patients.¹²⁸ Healthwatch England described how unsatisfactory 10 minute appointments can be:

Local Healthwatch across the country have heard from people unhappy with fixed length appointment slots, reporting they feel rushed and unable to make themselves heard.¹²⁹

82. Dr Chaand Nagpaul explained GPs cannot provide the best care for patients with multiple complex conditions within the confines of the traditional 10 minute appointment. Dr Nagpaul explained that GPs:

simply cannot see a patient with multiple morbidity, who is 80 years old, may have memory impairment, diabetes, heart disease, be arthritic and on 10 different drugs, and do it in 10 minutes. It just cannot be done safely, it is not being done humanely, and it is not being done with quality.¹³⁰

Katherine Murphy echoed these remarks and observed that 10 minute appointments are particularly inappropriate for patients with mental health problems.¹³¹

83. Ten-minute appointments do not allow adequate time for safe practice or to address whole person care. Relentless time pressure from short appointments tends to restrict patients to discussing only one problem with their GP and clinicians to working in a reactive rather than proactive manner. Given the increasing complexity of the long term conditions that are managed in primary care, allowing time to provide safe and holistic care must be a priority. We agree with the Primary Care Workforce Commission that reshaping primary care to give patients sufficient time to discuss their conditions with health professionals should be a central aim of the new models of care.

The blueprint for a new model of care

84. The report of the Primary Care Workforce Commission represents a vital step in illustrating how a new model of care can be delivered. As Professor Roland told us, “there is nothing fantastically revolutionary or new”¹³² in the report of his commission, but what it did present was a practical blueprint for the future services on which we all rely. This is a blueprint that we welcome and on which we expect the Government to act.

127 Q218 (Ms Bradley)

128 [Primary Care Workforce Commission](#), July 2015, para 2.4.3

129 Healthwatch England ([PRI 228](#)) p 2

130 Q291

131 Q209

132 Q2

Multi-disciplinary teams

85. The patient benefits and organisational efficiencies that can be achieved by restructuring primary care teams along these lines are quite clear. It was widely agreed amongst the witnesses we heard from that new models of care can only be delivered by teams of health professionals working in close collaboration as part of multi-disciplinary teams.

86. Professor Field illustrated the key patient benefits of working in this way and avoiding professional isolation:

There is a direct correlation between inadequate practices—on fewer nurses, fewer sessions—and outstanding practices, which have really good multiprofessional care, using nurses and therapists, and a few now are using physician associates and pharmacists.¹³³

87. The PCWC envisaged a workforce made up of a broad range of professions which could go as far as incorporating non-health specialists that can assist with social problems, and medical assistants to relieve GPs of some administrative tasks. Along with GPs and nurses, the heart of the new workforce will be comprised of pharmacists, physiotherapists, mental health workers and, potentially, physician associates.

Nurses

88. Nurses are already an integral part of the primary care team, as acknowledged by Professor Roland in evidence.¹³⁴ The PCWC outlined how the existing workforce could be better harnessed and nursing roles in primary care developed:

General practice nurses, supported by healthcare assistants, now take on a wide range of responsibilities which, depending on their training and experience, include management of the main long-term conditions such as diabetes and asthma, seeing vulnerable groups such as children, people with mental health problems and those with learning disability, as well as taking on generalist roles including the management of acute minor illness. We believe that nurses could take on substantially more care for both acute and chronic conditions.¹³⁵

89. The Royal College of Nursing (RCN) cited evidence in support of redistributing work within primary care that was published in 2003, which reiterated the point made by Professor Roland that the principles espoused by the PCWC are not necessarily new. They argued that nurses can ease the burden on GPs by triaging patients and that this process can be made more efficient by harnessing new technology.¹³⁶

90. We believe that advancing the role of nurses in primary care should not just be seen in the context of easing workload pressures on GPs. This should be a priority because we were told consistently that integrated teams provide better care for patients.¹³⁷

133 Q272

134 Q12

135 Royal College of Nursing ([PRI 63](#)) para 11.2

136 *ibid*, para 11.1

137 Qq2, 168

91. Evolution of responsibilities within the nursing workforce was highlighted by the Primary Care Workforce Commission, which observed in its report that the existing job titles for nurses do not particularly reflect or describe the work that they undertake:

We have chosen not to focus on individual nursing job titles or roles in our recommendations (such as specialist nurse, advanced nurse practitioner) as the actual tasks carried out by nurses often depend as much on experience and the supportive environment in which they are working as on formal qualifications.¹³⁸

We did hear concerns, however, that more needs to be done to support training and continuing professional development for practice nurses as well as other health professionals within the multidisciplinary team.¹³⁹

Pharmacists

92. Discussing the role of pharmacists, the PCWC said that the surplus of trained pharmacists should be exploited by deploying them in extended roles as part of the general practice team:

Pharmacists carry out a range of medicines optimisation tasks in general practices mostly linked to patients on long-term medication, including monitoring and rationalisation of repeat prescriptions, carrying out reviews for people on multiple medications, supporting adherence to medication, and advising on prescribing to care home residents, who are at particular risk of medication-related adverse events. Prescribing pharmacists can take increased responsibility in these roles.¹⁴⁰

Sandra Gidley, Chair of the English Pharmacy Board at the Royal Pharmaceutical Society, said that the report of the PCWC complemented their own views regarding the role of pharmacists in general practice teams:

What the report had to say was very positive about the inclusion of pharmacists. In fact, it chimes with some of the work we have been doing at the Royal Pharmaceutical Society working with the Royal College of General Practitioners to develop a scheme whereby there will be a number of pharmacists based in GP surgeries taking on a more clinically focused role. That seems to me not only a good use of pharmacists but a benefit for the patients.¹⁴¹

Community pharmacy

93. Whilst the widespread deployment of pharmacists as core parts of the primary care team could represent a departure from traditional model of care, the PCWC also emphasised the role of community pharmacy. The report of the commission recommended that:

138 [Primary Care Workforce Commission](#), July 2015, p 18

139 Qq112, 124

140 [Primary Care Workforce Commission](#), July 2015, p 43

141 Q101

Wider use should be made of community pharmacists and pharmacy support staff in managing minor illness and advising people about optimising their medicines. There should be agreed protocols for treatment and referral between local organisations of pharmacists and GP practices.¹⁴²

94. Pharmacy Voice, which represents community pharmacy providers, said that that up to 18% of general practice workload and 8% of Emergency Department consultations are estimated to relate to minor ailments.¹⁴³ Likewise, the government's evidence emphasised the ability of community pharmacy to relieve the burden of demand facing general practice teams:

Pharmacy already plays a vital role in supporting the health of people in their local communities, providing high quality care and support, improving people's health and reducing health inequalities. As we move to more integrated care, there is real potential for community pharmacists and their teams to play an even greater role in the future, particularly in keeping people healthy, supporting those with long term conditions and helping make sure patients and the NHS get the best use from medicines.¹⁴⁴

In particular the Government emphasised the benefits that can be achieved when community pharmacy is afforded access to summary care records (SCR):

We are investing up to £7.5 million to give community pharmacists the training and tools they need to access patients' SCR. A pilot has already shown that as a result of this, as many as nine out of ten people can get the help they need from their pharmacist without having to be sent to another service.¹⁴⁵

95. Given the potential offered by community pharmacy, we were disappointed that the Government has announced a 6.1 per cent cut in funding for community pharmacy.¹⁴⁶ We note that the Department of Health has implied that this announcement may lead to a rationalisation of services as "40% of pharmacies are in a cluster where there are three or more pharmacies within ten minutes' walk".¹⁴⁷ The Pharmaceutical Services Negotiating Committee has warned that as many as 3,000 community pharmacies could close.¹⁴⁸ The Government must ensure that this does not leave communities without access to pharmacy.

Physiotherapists

96. Professor Karen Middleton, Chief Executive of the Chartered Society of Physiotherapy, made the case that incorporating physiotherapists into core general practice teams not only improves services for patients but could reduce (and in some places already is reducing) the workload faced by GPs. Professor Middleton argued that allowing patients to self-refer to a practice physiotherapist also reduced onward referrals and enhanced patient satisfaction:

142 [Primary Care Workforce Commission](#), July 2015, para

143 Pharmacy Voice, [\(PRI 241\)](#)

144 Department of Health, NHS England and Health Education England [\(PRI 200\)](#) para 108

145 Department of Health, NHS England and Health Education England [\(PRI 200\)](#) para 118

146 Pharmacy Voice, [\(PRI 241\)](#)

147 Department of Health & NHS England, [Letter to Sue Sharpe, Chief Executive of the PSNC](#), 17 December 2015

148 Pharmaceutical Services Negotiating Committee, [PSNC Briefing 007/16: Campaign guidance for LPCs](#), February 2016

30% of what a GP sees, according to the British Orthopaedic Association, is MSK [musculo-skeletal conditions]. Physiotherapists are ideal to see those patients first off. [...] I visited a practice in Suffolk during the summer where they provide physiotherapy as the first point of contact across 27 sites. They have not only taken 30% of the caseload that the GPs were seeing before but they have reduced referral to secondary care. Hip and knee replacement surgery has reduced by 40%. The conversion rate for surgery for orthopaedics has gone up to 100%, so all those referred to secondary care actually need surgery. [...]

We are finding that not only are patients very satisfied with that approach but we know from all the evidence that has been accumulated around patients selfreferring that they are seen quicker, outcomes are better, they return to work faster and it saves a considerable amount of money for the taxpayer when a physiotherapist sees the patient rather than a GP. [...] When I talk about 30% of a GP's caseload being MSK, it is not 30% of the patients, it is actually many patients coming back again and again or then being referred unnecessarily to orthopaedics.¹⁴⁹

Physician associates

97. Extending the recruitment of physician associates in primary care is a somewhat more challenging proposal from a purely clinical perspective than attempting to embed the presence of physiotherapists and pharmacists in general practice or extending the role of practice nurses. How physician associates fit in with the rest of the workforce was described by Professor Veronica Wilkie, Professor of Primary Care and Medical Director for the MSc Physician Associate Course at the University of Worcester. Professor Wilkie sought to illustrate the core benefits of including this profession in the primary care workforce:

All of the students are required to pass a national exit examination, and are required to re sit a re-certifying examination every 6 years. Physician Associates remain generalists for the whole of their careers, and as such become flexible clinicians working across an increasingly specialised health economy.

The physician associate course will cover about 40% of the undergraduate medical curriculum. The curriculum is very practical (so that they can take blood, put up IV lines, suture, as well as take a history and perform an examination).

Physician Associates work very well alongside doctors, they are trained in the medical model, understand a significant amount of pharmacology, and work very well to make up junior doctor posts in hospitals or as part of the primary healthcare team in General Practice.¹⁵⁰

98. Research undertaken by Kingston University and St George's University of London assessing the merits of physician associates and published in the British Journal of General Practice reported positive accounts regarding their role in primary care:

149 Q107

150 Professor Veronica Wilkie ([PRI 236](#)) p 1

For patients attending for same-day or urgent appointments, PAs [physician associates] attended a younger patient group who present with less medically acute problems and fewer long-term conditions, compared to those attended by GPs. After adjusting for case mix, there was no difference between PA and GP consultations in the rate of investigations, referral to secondary care, prescriptions issued, or the rate of patient re-consultation for the same or a closely related problem within 14 days. Patients report high levels of satisfaction with PA and GP consultations. The average PA consultation was longer than with a GP, although costs per consultation with a PA were lower.¹⁵¹

99. The RCGP, on the other hand, has given the proposed expansion of the physician associate workforce a lukewarm reception and they appeared to be sceptical of the intention behind expanding the profession:

There is a need for more evaluation of the impact of new roles in primary care on outcomes for patients, and in particular for evaluation of the benefits of introducing particular roles, such as Physicians Associates, into general practice. It is important to be clear that whilst other professionals have an important role to play in supporting the delivery of patient care in general practice, these cannot replace GPs, and should not be considered an alternative solution to the GP workforce problems.¹⁵²

100. There is limited evidence as to the effectiveness of physician associates in primary care and this is acknowledged by the authors of the St George's research. Because of the limited evidence base the report of the PCWC exercised a degree of caution in its conclusions:

Physician associates [...] offer a relatively rapid way of attracting more healthcare professionals into the workforce to address current levels of need and demand, and it is much cheaper to train physician associates than additional GPs. However, more studies are needed to assess how effective and cost effective these roles are in the long term.

While we recognise considerable potential in developing these new roles, the governance of these new staff members will be of critical importance in ensuring the quality and safety of their work.¹⁵³

101. The Commission's report did, however, counter the implication that physician associates could be recruited to fulfil tasks that should be undertaken by GPs. Instead, they made the more subtle case that multi-disciplinary teams should take on responsibilities that have traditionally, but unnecessarily, rested with GPs.¹⁵⁴ Professor Roland argued that GPs should have more opportunity to focus more on "the things which only they can do, particularly for the complex elderly."¹⁵⁵

102. Government policy assumes that the physician associate workforce in primary care will grow relatively rapidly. Professor Cumming, Chief Executive of Health Education England (HEE), said that HEE had "given an undertaking that by 2020 we will have

151 British Journal of General Practice, [Physician associates and GPs in primary care: a comparison](#) (May 2015)

152 RCGP (PRI 174) para 19

153 [Primary Care Workforce Commission](#), July 2015, p 22

154 *Ibid*, July 2015, para 15

155 *Ibid*

trained into employment 1,000 physician associates working in primary care.”¹⁵⁶ We note that the lack of professional regulation of physician associates has been identified as a barrier to the recruitment of this workforce and we explore this further in Chapter 3.

Multi-disciplinary teams: conclusion

103. There are clear benefits for patients in basic reforms such as enabling self-referral to physiotherapists and incorporating pharmacists and other health professionals into general practice teams. We welcome the PCWC’s emphasis on drawing aspects of secondary care into primary care. We note, however, that fundamental barriers exist that can actively prevent this from happening. We explore these barriers in Chapter 3.

104. New models of care should not be about trying to replace GPs, but should allow them to take on a more specialist role focused on leading care delivered by multi-disciplinary teams. The benefits of integration, providing care coordinators and a single point of contact for patients with complex needs have been emphasised by many of those giving evidence.¹⁵⁷ Incorporating care coordination must be another feature of the new model of care.

105. Whilst the vision for a new model of primary care and the workforce to underpin it has been established, the challenge for the Government and NHS England is to overcome the barriers to building these new teams and to implement the necessary change at scale and pace. This is especially important given the existing and worsening workforce shortfall. We are concerned that basic reforms such as widening the responsibilities of nurses, self-referral to physiotherapy and the incorporation of pharmacists into general practice teams should be enabled and accelerated. In the response to this report we would like to see a clear plan and timetable for action.

106. We support the objective of training physician associates to work alongside GPs within multidisciplinary teams in primary care, but as their new roles and responsibilities develop they will need careful evaluation. Attention must also be paid to the continuing professional development needs and supervision of physician associates.

Specialists in primary care

107. The PCWC also made the case that secondary care specialists should be incorporated into primary care teams to support GPs and provide treatment for complex conditions in the community. Outlining how the new model should work the PCWC said:

Hospital doctors and nurses will increasingly work with others in community settings, for example, in care of the elderly. While hospital-based specialists may run clinics and see patients in the community, a major role will be to support clinicians in primary care.¹⁵⁸

156 Q38

157 Qq185 (Mr Redding), 204, 219 (Ms Bradley), 409 (Mr Burt)

158 [Primary Care Workforce Commission](#), July 2015, p 12

108. An essential recommendation of the PCWC's report that we believe should be implemented with great urgency relates to mental health. The report recommended that:

Practices or groups of practices should have access to a named consultant psychiatrist and to a named mental health worker such as a primary care mental health worker or community psychiatric nurse.¹⁵⁹

Healthwatch Lincolnshire illustrated why developing this type of collaborative working should be prioritised across primary care:

Across all areas limited or poor access to mental health services was seen as having a direct impact on people's wellbeing in the county. It was generally felt that doctors were supportive; however, there were concerns raised about specific doctors who the respondents felt didn't understand their mental health needs and as a result led to a patient's condition worsening.¹⁶⁰

109. These concerns have been reinforced by the recent findings of the Mental Health Taskforce, which concluded that there will have to be far greater collaboration between primary care and secondary care specialists to ensure that the physical health needs of people with mental health problems are not overlooked.¹⁶¹ The taskforce expressed concern that people with mental health problems are:

three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary care they are receiving.¹⁶²

110. Improving the relationship between primary care and mental health specialists is particularly vital for those primary care services dedicated to supporting vulnerable people such as those with drug and alcohol problems and the homeless. Meeting GPs during our visit to Sheffield, we heard how this patient population can be overlooked by traditional primary care commissioning processes.¹⁶³

111. We note in this context the introduction of new waiting time standards for the Improving Access to Psychological Therapies (IAPT) programme. The standards mandate that "75% of people referred to the IAPT programme will be treated within six weeks of referral, and 95% will be treated within 18 weeks of referral".¹⁶⁴ The Government has said that £460 million was invested in IAPT between 2010 and 2015 and a further £80 million was realised out of NHS budgets in 2015–16 to help meet the standards.¹⁶⁵

112. We endorse the recommendation of the Primary Care Workforce Commission that practices or groups of practices should have access to a named consultant psychiatrist and to a named mental health worker or community psychiatric nurse. We also welcome the improved access standards and additional funding for the Improving Access to Psychological Therapies programme as an opportunity to improve access for patients in primary care to mental health therapies.

¹⁵⁹ *Ibid*, p 32

¹⁶⁰ Healthwatch Lincolnshire (PRI 39) para 4

¹⁶¹ NHS England, [The Five Year Forward View for Mental Health](#), (February 2016), p 39

¹⁶² *Ibid*, p 31

¹⁶³ Note of Committee visit to Halifax & Sheffield

¹⁶⁴ HC Deb, 30 June 2015, c [3511](#) [Commons written answer]

¹⁶⁵ *Ibid*

Communication between primary and secondary care

113. Whilst Alistair Burt, Minister of State for Community and Social Care, identified technology as a driver of change in the long term,¹⁶⁶ the evidence from the Government did not reassure us that a systematic approach has been established to meeting some very basic technological challenges facing primary care. This is despite the fact that the PCWC highlighted the basic failings in this area:

We regard it as outdated that GPs and specialists are unable to communicate freely by email or by electronic messaging. Although some areas have commissioned services that enable GPs to email specialists for advice, these remain the exception rather than the rule. Often people need to be referred to hospital just for a simple query to be answered. At a time when there is so much focus on integration of care, it seems bizarre to us that provision is not made within the job plans and contracts of both GPs and specialists to encourage this basic level of communication.¹⁶⁷

The PCWC recommend that:

Email correspondence and electronic messaging should become routine between primary care healthcare professionals and hospital specialists, enabling both to seek advice and give guidance on patient care. While this may need protected time in the working day, there are significant potential cost savings in terms of reduced referrals to hospital.¹⁶⁸

114. We are concerned that there has been little emphasis on improving communication between primary and secondary care clinicians despite such improved communication depending on little more than routine use of email. We note that the PCWC concluded that achieving this would require “only minimal cost investment.”¹⁶⁹

115. New models of care will be built around multi-disciplinary working, including primary care clinicians working with secondary care specialists. **In the response to this report we invite NHS England to explain how they will act on the Primary Care Workforce Commission’s recommendation that GPs should be able to communicate routinely with specialists in secondary care by email and messaging.**

The role of federations

116. It was apparent from the conclusions of the Primary Care Workforce Commission that many of their recommendations are predicated on GP practices at least working in networks or more probably joining formal federations. The implication of the PCWC’s conclusions was that a new model of care to meet the needs of patients cannot realistically be delivered unless practices work collaboratively:

Federations and other collaborative networks are an important way of enabling primary care organisations such as GP practices to provide a wider range of services, while at the same time offering the benefits of a smaller organisation,

166 Q409

167 [Primary Care Workforce Commission](#), July 2015, para 2.31

168 [ibid](#), p 7

169 [ibid](#), p 11

such as convenient location and continuity of care. [...] Primary care providers working together can also help monitor and better understand variation in clinical performance by sharing comparative data. Working collaboratively and sharing ideas across federations and networks can also help new models of care and new staff roles to emerge.¹⁷⁰

117. Professor Roland said in oral evidence that these structures would provide the headroom for general practice to find ways to change their models of care and professional teams:

we think that groupings and federations of practices are going to be key, because generally it is a real struggle for practices to work out exactly how they are going to do this sort of stuff, but groups of half a dozen practices, or sometimes more, can make a real difference. [...] It is very difficult to innovate when you are constantly trying to catch up.¹⁷¹

118. Dr Maureen Baker illustrated the problems GPs face in finding the opportunity to step away from their daily routines in order to reshape patient care and move away from inadequate ten minute appointments:

Increasingly, though, we are seeing practices look at different ways of operating with a view to trying to give people with multiple, complex or difficult or dangerous conditions longer periods of time. The difficulty with this, as in so much else at the moment, is all this planning, thinking, testing and making sure it is safe takes time and headspace, and most colleagues at the moment struggle to get through the day, never mind trying to plan to make things better.¹⁷²

119. Building on these remarks, Professor Field illustrated how collaborative working is often at the heart of good patient care and poor quality stems from isolation:

we have a large number of smaller practices in inner cities that are failing and are inadequate. We think most of that is due to professional isolation—that they are not connecting with local practices. It is not really the size; it is the fact that they do not learn and share with others. [...]

the better practices link in with other practices, share their data, their performance improvement and services, but also link into community services very well.¹⁷³

120. We heard concerns that some federations are forming out of financial necessity without a clear vision of how they can improve patient care. Dr Steve Kell, Chair of NHS Clinical Commissioners, warned that federation of practices driven by financial considerations could miss opportunities to improve care:

It is also important that we have a clear narrative as to why practices would be working together. It is important that that is hopefully done in a proactive way, which improves patient quality, access and sustainability. I am more

170 [Primary Care Workforce Commission](#), July 2015, p 39

171 Q13

172 Q279

173 Q272

concerned when I think it is because of the financial need to do so, because then we lose some of the benefit that might happen. If it is because of changes to funding and so on that forces practices into that, we will get less benefit as commissioners.¹⁷⁴

121. The evidence we heard indicated that resources to support the development of federations are very limited. Although Clinical Commissioning Groups (CCGs) now have the freedom to co-commission general practice services with NHS England, the running cost allowance for CCGs has been reduced by 10 per cent to £22.07 per head for 2015/16,¹⁷⁵ which will inevitably make it more difficult for CCGs to support transformation at a local level.

122. We heard that the only national financial support for practices seeking to federate has emerged through the Prime Minister's Challenge Fund (PMCF).¹⁷⁶ This was not the fund's original or primary purpose. Rosamond Roughton, the National Director of Commissioning Development at NHS England, commented that the requirement for a minimum patient population to access resource from the PMCF "in effect" incentivised practices to work together,¹⁷⁷ but this requirement does not equate to formal support and resource for those that have already chosen to network or formally federate. Ms Roughton also told us that NHS England's local area teams, which are tasked with supporting the development of federations, work across large geographical areas.¹⁷⁸ In our view, thinly resourced local area teams which cover large geographic areas will struggle to provide targeted support to embryonic federations, especially given the number of practices that will be required to federate in the next few years in order to deliver improvements to patient care.

123. Federations and networks should be formed with the primary purpose of improving care for patients. NHS England Local Area Teams, in conjunction with clinical commissioning groups, should directly support the development of new models of care envisioned by the Primary Care Workforce Commission.

124. There must be assurance that federations and networks are forming with robust structures and leadership and a clear picture of how patient care and experience can be improved. We recommend that clinical commissioning groups, federations and networks also involve patient-facing charities and community organisations to help them maintain a focus on quality and local priorities for improving care.

Guarding against conflicts of interest

125. Now that CCGs are able to commission local GP services, NHS England will have a crucial role to play in preventing conflicts of interests developing between CCGs and large federations. Any suggestion that conflicts of interests are influencing commissioning decisions would undermine the credibility of commissioners, providers and the new structures that have been established in local areas. We recognise that NHS England has provided CCGs with guidance and established new systems and training in recognition

174 Q258

175 NHS Clinical Commissioners ([PRI 157](#)) para 5.7

176 Q258

177 Ibid

178 Q389

of this risk.¹⁷⁹ **We believe that continued vigilance is required at national and local level to guard against conflicts of interest influencing decisions taken by clinical commissioning groups in relation to general practice. The commissioning system must operate both fairly and transparently and be seen to be operating in this way.**

3 Building the new team

Primary care workforce

Workforce planning

126. Summarising the current position, the King’s Fund cited evidence from the Centre for Workforce Intelligence which concluded that:

there is likely to be a significant undersupply of GPs by 2020 unless immediate actions are taken to redress the imbalance between supply and demand and to increase training numbers for longer-term sustainability.¹⁸⁰

127. The Government outlined its broad ambition to increase the workforce in written evidence to us. It referred to 5,000 additional doctors working in general practice:

the Government has committed to increasing the primary and community care workforce by at least 10,000, including an estimated 5,000 more doctors working in general practice by 2020.¹⁸¹

Professor Ian Cumming explained that 5,000 additional doctors in general practice is not the same as 5,000 additional GPs:

The 5,000 figure is broken down into 4,000 additional GPs that HEE have a responsibility for producing and work on getting people to come back to GP practice, or work on persuading people not to leave. [...] We will have 1,000 through return to practice and better retention, and 4,000 through new trainees that HEE are putting in the system. The reason it is worded as “doctors in general practice” and not “GPs” is because we count GP registrars in the figure. These are people who are training to be GPs but they are in practices delivering care alongside the GPs, not when they are in the hospital period. So they are in both sides of the equation.¹⁸²

128. The Government’s evidence showed that 87.6% of GP training places were filled in 2014.¹⁸³ Professor Cumming told us that whilst the number of training places created is the number “that we think we need for the future” if the fill rate was “above 90%, personally I would be delighted.”¹⁸⁴

129. Ben Dyson, Director of the NHS Group, Department of Health, observed, however, that if the 3,250 training places are successfully filled by 2020 then the mechanisms designed to encourage retention of the existing workforce and help those who have left return to practice would not need to be as productive as Professor Cumming had estimated:

we would have an extra 4,400 or so doctors working in general practice. It is the balance between that and the 5,000 that would need to be made up through

180 The King’s Fund (PRI 191) para 18

181 Department of Health, NHS England and Health Education England (PRI 200) para 77
182 Q78

183 Department of Health, NHS England and Health Education England (PRI 200) para 84

184 Q84

improvements in both retention of the existing workforce and encouraging doctors who may have taken career breaks or may have gone overseas to come back into general practice.

130. The programme to bring doctors who have moved abroad back into English general practice is the induction and refresher scheme introduced in April 2015. Rosamond Roughton said that NHS England had identified a number of practical steps to improve the scheme which they would implement in early 2016, but even by July 2015 the scheme had shown that it was an improvement on previous arrangements.¹⁸⁵ The BMA warned that more funding will be required to fund further places and provide an adequate bursary for participants.¹⁸⁶ Ms Roughton said that to date no formal analysis had been undertaken of the financial support available in the first nine months of the scheme but it is something NHS England “will need to review”.¹⁸⁷

131. Ensuring there are 5,000 additional doctors in primary care by 2020 is dependent in part on attracting people to return to the profession. The induction and refresher scheme is a vital component of the efforts to do so. It should be subject to annual review to ensure that it is facilitating the return of qualified professionals as quickly as possible.

New starters and early leavers

132. Whilst Ben Dyson’s analysis provided some degree of encouragement as to the number of new doctors the system could produce it is clear that achieving even a 90% fill rate would be ambitious, especially as the initial rate for 2015 applications was 82%.¹⁸⁸ The Centre for Workforce Intelligence [CFWI] sounded a strong note of caution:

efforts to boost the number of GP trainees is proving difficult. The number of accepted offers to GP training posts in 2014 (2,608) was below its 2011 peak, and the first 2015 recruitment round left 616 GP trainee posts in England unfilled, requiring a second autumn round.¹⁸⁹

133. The Government’s assumptions about future GP numbers rely not only on very high fill rates for training places but also on the number of GPs leaving the profession remaining stable. Ben Dyson noted that in 2013–14 the difference between the number of GPs joining and leaving started to narrow¹⁹⁰ and the King’s Fund warned that “the number of GPs over-50 who intend to ‘quit direct patient care in the next five years’ rose from 42 per cent in 2010 to 54 per cent in 2012 (Hann et al 2013)”.¹⁹¹ The Health Foundation’s survey of 1,001 UK GPs reported that overall “29% of GPs in the UK want to leave the profession within five years.”¹⁹²

185 Q408

186 BMA ([PRI 49](#)) para 33

187 Q409

188 Department of Health, NHS England and Health Education England ([PRI 200](#)) para 83

189 Centre for Workforce Intelligence ([PRI 183](#)) section 3

190 Q391, Mr Dyson

191 Ibid

192 Health Foundation, Under pressure, [What the Commonwealth Fund’s 2015 international survey of general practitioners means for the UK](#) (February 2015), p 2

134. The British Medical Association reported that one finding of their GP Workforce Survey of 2015 was that “9% of GPs are hoping to move abroad in the next five years. This includes 19% of current GP trainees.”¹⁹³ In addition the Recruitment and Employment Confederation’s (REC) evidence said that amongst trainees:

1 in 10 hope to leave the UK to work overseas; this figure rises to 21 per cent amongst GP trainees (the number of GPs applying for certificates that enable them to leave the UK to work abroad has already increased by almost 50% [between] 2008 and 2014).¹⁹⁴

The Londonwide LMCs highlighted the problem of foreign employers targeting British doctors and said that “a number of overseas healthcare providers actively target young British GPs as part of their recruitment strategy.”¹⁹⁵

135. In light of the projected number of doctors leaving the profession it is almost certain that the fill rate for training places will not be sufficient to achieve the net increase in the number of doctors projected by the Government.

136. Alistair Burt told us that the additional GP numbers “will not just maintain the current status quo but will respond to the changes that are taking place”.¹⁹⁶ We believe that at best the Government’s proposals might allow primary care to absorb the pressure posed by additional demand. It will not be sufficient to allow routine seven day services in addition to existing extended hours services that practices already provide.

137. Whilst British trained doctors have long spent periods of time gaining work experience abroad, there will be a worsening workforce shortfall if they do not return from overseas. **The Government should publish an analysis of the trends in doctors leaving the profession. This analysis should encompass their age, experience, specialism, the length of time for which doctors work abroad, the reasons for leaving the profession, and rates of return.**

138. Approximately £500,000 is invested in educating and training an individual to the point that they qualify as a GP.¹⁹⁷ Patients cannot afford for the UK to lose this highly skilled workforce.

139. In our view this scale of investment by the NHS creates an obligation to public service in the UK. We are also aware, however, that as a consequence of university fees and living costs, medical undergraduates will accumulate significant debt during a five to six year year medical degree.

Selection of undergraduates

140. Professor Ian Cumming and Professor Steve Field both observed in evidence that to meet our long-term needs half of all medical school graduates will have to become GPs.¹⁹⁸ It is the opinion of the NHS Alliance, however, that the existing training arrangements:

¹⁹³ British Medical Association (PRI 49) para 31

¹⁹⁴ The Recruitment and Employment Confederation (PRI 179) para 4

¹⁹⁵ Londonwide LMCs (PRI 172) para 23

¹⁹⁶ Q392

¹⁹⁷ Q64

¹⁹⁸ Q84 & Q344

produce doctors who largely want to become specialists. They require a radical overhaul in order to restore the popularity of general practice and encourage more doctors to enter the profession.¹⁹⁹

The problem of the way in which medical schools prepare students for their careers was highlighted by Professor Field:

At medical school, we still have students who come to my own practice who have been told by specialists that general practice is an inferior career. While most medical school time is dominated by placements in hospitals, you are going to bring out hospital consultants at the end.²⁰⁰

141. Alistair Burt addressed this concern in the evidence he presented to us. He argued that undergraduate selection for medical degrees may have to evolve to reflect the skills required of a GP:

Medical schools may also have to look at their own intakes and who they are taking in. [...] You do not need the scientific qualifications you need to be a Nobel prize-winning scientist to qualify as a doctor and be in general practice. You need a very strong level of science, but you need the human feel as well. Looking at that background and enthusing people who want to work through the generations with people is a part of the encouragement as well.²⁰¹

Professor Field made a similar point:

We need to select people to medical school with a real commitment to working with people in the community in general practice. We need to look at how we select schoolchildren.²⁰²

142. A former Chair and President of the RCGP, Sir Dennis Pereira Gray OBE, told us in a written submission that the approach of medical schools represents a fundamental problem and noted that some do not teach general practice as an independent discipline:

Medical schools give three reasons for not teaching general practice as a subject. These are: problem-based learning, an “integrated curriculum ... we don’t teach disciplines,” or the need to focus on students learning clinical skills. None of these three arguments stand up to analysis.²⁰³

143. This view formed part of Sir Dennis’ wider argument that medical schools actively discriminate against general practice as a discipline. Sir Dennis reasoned that evidence of this ranges from medical schools failing to reference general practice in prospectuses to allocating only a small proportion of their teaching budgets to general practice.²⁰⁴ In addition he said:

If a medical school does not teach general practice as a subject, has no GP curriculum and provides no GP reading list, it is gives a powerful non-verbal signal that general practice is not important and that there is nothing written

199 NHS Alliance ([PRI 90](#)) para 3.2

200 Q343

201 Q402

202 Q343

203 Sir Denis Pereira Gray OBE ([PRI 238](#)) page 7

204 [Ibid](#), p 5

from or about general practice which future doctors need to read! The current generation of medical students are the most able academically ever, usually being selected on very high A level grades. They are thirsty for theory and principles and want to know the hows and whys of medical practice. If in five years they are not taught any theory or the principles of general practice, naturally they will tend to turn away from it or enter it only for other reasons.²⁰⁵

144. Medical schools should recognise that they have a responsibility to patients to educate and prepare half of all graduates for careers in general practice. Much greater emphasis should be placed on the teaching and promotion of general practice as a career which is as professionally and intellectually rewarding as any other specialism. Those medical schools that do not adequately teach primary care as a subject or fall behind in the number of graduates choosing GP training should be held to account by the General Medical Council.

145. Medical school entry requirements should look beyond pure scientific qualifications and actively to seek out candidates who not only possess academic ability, but can also demonstrate a commitment to providing care within their own community.

General practice as a rewarding career

146. Despite the pressure facing primary care, and GPs in particular, we heard that general practice remains a rewarding career. Professor Ian Cumming, illustrating how to persuade young doctors into general practice, gave the example of a hospital trainee who “had seen more pathology in a day in general practice than he had seen in a week in his hospital environment.”²⁰⁶ Even when discussing the challenges facing the profession, Dr Chaand Nagpaul argued that is external factors which can make a career in general practice less attractive to medical graduates, not the discipline itself.²⁰⁷

147. Outlining the merits of the profession, Professor Steve Field said:

I think general practice is the best job in the world. It is an amazing role where patient satisfaction is very high, the public esteem is high and you can get involved in education, research or medical politics. At the moment we are not selling that job and working systematically from school onwards to make it a better place for the youngsters to come in.

This theme was also acknowledged by Professor Cumming, who said:

Without in any way downplaying the pressures primary care is under, we need leaders of primary care to talk about what a fulfilling and rewarding profession it is. Yes, there are pressures at the moment, but we need to turn the corner. We will turn the corner by getting more people choosing to work in primary care.²⁰⁸

148. General practice places huge responsibilities onto the shoulders of GPs, but can deliver a unique sense of professional satisfaction. Senior GPs naturally have an obligation to provide young doctors with a realistic appraisal of the challenges that they will face

²⁰⁵ *Ibid*, p 5

²⁰⁶ Q84

²⁰⁷ Q342

²⁰⁸ Q84

when providing care at the heart of local communities, but they should also acknowledge the part they can play in attracting young graduates into the profession. GP leaders have a keen responsibility to promote the rewarding aspects of a career in general practice and to illustrate why they have dedicated their working lives to the profession.

Tackling local shortages

149. The CfWI outlined the challenge of filling training places in areas which prove unattractive to graduates and how increasing supply does not necessarily meet demand:

Simply increasing the supply of GPs will not necessarily lead to a more equal distribution, as several studies have found. Reducing geographical inequity in access to GP services requires targeted area-level policies, including increasing GP training opportunities in those areas with the poorest coverage.²⁰⁹

150. Health Education England has introduced a broad range of initiatives to make general practice a more attractive proposition to medical graduates and also to make shortage areas more attractive.²¹⁰ The ten point plan agreed by Health Education England, NHS England, the Royal College of General Practitioners and the British Medical Association in 2015 to improve the recruitment and retention of GPs included a recommendation to implement an additional year of post CCT (Certificates of Completion of Training) training (training after final qualification). The ten point plan said:

HEE will work with partners to resource an additional year of post CCT training to candidates seeking to work in geographies where it is hard to recruit trainees. The aim is to encourage new GP training applicants to those areas.²¹¹

Professor Ian Cumming explained how this incentive is expected to work:

They qualify as a GP, they get their certificate of completion of training, and then we say, “If you go to this part of the country, we will give you an extra year of training. In that year you will work as a GP for part of the time, but you will also train in mental health, paediatrics or emergency medicine, something that is needed in the local area, but also something that is a particular interest of yours. We are training you up, and at the end of that we expect you to stay in that area and practise as a GP but also practise in your specialist skill area.”²¹²

151. Professor Cumming outlined the extent of the shortages of trainees in some parts of the country. He highlighted the fact that expanding training places in London had produced unintended consequences:

because as we have created more training jobs we have continued to have 100% fill rate for GP training in London and the south-east. Effectively, we have filled all the training jobs in London and the south-east and drawn predominantly from the north and the east, with bits of the west midlands

209 Centre for Workforce Intelligence (PRI 183) p 2–3

210 Department of Health, NHS England and Health Education England (PRI 200) paras 86–89

211 RCGP, BMA, NHS England & Health Education England, [Building the Workforce – the New Deal for General Practice](#) (January 2015), recommendation 2

212 Q61

and the east midlands thrown in. In the north and the east numbers have gone down, in London the numbers have gone up, but we have maintained the same level overall.²¹³

Consequently, shortages of trainees translate into shortages of qualified GPs:

In some parts of the country, you would find that one in four training posts is not filled. [...] If you have one in four training posts not being filled, it is fair to say that there will be a 25% shortage of GPs coming to take posts in that area.²¹⁴

152. The extent of the problem was emphasised by UCL medical school. They said that in some areas up to 40% of training places have remained unfilled.²¹⁵ Healthwatch Coventry reported that:

There is also evidence that local GP training places not being filled within the Deanery of Health Education West Midlands. There are 350 vacancies, which is 47% of places. This raises concerns about how appealing trainee Drs find the option of training as a GP and how trainees are recruited to local training.²¹⁶

Financial incentives

153. Professor Roland acknowledged that ‘golden handshakes’ (i.e. financial incentives) had been used in the past as a mechanism to attract young doctors into general practice. He told us that there was a “£5,000 incentive to work in deprived areas sometime around 1996 or 1997”.²¹⁷ During our visit to Sheffield a number of GPs told us that they felt that this had been a useful tool in increasing GP numbers.²¹⁸

154. We note that a limited scheme is already in operation whereby a bursary of £20,000 will be made to trainees who agree to work in one of 119 locations that have historically struggled to attract trainees.²¹⁹ The success of this scheme should be kept under review to build an evidence base for the use of financial incentives in workforce planning. We recommend that the Government should assess the merits of supporting student loan repayments for newly qualified GPs and nurses working in primary care especially in areas with acute recruitment challenges, over a concurrent period of obligated service to the NHS.

155. In light of the current workforce crisis we recommend that in response to this report the Government should provide a comprehensive assessment of the full range of incentives that are available to attract young primary care professionals into general practice and to encourage returners and retention in areas where the need is greatest.

213 Q78

214 Q90

215 UCL Medical School ([PRI 223](#)) p 1

216 Healthwatch Coventry ([PRI 71](#)) para 1.31

217 Q66

218 Note of Committee visit to Halifax & Sheffield

219 GP National Recruitment Office '[Targeted Enhanced Recruitment Scheme in England](#)' accessed 11 March 2016

Nursing

156. The challenges for primary care nursing are similar to those faced by GPs. Just as primary care competes with other parts of the NHS for young doctors to choose general practice as a career, the same applies in nursing. Unless these challenges are met, the development of multi-disciplinary teams will founder amid a shortage of nurses vital to the provision of patient centred care. The Nuffield Trust's evidence noted that:

Like general practice, primary care nursing also struggles to attract trainees and faces the impact of large numbers of retiring nurses over the next decade. For this reason, the Primary Care Workforce Commission has rightly highlighted the need for measures equivalent to the Ten Point Plan agreed for GPs to improve recruitment and retention in primary care nursing.²²⁰

157. The Royal College of Nursing's written evidence argued that the age profile of practice nurses, and national drivers behind nurse recruitment, had adversely affected primary care. The RCN said:

Many sections of the non-acute sector workforce have experienced significant under investment over the last four years: it is an unfortunate consequence of the system's response to the Francis Report that necessary investment in acute, elderly and general medicine sectors has been at the expense of community based nursing. [...]

A further challenge is the demographic of the existing workforce: available estimates of the age profile of the total nursing workforce show a progressively ageing primary care nursing workforce. The nursing workforce as a whole is ageing, in 2013 46 per cent of the workforce was aged over 45, compared with 37 percent in 2005. The average age is even higher in the community than in acute settings and there is expected to be an increase in the numbers of senior nurses retiring within the next five years, which will lead to worrying shortages in some areas.²²¹

158. Commenting on the nursing workforce challenge facing primary care, Professor Ian Cumming told us that in the long term supply and demand should balance out:

We have a huge shortfall at the minute—somewhere in the region of 15,000 to 20,000 fewer nurses than we actually need—but that is because the NHS, as a result of Mid Staffordshire and the focus on quality, has increased the establishment for nurses by about 25,000, and we train 20,000 nurses a year, give or take. [...] By 2019 or 2020, we should be back in equilibrium in terms of supply and demand.²²²

159. Candace Imison of the Nuffield Trust, however, questioned the wisdom of working towards a specific target designed to alleviate nurse shortages:

We have underpinned our nursing workforce—traditionally—from international sources, and as things change internationally people who have

²²⁰ The Nuffield Trust (PRI 175) para 6.2

²²¹ Royal College of Nursing (PRI 63), paras 8.3 – 8.4

²²² Q89

come here may well go back again. That argues for an active policy to oversupply nurses, not to try to land the jumbo jet on a pin, which is traditionally what we have tried to do in workforce planning and inevitably come unstuck.²²³

Professor Chris Ham of the King's Fund remarked that if "there is equilibrium in demand and supply, it will be the first time in the history of the NHS."²²⁴

Attracting nurses to primary care

160. The RCN believes that reform to pay mechanisms could be significant in retaining nurses in primary care, preventing a drain into the acute sector and ensuring there is a sufficient workforce to support new teams. They observed that:

Recruitment and retention for primary care nurses must also be seen in the context of individual local health economies. It is important to note that unlike acute or other community nurses there is no agreed pay scale for nurses working in general practice. This has led to a gap in terms and conditions between nurses working in general practice and those working in the wider NHS.

Primary care staff do not have the same access to the annual incremental rise under Agenda for Change (AfC) available to staff in acute care and independent practitioners' pay remains at the discretion of the employing GPs. The RCN advocates the adoption of AfC terms and conditions for all nurses employed within primary care.²²⁵

161. Developing this view, Janet Davies, Chief Executive of the RCN, explained that what is most important is providing consistency for nurses across employers in primary care:

The problem is consistency. There are some surgeries that are fantastic employers—there is lots of opportunity for continuing education and nurses are encouraged to develop their skills—and then there are others where the terms and conditions are poor, they do not get paid very well and they do not have those opportunities.²²⁶

Primary care nurses: conclusion

162. We recognise that nurses in primary care face uncertain and varied career development and locally agreed terms & conditions all determined by their employer. This acts as a deterrent to those who may wish to pursue a career in primary care.

163. We recommend that Health Education England, NHS England and the Royal College of Nursing develop a plan for primary care nursing akin to the 10 point plan agreed for general practice. This should include proposals to attract trainees, reform undergraduate training and ongoing professional development, establish recommended pay and conditions, and outline examples of different types of careers

223 Q16

224 Ibid

225 Royal College of Nursing ([PRI 63](#)) paras 9.2 – 9.3

226 Q104

that can be accomplished in primary care. As well as focusing on retention of the existing workforce, greater attention should be paid to incentivising qualified nurses to return to primary care after taking career breaks or working abroad.

Training and education

164. Exposure to primary care at undergraduate level is a pre-requisite of attracting sufficient numbers and quality across all professions. This includes GPs, nurses, pharmacists and physiotherapists—the core of the multi-disciplinary team in primary care. Janet Davies said that providing exposure to primary care during nurse training should be a central element to attracting nurses into the profession. She described the nursing degree as being

almost like a graduate apprenticeship, so nurses are trained partly in university and 50% of the time is in clinical practice. In that 50% of time we need to ensure that nurses are all exposed to what they are likely to be doing in the future, not just focusing on hospital, which I know is not the case. There has been until recently very little exposure to primary care, working in general practice at that level.²²⁷

165. The significance of this was underlined by Professor Cumming, who said that:

We know from several pieces of work that have been undertaken that there is a correlation between how much time people spend in a particular area and how likely they are to choose that as a future career.²²⁸

166. We recommend that the Nursing and Midwifery Council urgently review nurse training curriculums with a view to increasing the exposure to primary care for healthcare professionals in training. The same principle should apply across the wider primary care team including physiotherapists and pharmacists. The education and training programme for physician associates should also be tailored in this fashion given their potential contribution to primary care and the developing nature of the profession.

SIFT payments

167. Concern has been expressed that a failure to adequately renegotiate Service Increment for Teaching (SIFT) payments is, in some cases, making it impossible for general practice to offer placements to undergraduates.

168. SIFT payments offset the costs of offering undergraduate medical (and dental) students clinical placements. The Society for Academic Primary Care (SAPC) expressed concern that renegotiation of these payments has become an obstacle to offering placements in general practice to medical students. They said there is an “urgent need to expedite the review of national funding arrangements (SIFT funding) to increase capacity for undergraduate placements in primary care.”

169. The evidence submitted by University College London Medical School illustrated an even more worrying picture. They noted that:

a published survey of all UK medical schools has found that on average medical students spend only 13% of their time based in GP surgeries and that this time has declined since 2002 (Harding et al BJGP June 2015).²²⁹

170. In discussing the various factors which have contributed to the decline in undergraduate exposure to general practice UCL Medical School said:

SIFT (Service Increment for Teaching) payment available to reimburse practices providing undergraduate placements has been static for more than 10 years and no longer reflects the cost of re-providing service lost when they are teaching students. [...]

The Department of Health working group set up to review GP SIFT arrangements with a view to costing primary care education and replacing SIFT with a new Primary Care Education Tariff has not met since November 2013. Uncertainties around the new Tariff arrangement have blighted medical schools' ability to deliver current levels of GP based teaching let alone expand this provision in line with future workforce needs.²³⁰

171. The RCGP has called for “greater exposure to general practice by increasing the funding available to medical schools for GP teaching and research staff through the medical undergraduate placement tariff.”²³¹ Professor Cumming addressed this matter in oral evidence, noting that Health Education England had commissioned a piece of work on training GPs, which he expected to address the issue of remuneration for training undergraduates.²³²

SIFT payments: conclusion

172. It is unacceptable that a failure to provide sufficient funding should make it more difficult for medical students to gain experience of primary care. Financial constraints which limit undergraduate exposure to primary care represent a false economy which will only generate costs elsewhere. We were, however, encouraged that Alistair Burt said that the Government is “working to develop a national payment mechanism for primary care with payments that better reflect the costs of the placements”.²³³ **We recommend that the Government accelerate their work to create a payment mechanism which reflects the true cost to GP practices of teaching medical students. The objective of this work should be to ensure that reimbursement of the costs of training is not a barrier to undergraduates being able to access training in general practice. With this in mind, new proposals to replace the existing SIFT arrangements should be in place by the beginning of the 2016–17 academic year.**

229 UCL Medical School (PRI 223) p 1

230 *Ibid*

231 RCGP (PRI 174) para 16

232 Q85

233 Q417

Workforce and federations

173. Chapter 2 described the way in which federations and networks of practices will be central to developing new models of care. Professor Roland made a strong case to illustrate how collaborative working can make advancing the workforce a more realistic prospect for groups of practices. He said that new structures provide the headroom for general practice to find ways to change their models of care and professional teams as it “is very difficult to innovate when you are constantly trying to catch up.”²³⁴ Professor Roland gave an example of how bigger structures can improve the workforce, telling us that the PCWC envisaged:

networks and federations playing a key role. For example, in terms of the new roles, such as physician associates, how are we going to train them and how are we going to deal with governance issues and liability? Those are the sorts of things that an individual practice will find really hard.²³⁵

174. Similarly, Professor Roland emphasised the support that federations will have to offer in crucial areas such as developing leadership roles for nurses in primary care:

We could see a very good case, for example, for a federation having a lead nurse who would take some responsibility for the training and support of nurses in the practices in that federation.²³⁶

175. Co-commissioning of general practice services by clinical commissioning groups presents an opportunity to tailor services to patient needs by making best use of local knowledge and experience. Allied with NHS England local area teams, Clinical Commissioning Groups should use their co-commissioning powers to oversee and guide the development of federations so that patient care is central to their ambitions. We recommend that a principal element of this oversight should be a requirement for federations to develop multi-disciplinary teams focused on enhancing access to primary care and improving the quality and range of services available.

176. In order to accelerate the development of nursing roles in primary care we recommend that federations appoint a lead nurse to design and implement career pathways and continuing professional development for nurses. Health Education England should assist in setting standards and supporting federations and networks to meet them.

Regulation

177. Over the course of this inquiry we sought to assess the merits of extending the role of physician associates within general practice and in Chapter 2 we commented on their potential to contribute to new models of care. Whilst the majority of witnesses have been largely positive regarding the clinical role they can play, the lack of professional regulation of this profession is a significant barrier to their further deployment.

234 Q13

235 Q2

236 Q30

178. This point is of significance given the substantial expansion of the physician associate workforce that is planned and the fact that the PCWC endorsed the principle of physician associates forming part of the multi-disciplinary general practice team.

179. The Nuffield Trust identified the restrictions on physician associates as an impediment to expanding this workforce:

New roles such as physicians' associates are hampered by their inability to prescribe medicines. They need to be formally regulated in order to enable this and we would urge the committee to support this change.²³⁷

180. Professor Roland discussed the ways in which physician associates should work in the context of them being an un-registered profession for whom the employing GPs would be vicariously liable. Professor Roland said the view of the Primary Care Workforce Commission

would be that in due course they should have a limited prescribing list, yes, because that would significantly extend what they can do with minimal risk to patients. I think it is a limitation. In the same way we have pretty slowly seen prescribing pharmacists, prescribing nurses, obviously, and now prescribing physiotherapists.²³⁸

He noted, however, that many of the major challenges related to the expansion of the physician associate workforce have not yet been addressed, adding:

There is a question, for example, as to whether they should be seeing children and pregnant women, so there are physician associates who quite significantly limit their practice at the moment to, for example, acutely ill adults.²³⁹

Acknowledging the risk carried by GPs, Prof Roland said the GP

is in a position of personally, potentially, taking responsibility. The issues of liability are important and for that reason, regulation of the profession would be desirable.²⁴⁰

181. Dr Chaand Nagpaul of the BMA outlined and emphasised the concerns relating to regulation and also raised the issue of physician associates' qualifications:

There are some very real and understandable concerns about the role of physician associates in terms of their qualifications, the indemnity and the regulation. Rather than starting with some target of 1,000 physician associates and looking at it in terms of physician associates, why not look at the skill mix that can support general practice? [...] Being simplistic and saying it is about 1,000 physician associates is probably not the way to interpret it.²⁴¹

237 The Nuffield Trust ([PRI 175](#)) para 6.5

238 Q42

239 Q43

240 Q43

241 Q347

182. The Medical Protection Society's written evidence implied that ascribing additional responsibilities to physician associates could increase the indemnity costs faced by practices:

The level of risk attached to any one individual will obviously depend on their role and degree of autonomy, regulatory requirements, level of delegated authority and most especially the extent of autonomous decision making.²⁴²

183. The General Medical Council has indicated that it would be supportive of measures to regulate physician associates, although they stopped short of committing themselves to assuming this function:

The GMC has received a number of approaches about taking on the regulation of physician associates. We support the proposal that they should be subject to statutory regulation and we have made clear that should the four UK governments ask the GMC to take on this role, we would at least consider doing so.²⁴³

Physician associates: conclusion

184. Without expansion of the workforce, the role of the physician associate cannot naturally evolve to meet the demands of working in general practice as part of multi-disciplinary teams. The Government should heed the warnings of general practice and indemnity providers that 1,000 additional physician associates will not be recruited into primary care unless there is a regulatory structure to underpin their clinical work. The vicarious liability faced by employers as a consequence of employing clinicians who work without professional regulation is a clear disincentive to recruitment.

185. We welcome the fact that the Royal College of Physicians now hosts a faculty which will operate the re-certifying process for physician associates, but this is not an adequate substitute for professional regulation.²⁴⁴ Regulatory change is required for the statutory regulation of physician associates to be made possible.²⁴⁵ Within 12 months we expect the Government to have drafted proposals that will achieve the objective of professionally regulating physician associates. It is unacceptable to encourage new graduates to train as physician associates without giving the public or these new members of the primary care workforce the assurance that they will be a regulated professional group.

GP leadership

186. GP leaders have a key role to play in helping to mobilise professional support for implementing the recommendations of the Primary Care Workforce Commission, for example by emphasising the benefits not only for patients but for professional colleagues. We heard in evidence that working collaboratively is often associated with delivering excellent care and provides a positive environment in which to work.²⁴⁶ Innovative examples of new models of care have already begun to develop and these range

²⁴² The Medical Protection Society (PRI 235) para 55

²⁴³ General Medical Council (PRI 217) para 19

²⁴⁴ Faculty of Physician Associates at the Royal College of Physicians

²⁴⁵ Prof Veronica Wilkie (PRI 236)

²⁴⁶ Qq 272 343

from a nurse led practice in west London to practices making active use of self-referral to physiotherapists in Suffolk. **We would welcome the RCGP and BMA taking a greater role in helping to promote and drive forward multidisciplinary working and new models of care.**

4 Funding

Changing incentives in the system

187. The way in which the NHS tariff system remunerates hospitals represents a fundamental barrier to the development of new models of care. Bringing specialists out of hospitals so that they can work alongside primary care and community services can bring great benefits for patients and the wider healthcare team. Unfortunately activity-based financial incentives encourage secondary care providers to retain services within their organisational boundaries as this maintains income. Professor Roland described how this acts as a barrier to change:

Perhaps the most revolutionary, but simultaneously obvious, recommendation is that the current tariff basis for funding hospitals will not work for the new models of care that are being proposed. If you look, for example, at multi-specialty community providers, we expect hospitals to send their consultants out into the community to support GPs and enable them not to send so many patients to outpatients and not to admit so many patients, and those are the things on which the hospital depends for its income. There is a fundamental flaw, if we are looking for a more integrated model of care, in the current tariff system. We need to incentivise trusts to strengthen their links with primary care, particularly in geriatrics, paediatrics and mental health, which are three key areas.²⁴⁷

188. This approach has been endorsed by the King's Fund, who themselves provided a practical example of how patients can benefit from moving specialist care out of hospitals:

One example is the Imperial Child Health Hubs, where paediatric consultants from St Mary's [St Mary's Hospital] run an email and telephone helpline for GPs and attend multidisciplinary team meetings, run education sessions and hold outreach clinics at local GP practice hubs (Robertson et al 2014). By supporting primary care staff to treat patients themselves, they have reduced waiting times and the number of hospital referrals and receive high patient satisfaction scores.²⁴⁸

189. The King's Fund pointed to the challenge of developing models of funding that would encourage the development of integrated primary care teams and, thus, new models of working. They have associated changing funding mechanisms with the evolution of networks and federations:

we argue for a new approach that brings together funding for general practice with funding for many other services to deliver care that goes well beyond what is currently available in general practice, potentially via models that operate on the scale required for effective integration of services such as federations or networks of practices. At the heart of this approach would be the use of a population-based capitated contract under which providers would be expected to deliver defined outcomes for the populations they serve.²⁴⁹

247 Q2

248 The King's Fund ([PRI 191](#)) para 33

249 [Ibid](#) para 25

190. Professor Chris Ham told us that fee for service payment arrangements do not encourage multi-disciplinary working and “incentivise activity and contacts rather than continuity of care.”²⁵⁰ Professor Ham argued for a system based on capitation with additional payments for quality.²⁵¹ Capitation is a mechanism which works on the basis that providing a global sum to a provider for patient care will encourage earlier intervention to prevent conditions from escalating and, consequently, costing more to treat:

capitated payment or capitation means paying a provider or group of providers to cover the majority (or all) of the care provided to a target population, such as patients with multiple long term conditions (LTCs), across different care settings. The regular payments are calculated as a lump sum per patient. If a provider meets the specified needs of the target population for less than the capitated payment, they will generate a financial gain to the local health system. Allowing providers to share in any such gain gives them an added incentive to keep patients in their target population healthy. They are more likely to identify risks, intervene early and arrange the right treatment for patients, at the right place and the right time to aid patients’ recovery, continued wellness and better management of long term conditions.²⁵²

191. It is encouraging that some local health economies are now shaping care around payment systems that encourage cooperation. We are pleased that NHS England has incorporated capitated payment systems as part of some of the vanguard projects:

we are supporting MCP [multispecialty community provider] and PACS [integrated primary and acute care system] vanguards to move towards capitated payments for a whole population. The MCP model, based on a GP registered list, will build in additional community and mental health services and social care as appropriate, converting these into an amount per patient that can be combined with core general practice funding.²⁵³

192. Areas outside vanguard projects are not prevented from doing similarly and Julie Wood, Chief Executive of NHS Clinical Commissioners, observed that giving CCGs the ability to commission primary care will make it easier to draw diverse budgets together at a local level.²⁵⁴ Sir Bruce Keogh confirmed that federations could be commissioned to provide care via a capitated payment system²⁵⁵ and this would build on the GP’s traditional role as the budget holder for patients.

193. The Government should, as a priority, evaluate the experimental projects involving capitated payment systems, with a view to extending them to primary care federations. As the vanguard projects begin to mature we expect NHS England to identify good practice and provide clinical commissioning groups with clear guidance on redesigning financial incentives to move care out of hospital, better coordinate care and, ultimately, reduce hospital admissions.

250 Q166

251 Q167

252 NHS England, Monitor, [Capitation: a potential new payment model to enable integrated care](#), (November 2014), p 3

253 Department of Health, NHS England and Health Education England ([PRI 200](#)) para 73

254 Q247

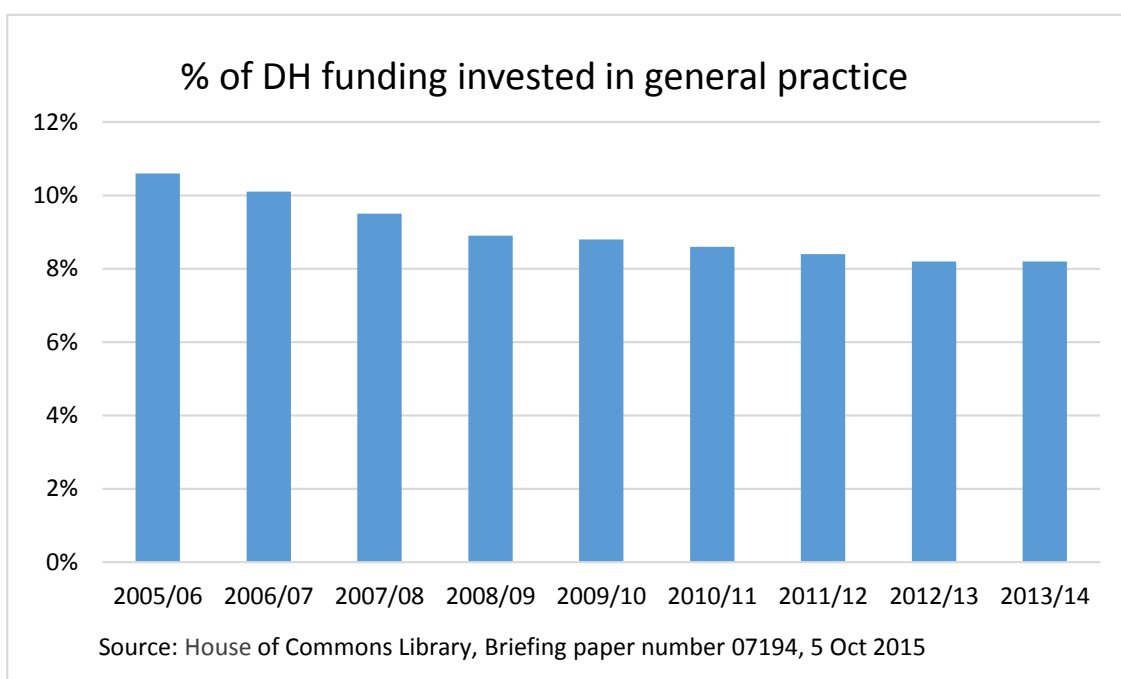
255 Q261

194. Ensuring that clinical commissioning groups, federations and trusts working collaboratively have the power to change payment systems is an essential component of reform. The challenge to local health systems should change from ‘you could do this’ to ‘why aren’t you doing this?’.

Investing in primary care

Proportion of NHS spending on primary care

195. Despite increasing workload, the proportion of NHS funding dedicated to primary care has very significantly declined over the past decade. Health and Social Care Information Centre data analysed by the House of Commons Library “shows a shift on the share of funding for general practice from 10.6% in 2005/06 to 8.2% in 2013/14.”²⁵⁶ As outlined in chapter 1, this is not the outcome of a conscious policy decision but a symptom of the tariff system which encourages the paid-for activity and specialised costs inherent to secondary care.



196. The RCGP’s Comprehensive Spending Review submission to the Treasury outlined the scale of investment required to return general practice funding to the proportion of the NHS budget it received in 2005–06:

The RCGP has called for 11% of the NHS budget to be invested in general practice, restoring it to the proportion of funding that it received a decade ago. To get to this level would mean that, by April 2020, general practice across the UK needs to be receiving £3.8bn per year more than it currently does, and general practice in England £3.1bn per year more.²⁵⁷

²⁵⁶ [General Practice in England](#), Briefing Paper 07194, House of Commons Library, October 2015

²⁵⁷ RCGP, [Resourcing General Practice To Improve Patient Care And Ensure A Sustainable NHS: RCGP Submission For The 2015 Spending Review](#), (November 2015)

197. **We believe that primary care should receive a larger proportion of overall NHS spending.** As we note below, there is a wealth of evidence that expenditure on primary care has the potential to reap significant financial benefits because of the savings it can realise elsewhere in the system. This, however, can only be achieved if the structures within the NHS are reformed to change incentives and to prioritise early intervention and care outside hospital. Increasing the share of the NHS budget invested in primary care should be part and parcel of developing new models of care and reformed payment systems to underpin them.

198. The RCGP has illustrated the financial benefit to the NHS as a whole from investing in primary care:

Independent research produced for the RCGP by Deloitte sets out a case that increased spending on general practice across the UK could lead to short term savings of up to £447m annually, comprising:

- £133.9m per year, through diverting up to 1.7m patients away from A&E
- £143.3m per year, through reducing the number of unnecessary ambulance call-outs
- £170.1m per year, through reducing the length of hospital stays for patients aged over 65, by providing greater primary care support at home.²⁵⁸

199. **It is unacceptable that financial mechanisms and a failure to coordinate health and social care continue to divert too many patients to inappropriate and more expensive secondary care. We recommend that the Government set out a clear timetable and framework for delivering the practical financial tools by which local commissioners and providers can work together to improve patient care and to reduce demand and costs elsewhere in the system.**

Future funding

200. In December 2015, NHS England announced a multi-year financial settlement for primary care:

Spending on GPs and primary medical care services will grow in real terms at a higher rate than for other health services, with an extra 4%-5.4% per cent cash funding every year for five years.²⁵⁹

201. The figures published by NHS England account for only core funding and do not directly tally with those produced by the Health and Social Care Information Centre as the latter incorporate some additional funding streams.²⁶⁰ In itself, however, this settlement will only increase the proportion of the NHS budget invested in primary care from 7.3% in 2015–2016 to just 7.7% by 2020–21.²⁶¹

²⁵⁸ *Ibid*

²⁵⁹ NHS England, [NHS England allocates £560 billion of NHS funding to deliver NHS Five Year Forward View](#) (December 2015)

²⁶⁰ HSCIC, [Investment in General Practice, 2010–11 to 2014–15, England, Wales, Northern Ireland and Scotland](#) (September 2015)

²⁶¹ NHS England, [Allocation of resources to NHS England and the commissioning sector for 2016/17 to 2020/21](#) (December 2015), para 20

202. The five year funding settlement for primary care provides only a very limited uplift in investment over the course of this parliament. Therefore, if primary care is to benefit from any further additional funding this process will have to be driven by local health economies. It will be for clinical commissioning groups, GP federations and secondary care providers to decide whether and how to develop primary care centred models of care built on capitated budgets if that is the right thing for patients and for their local health economy. For this to become a reality existing sites experimenting with these systems must succeed in developing models which can be replicated by other local areas that wish to follow suit. **We recommend that by April 2017 NHS England present to Parliament a report outlining the achievements of the vanguards to date and identifying models of payment systems which produce better care for patients which can be replicated elsewhere across England.**

203. The RCGP's submission to the 2015 spending review outlined the degree of investment required to build the core parts of the workforce described by the PCWC:

The College calculates that implementing the Commission's recommendations will cost an additional £1.66bn in general practice annually by 2019/20 in inflation adjusted terms [...]. This would deliver an additional 5,000 GPs, 5,000 medical assistants, 4,300 practice based pharmacists, 1,000 physician associates, 2,275 practice nurses.²⁶²

204. This analysis includes only salary costs,²⁶³ makes no assessment of infrastructure costs and does not examine the cost of recruiting other health professionals such as physiotherapists. We heard that patient demand for physiotherapy services could require 1,500 additional physiotherapists over the next 3 years but no costing has been attached to this figure.

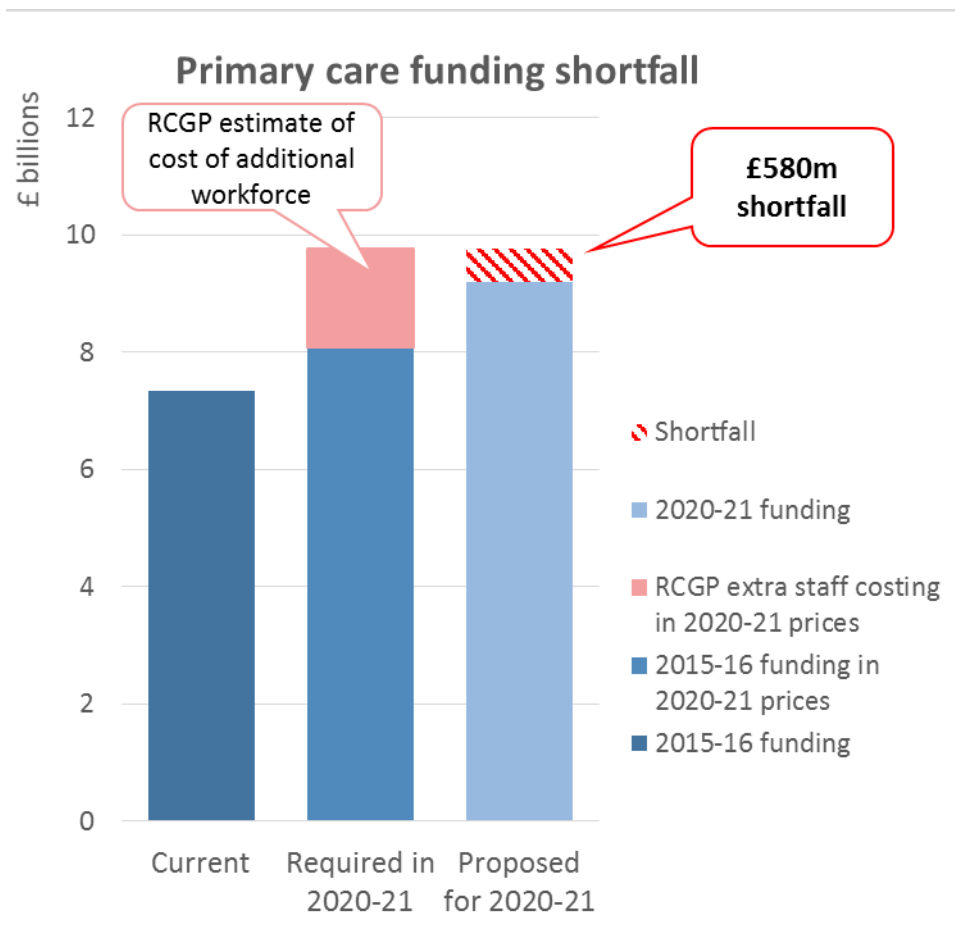
205. The total increase in funding for primary care proposed by NHS England by 2021 amounts to £1.8 billion, but analysis by the House of Commons Scrutiny Unit shows that that even if this investment was used solely to fund the new workforce it would not be sufficient in itself to meet the costs outlined by the RCGP.²⁶⁴ In real terms there would be still be a shortfall of approximately £580 million by 2021.²⁶⁵

262 RCGP, [Resourcing General Practice To Improve Patient Care And Ensure A Sustainable NHS: RCGP Submission For The 2015 Spending Review](#), (November 2015)

263 Q355

264 House of Commons Scrutiny Unit ([PRI 243](#)) February 2016

265 Ibid



Infrastructure

206. The estimated £1.65bn cost of funding the core elements of the PCWC proposals differed somewhat from the £3.1bn additional investment requested by the RCGP to return the proportion of total funding for primary care to 11%. Answering this point Dr Maureen Baker said:

In doing these costings, we concentrated on salary costs—what you are paying the individual and the on-costs. We have not factored in there the infrastructure costs, such as the rooms or the areas for these people to sit in, the equipment they will use, the training they will need and how you will provide new services. This is just salary costs.²⁶⁶

207. Building on these remarks, Dr Nagpaul explained the limitations placed on general practice by the existing infrastructure:

In terms of infrastructure, we conducted a comprehensive survey of the state of GP premises. As we speak, only four out of 10 GP surgeries feel they can offer core basic services. They do not have the space—enough rooms—to provide an adequate level of general practice services. Seven out of 10 say they do not have space to provide extended services. If you look at the agenda to move care into

the community out of hospitals, there just is not the space, and you and I know that if you walk into a GP surgery most are overstretched, there is not enough reception space or waiting room space, and the doctors are hot-desking. There is a real need to expand the infrastructure estate. [...]

If you have less care provided in hospitals, you have to have some facilities in the community.²⁶⁷

208. The Government's existing approach to investing in primary care infrastructure and, in particular, premises is based on:

the Primary Care Infrastructure Fund, a £1 billion fund over four years, to accelerate improvements in GP premises and infrastructure like Information Technology. In January 2015, NHS England invited general practices to submit proposals for investment in 2015/16 and bids were approved where they would enable improved access to clinical services and support the delivery of new services to reduce emergency admissions. Investment of £750 million over the next three years will support a more strategic approach to premises development, including dedicated support for national IT projects, helping practices come together and link to other services.²⁶⁸

209. The NHS Alliance, however, warned that much of the capital investment has been in single projects and does not constitute recurrent funding:

Recent announcements that increase primary care capital are welcome after years when the development of primary care premises has been virtually static. Initially this has been invested in "catch up" and capital projects. Increasing investment will need to be directed towards the recurrent funding of new and out of hospital services.²⁶⁹

Similarly, the Dispensing Doctors said that the long-term viability of the projects funded by these schemes is in doubt because the resource is time limited and non-recurrent.²⁷⁰

210. The Primary Care Infrastructure Fund has been renamed the Primary Care *Transformation* Fund, which lends credence to the warning made by Dr Nagpaul in October 2015 that the fund would not be dedicated purely to improving infrastructure:

it now appears that some of the funding may now be siphoned off into other projects and priorities. This is simply unacceptable: ministers promised this funding would improve GP services infrastructure and they should stick to that commitment.²⁷¹

211. The General Pharmaceutical Council inadvertently illustrated how funding which, theoretically, is earmarked for infrastructure projects can be diverted to support broader ambitions. In this case funding was used for the expansion of practice teams:

267 Q335

268 Department of Health, NHS England and Health Education England ([PRI 200](#)) para 50–51

269 NHS Alliance ([PRI 90](#)) para 4.1

270 The Dispensing Doctors' Association ([PRI 193](#)) para 5

271 British Medical Association, [BMA warns that investment in GP facilities is "faltering"](#) (October 2015)

funding from the primary care infrastructure fund would be used to employ pharmacists in GP practices in England to help GPs deliver a seven-day-a-week service.²⁷²

212. Rosamond Roughton conceded that the fund is not entirely dedicated to estates and technology and is being used for a scheme to place 400 clinical pharmacists in general practice teams.²⁷³ Whilst this is a welcome initiative in line with the recommendations of the PCWC, the funding available will decline to zero over three years.²⁷⁴ This does not encourage a sustainable workforce model that primary care can build on and diverts resource away from infrastructure investment, which was the original purpose of the fund.

Funding the new workforce: conclusions

213. There needs to be greater clarity about meeting the costs of premises and IT for new teams. The schemes which are in place to fund infrastructure development such as the transformation fund are not dedicated solely to this purpose and do not provide recurrent funding. Bringing secondary care further into primary care through federations and expanding the multidisciplinary workforce will require suitable infrastructure.

214. The costs of developing a new workforce, establishing the necessary technology and building new premises to allow for new models of care to flourish have yet to be established. By the end of 2016 we expect the Government to provide us with a full indicative costing in order for a full evaluation of the scale of this challenge to be available to the public.

215. We endorse the recommendations of the Primary Care Workforce Commission and believe the process of implementing a new model of primary care is a vital step in ensuring the long-term sustainability of the NHS. It is now the Government's responsibility to illustrate how it will provide the necessary investment to meet the cost of developing multi-disciplinary teams that will better meet the needs of patients.

272 General Pharmaceutical Council ([PRI 111](#)) p 1

273 Q434

274 RCGP, BMA, [NHS England & Health Education England, Clinical Pharmacists in General Practice Pilot](#) (July 2015), p 6

Conclusions and recommendations

Improving access to primary care

1. We believe that it is vital that patients have timely access to primary care services. This includes both access to urgent appointments and the ability to book routine appointments in advance. (Paragraph 25)
2. Evidence from the National Audit Office shows that people who work during the week would like to make use of extended hours at weekends. We welcome the principle of improving access for people whose working lives make it very difficult to obtain appointments during the week and recognise that this was one of the Government's manifesto commitments. The Government should, however, bear in mind evidence that there may be more demand for access to GPs in the evenings or on Saturdays than on Sundays. (Paragraph 26)
3. There should be a full evaluation of the pilot programmes testing the provision of routine weekend appointments before any new system is rolled out around the country. The Government's approach should be evidence based, learn from best practice and avoid unintended consequences such as damaging weekday services, continuity of care or existing urgent out-of-hours primary care services. (Paragraph 27)
4. An essential component of extending primary care services to weekends should be making those patients currently disenfranchised by the existing model of care aware of improved access. Ongoing evaluation of Prime Minister's Challenge Fund backed projects should, at a local level, incorporate an analysis of patient awareness of weekend services. (Paragraph 29)
5. Continuity of care demands continuity of record keeping. Patient safety is compromised by inadequate access to patient records. There is greater risk of medical errors as well as the unnecessary costs of increased bureaucracy where patient records cannot be accessed and electronically updated at every point of contact. Routine appointments, especially for complex patients, without access to patient records give rise to an avoidable risk. (Paragraph 32)
6. It is essential, both for patient safety and to reduce bureaucracy, for patient records, accessed with their consent, to be directly accessible by all the health professionals seeing patients registered with any practice within a federation, network or out-of-hours provider. The response to this report should lay out a clear timetable for these arrangements to be in place including for shared access between primary and secondary care. Efforts should be made to ensure that such arrangements apply UK wide. (Paragraph 33)
7. We recommend that clinical commissioning groups, federations and networks be given the flexibility to develop local solutions for weekend access to meet the needs of those who cannot attend routine services between Monday and Friday. Clear and consistent statements affirming the Government's commitment to local flexibility are required to assist both implementation and public comprehension of the policy. Implementation of new weekend routine services must also take account

of the impact on local provision of existing out of hours services for urgent primary care. We recommend that locally led design underpinned by adequate funding and resource from the centre should form the basis of the Government's implementation of its manifesto commitment to 7-day primary care services. (Paragraph 38)

8. In 2013 our predecessor committee recommended in its report on urgent and emergency services that urgent care centres providing out of hours GP services should be co-located on hospital sites where appropriate for the local population. The future location of extended primary care provision should take this recommendation into account as part of a process of simplifying and concentrating the confusing array of urgent primary care services. Local demographics and the location of hospitals will not always make this possible, therefore local input is vital to determine the optimum locations for patient access. (Paragraph 39)

Utilising information technology

9. We firmly believe that harnessing the opportunities presented by IT could improve access and quality of care. Patients expect to be able to book appointments online and practice websites should facilitate that. Whilst many patients will prefer or require a face to face consultation, for those who do not, primary care providers should facilitate telephone and eventually online consultations. (Paragraph 51)
10. NHS England must offer support by sharing and promoting best practice on the use of IT to facilitate remote consultations. Practice partners and managers would benefit from clear guidance and support in helping them to understand how technology can be harnessed to improve access and clinical standards of care in the most cost effective manner. We recommend that NHS England undertake research to support this objective with the aim of formally assessing demand, risk and potential benefits. (Paragraph 52)

Variable quality

11. We welcome Care Quality Commission (CQC) inspection of GP practices and the benefit which it has brought for patients. Independent regulation supported by robust inspection is a useful tool in driving improvement, ensuring quality and giving the public confidence in the services they pay for. Since the CQC's remit was extended to primary care it has played an important role in identifying failing and underperforming practices, closing some down and ensuring others improve. (Paragraph 73)
12. We reject the calls from the British Medical Association and the Royal College of General Practitioners to scrap the current regulatory regime. We urge them to work constructively with the Care Quality Commission to protect the public from the small minority of dangerous practitioners and to help to turn around underperforming practices. (Paragraph 74)
13. We heard evidence of duplication of data requests resulting from the Care Quality Commission's (CQC) primary care inspection methodology. Like all good regulators the CQC should constantly examine its procedures and methods to avoid or minimise unnecessary burdens or duplication. NHS England, the CQC,

the General Medical Council and Local Education and Training Boards must work together to agree a common framework and data set to reduce bureaucracy and unnecessary duplication. It is essential that time which should be devoted to patient care is not eroded by an excessive bureaucratic burden. (Paragraph 76)

Improving the patient experience

14. Ten-minute appointments do not allow adequate time for safe practice or to address whole person care. Relentless time pressure from short appointments tends to restrict patients to discussing only one problem with their GP and clinicians to working in a reactive rather than proactive manner. Given the increasing complexity of the long term conditions that are managed in primary care, allowing time to provide safe and holistic care must be a priority. We agree with the Primary Care Workforce Commission that reshaping primary care to give patients sufficient time to discuss their conditions with health professionals should be a central aim of the new models of care. (Paragraph 83)

Multi-disciplinary teams

15. Whilst the vision for a new model of primary care and the workforce to underpin it has been established, the challenge for the Government and NHS England is to overcome the barriers to building these new teams and to implement the necessary change at scale and pace. This is especially important given the existing and worsening workforce shortfall. We are concerned that basic reforms such as widening the responsibilities of nurses, self-referral to physiotherapy and the incorporation of pharmacists into general practice teams should be enabled and accelerated. In the response to this report we would like to see a clear plan and timetable for action. (Paragraph 105)
16. We support the objective of training physician associates to work alongside GPs within multidisciplinary teams in primary care, but as their new roles and responsibilities develop they will need careful evaluation. Attention must also be paid to the continuing professional development needs and supervision of physician associates. (Paragraph 106)
17. We endorse the recommendation of the Primary Care Workforce Commission that practices or groups of practices should have access to a named consultant psychiatrist and to a named mental health worker or community psychiatric nurse. We also welcome the improved access standards and additional funding for the Improving Access to Psychological Therapies programme as an opportunity to improve access for patients in primary care to mental health therapies. (Paragraph 112)
18. In the response to this report we invite NHS England to explain how they will act on the Primary Care Workforce Commission's recommendation that GPs should be able to communicate routinely with specialists in secondary care by email and messaging. (Paragraph 115)

The role of federations

19. Federations and networks should be formed with the primary purpose of improving care for patients. NHS England Local Area Teams, in conjunction with clinical commissioning groups, should directly support the development of new models of care envisioned by the Primary Care Workforce Commission. (Paragraph 123)
20. There must be assurance that federations and networks are forming with robust structures and leadership and a clear picture of how patient care and experience can be improved. We recommend that clinical commissioning groups, federations and networks also involve patient-facing charities and community organisations to help them maintain a focus on quality and local priorities for improving care. (Paragraph 124)

Guarding against conflicts of interest

21. We believe that continued vigilance is required at national and local level to guard against conflicts of interest influencing decisions taken by clinical commissioning groups in relation to general practice. The commissioning system must operate both fairly and transparently and be seen to be operating in this way. (Paragraph 125)

Workforce planning

22. Ensuring there are 5,000 additional doctors in primary care by 2020 is dependent in part on attracting people to return to the profession. The induction and refresher scheme is a vital component of the efforts to do so. It should be subject to annual review to ensure that it is facilitating the return of qualified professionals as quickly as possible. (Paragraph 131)
23. The Government should publish an analysis of the trends in doctors leaving the profession. This analysis should encompass their age, experience, specialism, the length of time for which doctors work abroad, the reasons for leaving the profession, and rates of return. (Paragraph 137)

Selection of undergraduates

24. Medical schools should recognise that they have a responsibility to patients to educate and prepare half of all graduates for careers in general practice. Much greater emphasis should be placed on the teaching and promotion of general practice as a career which is as professionally and intellectually rewarding as any other specialism. Those medical schools that do not adequately teach primary care as a subject or fall behind in the number of graduates choosing GP training should be held to account by the General Medical Council. (Paragraph 144)
25. Medical school entry requirements should look beyond pure scientific qualifications and actively to seek out candidates who not only possess academic ability, but can also demonstrate a commitment to providing care within their own community. (Paragraph 145)

Tackling local shortages

26. We note that a limited scheme is already in operation whereby a bursary of £20,000 will be made to trainees who agree to work in one of 119 locations that have historically struggled to attract trainees. The success of this scheme should be kept under review to build an evidence base for the use of financial incentives in workforce planning. We recommend that the Government should assess the merits of supporting student loan repayments for newly qualified GPs and nurses working in primary care especially in areas with acute recruitment challenges, over a concurrent period of obligated service to the NHS. (Paragraph 154)
27. In light of the current workforce crisis we recommend that in response to this report the Government should provide a comprehensive assessment of the full range of incentives that are available to attract young primary care professionals into general practice and to encourage returners and retention in areas where the need is greatest. (Paragraph 155)

Nursing

28. We recommend that Health Education England, NHS England and the Royal College of Nursing develop a plan for primary care nursing akin to the 10 point plan agreed for general practice. This should include proposals to attract trainees, reform undergraduate training and ongoing professional development, establish recommended pay and conditions, and outline examples of different types of careers that can be accomplished in primary care. As well as focusing on retention of the existing workforce, greater attention should be paid to incentivising qualified nurses to return to primary care after taking career breaks or working abroad. (Paragraph 163)

Training and education

29. We recommend that the Nursing and Midwifery Council urgently review nurse training curriculums with a view to increasing the exposure to primary care for healthcare professionals in training. The same principle should apply across the wider primary care team including physiotherapists and pharmacists. The education and training programme for physician associates should also be tailored in this fashion given their potential contribution to primary care and the developing nature of the profession. (Paragraph 166)
30. We recommend that the Government accelerate their work to create a payment mechanism which reflects the true cost to GP practices of teaching medical students. The objective of this work should be to ensure that reimbursement of the costs of training is not a barrier to undergraduates being able to access training in general practice. With this in mind, new proposals to replace the existing SIFT arrangements should be in place by the beginning of the 2016–17 academic year. (Paragraph 172)

Workforce and federations

31. Co-commissioning of general practice services by clinical commissioning groups presents an opportunity to tailor services to patient needs by making best use of local knowledge and experience. Allied with NHS England local area teams, Clinical Commissioning Groups should use their co-commissioning powers to oversee and guide the development of federations so that patient care is central to their ambitions. We recommend that a principal element of this oversight should be a requirement for federations to develop multi-disciplinary teams focused on enhancing access to primary care and improving the quality and range of services available. (Paragraph 175)
32. In order to accelerate the development of nursing roles in primary care we recommend that federations appoint a lead nurse to design and implement career pathways and continuing professional development for nurses. Health Education England should assist in setting standards and supporting federations and networks to meet them. (Paragraph 176)

Regulation

33. We welcome the fact that the Royal College of Physicians now hosts a faculty which will operate the re-certifying process for physician associates, but this is not an adequate substitute for professional regulation. Regulatory change is required for the statutory regulation of physician associates to be made possible. Within 12 months we expect the Government to have drafted proposals that will achieve the objective of professionally regulating physician associates. It is unacceptable to encourage new graduates to train as physician associates without giving the public or these new members of the primary care workforce the assurance that they will be a regulated professional group. (Paragraph 185)

GP leadership

34. GP leaders have a key role to play in helping to mobilise professional support for implementing the recommendations of the Primary Care Workforce Commission, for example by emphasising the benefits not only for patients but for professional colleagues. We would welcome the RCGP and BMA taking a greater role in helping to promote and drive forward multidisciplinary working and new models of care. (Paragraph 186)

Changing incentives in the funding system

35. The Government should, as a priority, evaluate the experimental projects involving capitated payment systems, with a view to extending them to primary care federations. As the vanguard projects begin to mature we expect NHS England to identify good practice and provide clinical commissioning groups with clear guidance on redesigning financial incentives to move care out of hospital, better coordinate care and, ultimately, reduce hospital admissions. (Paragraph 193)

36. We believe that primary care should receive a larger proportion of overall NHS spending. (Paragraph 197)

Investing in primary care

37. It is unacceptable that financial mechanisms and a failure to coordinate health and social care continue to divert too many patients to inappropriate and more expensive secondary care. We recommend that the Government set out a clear timetable and framework for delivering the practical financial tools by which local commissioners and providers can work together to improve patient care and to reduce demand and costs elsewhere in the system. (Paragraph 199)

Future funding

38. We recommend that by April 2017 NHS England present to Parliament a report outlining the achievements of the vanguards to date and identifying models of payment systems which produce better care for patients which can be replicated elsewhere across England. (Paragraph 202)
39. The costs of developing a new workforce, establishing the necessary technology and building new premises to allow for new models of care to flourish have yet to be established. By the end of 2016 we expect the Government to provide us with a full indicative costing in order for a full evaluation of the scale of this challenge to be available to the public. (Paragraph 214)
40. We endorse the recommendations of the Primary Care Workforce Commission and believe the process of implementing a new model of primary care is a vital step in ensuring the long-term sustainability of the NHS. It is now the Government's responsibility to illustrate how it will provide the necessary investment to meet the cost of developing multi-disciplinary teams that will better meet the needs of patients. (Paragraph 215)

Annex: Visit to Halifax and Sheffield

The Committee visited the Calderdale vanguard in Halifax and Sheffield Page Hall Medical Centre on Monday 23 November 2015.

Committee members present: Dr Sarah Wollaston (Chair), Dr James Davies, Andrea Jenkyns, Emma Reynolds, Paula Sherriff, Maggie Throup, Helen Whately and Dr Philippa Whitford.

Calderdale Health & Social Care Economy

Representatives of the Calderdale Health and Social Care Economy vanguard project included Matt Walsh, Chief Executive of Calderdale Clinical Commissioning Group (CCG), & Ian Baines, Head of Safeguarding and Quality, Calderdale Metropolitan Borough Council. Louise Watson of NHS England also attended.

Introduction to the Calderdale vanguard project

Calderdale is a mixed urban and rural economy. The registered population is approximately 215,000 situated in a large geographical area. Health inequalities persist and there is a ten year mortality gap. Seven organisations including two foundation trusts, the CCG and the local authority are partners in the vanguard project.

The Committee heard that there is still much to change within the area. There had been lots of work on engagement, the public have been consulted and 4 top themes have emerged from that work: clear information; flexibility of services; services closer to home; and understand-ability.

Political engagement proved difficult because the early part of the process was about closing and reconfiguring services. A politically mandated independently chaired 'people's commission' was established which integrated evidence received during conversations and made a series of recommendations.

Local consensus within the people's commission was regarded as important. During the course of the consultation the public said that they do not want to have to repeat medical details and they want care closer to home. They want the first point of contact with all of their details and a single key worker for each client/patient. The Health & Wellbeing Board has taken responsibility for implementing the recommendations of the 'people's commission'.

National overview of the vanguard programme

The national vanguard programme is in charge of delivering the 5 year forward view, a shared vision across 7 national bodies. The focus of the vanguards is on delivering 5 models of care sustainably. 50 vanguards were selected. There is substantial cross-over of purpose between the various models of vanguards: for example, multi-community specialty providers (such as Calderdale) have a great focus on Care Home care even though there are separate vanguards operating with this specific purpose.

Examples of success include: Birmingham - 60% digital consulting rates taken over the 'phone; Whitstable - paramedics are embedded in practices and have access to patient notes; Corby - mental health crisis teams linked back to practice teams and Stockport - 92% of people chose place of death.

Quest for quality in care homes

It was explained to the Committee that the vanguard incorporates a care home element in which 24 care homes in the local area volunteered to be in the two year scheme. The objective of the programme was described as supporting self-management and enhancing telehealth. Using technology to prevent the need for home visits was an objective but it was observed that staff have needed support to improve their skills. Interoperability of systems and allowing GPs to access patient records has been the priority, but rural locations can make connectivity to IT difficult. Variation in the quality of care was attributed to problems with training and a lack of leadership in care homes.

The programme is based around a multi-disciplinary team including pharmacists who have rationalised prescribing and consultant geriatricians' 'skilling up' staff in care homes during visits. Anticipatory care planning is designed to prevent Accident and Emergency (A&E) admissions and it has been observed that that staff have had better informed discussions about residents' conditions. It was emphasised that increasing the skills of staff is important because making a decision as to the best care a resident requires can be very difficult when staff don't have quick access to a doctor.

The Committee then discussed elements of the care home programme with the leaders of the project. They explained that managing data exchange, consent and technology issues is an ongoing challenge, but this is something that all vanguards are grappling with and common shared practice can be developed.

Another challenge in the care home sector is retaining staff in what is a low pay environment. As well as implementing the Government's national living wage the vanguard said it was looking to develop better career pathways for staff as turnover of staff in this sector had been high.

Discussing the purpose of the vanguard more broadly the Committee was told that being given the status as a vanguard acted as an 'enabler', and helped to formalise existing projects. Members were told that communication between different parts of the system has improved and there is backing to deliver collaborative working. Working as a vanguard means that the project has been externally validated but additional investment will be required to double run services as the process changes.

Development of the new community specialist respiratory service for Calderdale residents

The Committee heard about a specific project aimed at tackling chronic obstructive pulmonary disease. The service was disjointed so specialist teams were co-located as part of a programme to deliver 7 day care. Additional nurses were recruited to the team and moved into primary care rather than secondary care.

Other changes included facilitating same day access to consultants at the front end of the patient pathway. The overall ambition is to create an anticipatory care model, but the reactive elements can also be designed to work better. At the heart of the changes is the need to achieve quick and accurate diagnoses and engage patients in activity that will improve their conditions.

The Committee heard that problems had included an inability to capture data around GP usage and information about prescribing costs and patterns. However, technology has helped more patients to understand and manage their conditions without recourse to other NHS services such as A&E.

Children and young people with complex needs

The Committee was told that there had been huge increase in the number of children with autism and sensory impairment - this has partly been due to better early identification. The Committee heard that being part of the vanguard released some non-recurrent funding for this aspect of care. There had been concerns about a lack of funding to provide adequate care but investing significant additional resource to address a single problem was not seen to be a solution. Similarly, it was decided that reforming the whole system was not wise as this could take care in the wrong direction. The members were told that waiting times for Child and Adolescent Mental Health services were still too long and the problems were rooted in primary care.

Concluding discussion

A short question and answer session discussed key issues relating to payment systems and workforce. The members were told that it is essential that the Vanguard delivers a saving but, fundamentally, there is not enough investment in the system at a national level. The view expressed by the project leaders was that funding should move away from tariffs to a population health led model.

The issue of workforce is complex and the members were told that offering incentives to work in one area which effectively drains a neighbouring area of staff is not a sustainable option. This is particularly relevant in Calderdale as patients will often be referred for treatment to hospitals in larger cities outside of the vanguard area. The vanguard is not working on the assumption that there will be more GPs as there are not enough GPs training locally to deliver this.

Page Hall Medical Centre

Background

The Committee had a meeting with staff and patient representatives from the Page Hall Medical Centre (PHMC) in Sheffield, including a presentation by Dr Kate Bellingham, a partner at PHMC.

PHMC comprised a team of 7 doctors (4.5 full time), 5 nurses (3.4 full time) and 2 Health Care Assistants. It has 7321 patients—1627 patients per full time doctor. The nurses perform a role that is very similar to that of the physician associate. The members were

told that the practice has strong links with local communities. It is part of a newly formed federation with 7 local practices. The federation will allow the sharing of capacity and back office staff.

Challenges facing the practice

PHMC argued that the payment mechanism within the existing funding formula weights inadequately and does not account for the heightened health needs of newly arrived migrants. This includes early onset of complex illnesses associated with deprivation and also many patients being illiterate in their native language as well as English. Consequently, they said, there is a huge unfunded workload.

The members heard that 83% of patients are BME and 32% of consultations require an interpreter, rising to 85% for new registrations. Appointments requiring an interpreter inevitably take a long time and a ten minute appointment slot is unrealistic for this population.

In discussion with the members of the Committee the practice staff said that they offer a bespoke service for a specific patient group but the formula does not recognise these patients or reward the innovation required to manage them. Deprivation has traditionally been measured by social housing occupancy and numbers of benefit claimants but the migrant populations in Page Hall live in private houses of multiple occupancy and do not routinely claim benefits.

The discussion revealed that GP retention has been good at the practice. This was attributed to the fact that it is a training practice and trainees have wanted to build their careers at PHMC. In addition, the practice has made use of a pharmacist that has reduced the time taken by a GP to manage care home prescriptions from 3 hours to 25 minutes.

The members were told that five Prime Minister's Challenge Fund extended hours hubs are now in operation within Sheffield. The feedback from the GPs at PHMC was that the hubs had drawn doctors away from out of hours services because the hubs provide better remuneration, as a consequence out of hours had been undermined.

The members then heard patient testimonials which emphasised the importance of the practice to the local community and the fear that if the practice closed the detailed knowledge of the local community that PHMC enjoys could not be replaced by alternative provision. At least two petitions have been launched with the purpose of keeping PHMC open.

Meeting with GPs that submitted evidence to the inquiry

The Committee invited the GPs who had contributed written evidence to its primary care inquiry. 14 GPs drawn from across England were able to attend.

Recruitment & retention

The Committee was told that workload and consequent stress make it impossible to recruit partners in some areas. It was also noted that some training practices do not have trainees because of the poor perception of general practice. Trainees witness the environment that partners work in and prefer to take locum of salaried positions.

It was observed that the lack of trainees and resource dedicated to primary care should be a matter of public concern. The Committee was told that exhaustion amongst GPs should be a cause of great alarm to the public. It was observed that golden hellos had been successful in improving GP recruitment in the 1990s.

Recommendations to improve primary care

The problems associated with declining real terms funding and the failure of the formula to adequately recognise deprivation were emphasised. A reduction in administration and bureaucracy was regarded as a key mechanism for creating room for patient care. The GPs agreed that 10 minute appointments should be a thing of the past but patient expectations should be managed. The GPs said that as a profession they ‘feel bashed’ by the tabloid media narrative which is regarded as ‘outright hostility’.

Multi-disciplinary working

The GPs discussed how they would like to interact with other parts of the primary care team. It was said that the principle of multi-disciplinary working is good but other health professionals must be autonomous so that problems related to issues such as prescribing do not come back to GPs. The Committee heard that indemnity costs are a barrier to expanding the primary care team, but it was noted that some practices have found ways of utilising physician associates. Working collaboratively with other GPs in other practices was seen as a mechanism for enhancing quality and making much better use of pharmacists in medicines management was regarded as priority.

7-day NHS routine care

The point was made to the Committee that offering routine services through federations in rural areas will be of little use if two practices are ten miles apart. GPs agreed that patients will not travel that far on a Sunday to attend a routine appointment. The Committee was told that a seven day service already exists in out of hours and the Government’s proposals risk undermining current services and continuity of care. Concern was expressed that offering routine weekend care could create supply induced demand rather than meeting existing demand. The GPs said that local areas should be empowered to develop their own solutions.

Conclusions

The point was made that primary care extends beyond they typical practice. Vulnerable patients can get lost in the system without a skilled approach from commissioners. The Committee was told that changes to pensions and loss of seniority payments have changed incentives for older GPs—there need to be more mechanisms to create extended roles for GPs to keep GPs from retiring early. Creating routes back into primary care for registrars who leave is important. It was agreed that morale is very low and there is a crisis in primary care. The GPs said that patients are more challenging than ever. The systems cannot stand still and should focus on servicing patient needs as opposed to wants.

Formal Minutes

Tuesday 12 April 2016

Members present:

Dr Sarah Wollaston, in the Chair

Ben Bradshaw

Maggie Throup

Dr James Davies

Helen Whately

Andrea Jenkyns

Dr Philippa Whitford

Paula Sherriff

Draft Report (Primary care), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 215 read and agreed to.

Summary agreed to.

Annex [Visit to Halifax and Sheffield] agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 19 April at 2.00 pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 3 November 2015

Question number

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

[Q1–99](#)

Tuesday 10 November 2015

Professor Karen Middleton CBE, Chief Executive, Chartered Society of Physiotherapy, **Sandra Gidley**, English Pharmacy Board Chair, Royal Pharmaceutical Society, and **Janet Davies**, Chief Executive and General Secretary, Royal College of Nursing

[Q100–144](#)

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

[Q145–182](#)

Tuesday 8 December 2015

Anna Bradley, Chair, Healthwatch England, **Don Redding**, Director of Policy, National Voices, and **Katherine Murphy**, Chief Executive, The Patients Association

[Q183–236](#)

Rosamond Roughton, National Director of Commissioning Development, NHS England, **Professor Sir Bruce Keogh**, National Medical Director, NHS England, **Julie Wood**, Chief Executive, NHS Clinical Commissioners, and **Dr Steve Kell OBE**, Co-chair, NHS Clinical Commissioners and Chair, NHS Bassetlaw CCG

[Q237–267](#)

Tuesday 15 December 2015

Dr Maureen Baker CBE, Chair of RCGP Council, Royal College of General Practitioners, **Professor Steve Field CBE**, Chief Inspector of General Practice, Care Quality Commission, and **Dr Chaand Nagpaul**, Chair of the BMA General Practitioner Committee, British Medical Association

[Q268–356](#)

Tuesday 12 January 2016

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

[Q357–440](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

PRI numbers are generated by the evidence processing system and so may not be complete.

- 1 Action Cerebral Palsy ([PRI0118](#))
- 2 Age UK ([PRI0176](#))
- 3 Albion Health Centre ([PRI0083](#))
- 4 Alzheimer's Society ([PRI0156](#))
- 5 APP Pharmacy Group ([PRI0210](#))
- 6 Arma ([PRI0139](#))
- 7 Arthritis Research UK ([PRI0208](#))
- 8 Association of Surgeons in Primary Care ([PRI0107](#))
- 9 Association of Surgeons in Primary Care ([PRI0219](#))
- 10 Bayer ([PRI0189](#))
- 11 Boehringer Ingelheim Ltd ([PRI0095](#))
- 12 Brian Stewart ([PRI0056](#))
- 13 British Dental Association ([PRI0148](#))
- 14 British Geriatrics Society (Bgs) ([PRI0075](#))
- 15 British In Vitro Diagnostics Association (Bivda) ([PRI0059](#))
- 16 British Medical Association ([PRI0049](#))
- 17 British Medical Association, supplementary evidence ([PRI0232](#))
- 18 British Orthopaedic Association ([PRI0116](#))
- 19 British Society for Rheumatology ([PRI0168](#))
- 20 Brook ([PRI0164](#))
- 21 Brunswick House Medical Group ([PRI0019](#))
- 22 Cambridge Weight Plan ([PRI0115](#))
- 23 Cancer Research UK ([PRI0198](#))
- 24 Care England ([PRI0013](#))
- 25 Care Quality Commission ([PRI0202](#))
- 26 Carers UK ([PRI0137](#))
- 27 Centre for Health Innovation Leadership and Learning, ([PRI0122](#))
- 28 Centre for Workforce Intelligence ([PRI0183](#))
- 29 Chartered Society of Physiotherapy ([PRI0050](#))
- 30 Chris Mowbray ([PRI0053](#))
- 31 Chronic Pain Policy Coalition ([PRI0169](#))
- 32 Clic Sargent ([PRI0068](#))
- 33 Clinical Council for Eye Health Commissioning ([PRI0030](#))

- 34 Coeliac UK ([PRI0086](#))
- 35 College Surgery Partnership ([PRI0177](#))
- 36 Consortium of Local Medical Committees - Cumbria and Lancashire ([PRI0088](#))
- 37 Cumbria LMC ([PRI0089](#))
- 38 Denplan Limited ([PRI0145](#))
- 39 Department of Health ([PRI0242](#))
- 40 Department of Health ([PRI0200](#))
- 41 Devon Local Medical Committee ([PRI0222](#))
- 42 Devon Local Optical Committee ([PRI0091](#))
- 43 Devon Local Pharmaceutical Committee ([PRI0181](#))
- 44 Diabetes UK ([PRI0166](#))
- 45 Dr Chris Corrigan ([PRI0038](#))
- 46 Dr David Jewell ([PRI0182](#))
- 47 Dr Donal Hynes ([PRI0058](#))
- 48 Dr French and Partners ([PRI0025](#))
- 49 Dr Gareth Allen ([PRI0101](#))
- 50 Dr Graham Ironside ([PRI0020](#))
- 51 Dr Graham Johnson ([PRI0234](#))
- 52 Dr Helen Lawrence ([PRI0015](#))
- 53 Dr Ian Whyte ([PRI0069](#))
- 54 Dr James Howarth ([PRI0187](#))
- 55 Dr James Robertson ([PRI0109](#))
- 56 Dr Jane Wilcock ([PRI0037](#))
- 57 Dr Jay Kuruvatti ([PRI0033](#))
- 58 Dr Jennifer Martineau ([PRI0005](#))
- 59 Dr Jill Wilson ([PRI0226](#))
- 60 Dr Joan Flower ([PRI0027](#))
- 61 Dr John Ford ([PRI0066](#))
- 62 Dr Jose Quevedo ([PRI0082](#))
- 63 Dr Kate Bellingham ([PRI0152](#))
- 64 Dr Kate Elliott ([PRI0092](#))
- 65 Dr Kimberley Brownlee ([PRI0197](#))
- 66 Dr Michael Caley ([PRI0003](#))
- 67 Dr Morgan Walters ([PRI0052](#))
- 68 Dr Nasrin Razzaq ([PRI0209](#))
- 69 Dr Naureen Bhatti ([PRI0080](#))
- 70 Dr Nicholas Foreman ([PRI0002](#))
- 71 Dr Nigel Price ([PRI0094](#))

- 72 Dr Nigel Starey ([PRI0047](#))
- 73 Dr Peter Bailey ([PRI0011](#))
- 74 Dr Rupert Lee ([PRI0100](#))
- 75 Dr Russell Thorpe ([PRI0004](#))
- 76 Dr Russell Thorpe ([PRI0225](#))
- 77 Dr Sarah Marwick ([PRI0204](#))
- 78 Dr Sean Hudson ([PRI0031](#))
- 79 Dr Sheila Jackson ([PRI0065](#))
- 80 Dr Stephen Hardwick ([PRI0146](#))
- 81 Dr Timothy Whelan ([PRI0178](#))
- 82 Elizabeth Cecil ([PRI0240](#))
- 83 England Centre for Practice Development Canterbury Christ Church University ([PRI0072](#))
- 84 Epilepsy Society ([PRI0084](#))
- 85 Essex County Council ([PRI0211](#))
- 86 Faculty for Sexual & Reproductive Healthcare ([PRI0135](#))
- 87 Family Doctor Association ([PRI0060](#))
- 88 General Medical Council ([PRI0217](#))
- 89 General Optical Council ([PRI0214](#))
- 90 General Pharmaceutical Council ([PRI0111](#))
- 91 GP Survival ([PRI0103](#))
- 92 Healthwatch Brighton and Hove ([PRI0041](#))
- 93 Healthwatch Cambridgeshire ([PRI0074](#))
- 94 Healthwatch Coventry ([PRI0071](#))
- 95 Healthwatch England ([PRI0228](#))
- 96 Healthwatch Gloucestershire ([PRI0014](#))
- 97 Healthwatch Lincolnshire ([PRI0039](#))
- 98 Healthwatch Richmond ([PRI0077](#))
- 99 Healthwatch Suffolk ([PRI0167](#))
- 100 Healthwatch Worcestershire ([PRI0194](#))
- 101 Healthwatch York ([PRI0140](#))
- 102 Ian Brown ([PRI0218](#))
- 103 IC24 ([PRI0163](#))
- 104 Irwell Medical Practice ([PRI0104](#))
- 105 Ivry Street Medical ([PRI0022](#))
- 106 Kernow Health CIC ([PRI0024](#))
- 107 Lancashire & Cumbria Consortium of LMCS ([PRI0087](#))
- 108 Layton Medical Centre ([PRI0126](#))

- 109 Leicester City Council Health & Wellbeing Board ([PRI0205](#))
- 110 LGA ([PRI0070](#))
- 111 Lighterlife ([PRI0117](#))
- 112 Londonwide LMCS ([PRI0172](#))
- 113 Marie Curie ([PRI0142](#))
- 114 Medical and Dental Defence Union of Scotland (MDDUS) ([PRI0185](#))
- 115 Million+ ([PRI0190](#))
- 116 Millom Surgery ([PRI0021](#))
- 117 Mimex Montague Healthcare Limited ([PRI0045](#))
- 118 Mr Andrew McHugh ([PRI0032](#))
- 119 Mr Andrew Pow ([PRI0051](#))
- 120 Mr John Cottingham ([PRI0173](#))
- 121 Mr Nicholas Rumney ([PRI0124](#))
- 122 Mr Nick Welch ([PRI0012](#))
- 123 Mr Richard Wakeford ([PRI0206](#))
- 124 Mr Roger Tuckett ([PRI0026](#))
- 125 Mr Thomas Cowling ([PRI0057](#))
- 126 Mrs Eileen Newby ([PRI0006](#))
- 127 Ms Carol Saunders ([PRI0114](#))
- 128 MS Society ([PRI0188](#))
- 129 National Community Hearing Association ([PRI0085](#))
- 130 National Osteoporosis Society ([PRI0158](#))
- 131 National Voices ([PRI0144](#))
- 132 Newbury & District, North & West Reading, South Reading and Wokingham CCGs ([PRI0134](#))
- 133 NHS Alliance ([PRI0090](#))
- 134 NHS Castle Point & Rochford CCG ([PRI0171](#))
- 135 NHS Clinical Commissioners ([PRI0157](#))
- 136 NHS Confederation ([PRI0128](#))
- 137 NHS Partners Network ([PRI0162](#))
- 138 NHS Providers ([PRI0130](#))
- 139 NHS Survival ([PRI0099](#))
- 140 NHSCC Mental Health Commissioners Network ([PRI0097](#))
- 141 NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester ([PRI0155](#))
- 142 Ninawatie Vimal Tiwari ([PRI0112](#))
- 143 Nora Everitt ([PRI0048](#))
- 144 Nuffield Trust ([PRI0175](#))
- 145 Optical Confederation and Local Optical Committee Support Unit ([PRI0151](#))

- 146 Paediatric Continence Forum ([PRI0119](#))
- 147 Pancreatic Cancer UK ([PRI0138](#))
- 148 Park Road Surgery ([PRI0110](#))
- 149 Parkinson's UK ([PRI0044](#))
- 150 Personal Submission (GP at Huddersfield Road Surgery, Barnsley S70 2 LT). ([PRI0078](#))
- 151 Pharmaceutical Services Negotiating Committee ([PRI0133](#))
- 152 Pharmacy Voice ([PRI0201](#))
- 153 Pharmacy Voice ([PRI0241](#))
- 154 Policy Research Unit in Commissioning and the Healthcare System ([PRI0046](#))
- 155 Primary Care Child Safeguarding Forum ([PRI0170](#))
- 156 Primary Care Children's Safeguarding Forum ([PRI0147](#))
- 157 Primary Health Properties ([PRI0061](#))
- 158 Primary Healthcare Darlington Ltd ([PRI0113](#))
- 159 Professor Clare Gerada ([PRI0192](#))
- 160 Professor Martin Roland ([PRI0221](#))
- 161 Professor Nadine Foster ([PRI0096](#))
- 162 Professor Nick Cooper ([PRI0180](#))
- 163 Professor Sir Denis Pereira Gray ([PRI0238](#))
- 164 Professor Vari Drennan ([PRI0227](#))
- 165 Professor Veronica Wilkie ([PRI0236](#))
- 166 Proprietary Association of Great Britain (PAGB) ([PRI0154](#))
- 167 Pulse ([PRI0165](#))
- 168 Recruitment and Employment Confederation ([PRI0179](#))
- 169 Regional Medical Directorate (South), NHS England ([PRI0230](#))
- 170 Royal College of Chiropractors ([PRI0062](#))
- 171 Royal College of General Practitioners ([PRI0174](#))
- 172 Royal College of General Practitioners ([PRI0216](#))
- 173 Royal College of General Practitioners, supplementary evidence ([PRI0233](#))
- 174 Royal College of Paediatrics and Child Health ([PRI0064](#))
- 175 Royal College of Physicians ([PRI0120](#))
- 176 Royal College of Psychiatrists ([PRI0207](#))
- 177 Royal Pharmaceutical Society ([PRI0199](#))
- 178 Sanofi ([PRI0102](#))
- 179 Save Our Surgeries ([PRI0105](#))
- 180 Scrutiny Unit, House of Commons ([PRI0243](#))
- 181 Sheffield CCG ([PRI0127](#))
- 182 Sir Donald Irvine ([PRI0239](#))
- 183 Society for Academic Primary Care ([PRI0108](#))

- 184 South Manchester Clinical Commissioning Group ([PRI0141](#))
- 185 St Gabriel's Medical Centre ([PRI0009](#))
- 186 St Paul's Medical Centre ([PRI0073](#))
- 187 Sue Ryder ([PRI0131](#))
- 188 Teenage Cancer Trust ([PRI0093](#))
- 189 The Allied Health Professions Federation ([PRI0067](#))
- 190 The Association of the British Pharmaceutical Industry ([PRI0186](#))
- 191 The Brain Tumour Charity ([PRI0132](#))
- 192 The British Lymphology Society ([PRI0023](#))
- 193 The College of Optometrists ([PRI0029](#))
- 194 The College of Podiatry ([PRI0129](#))
- 195 The College of Social Work ([PRI0125](#))
- 196 The Dispensing Doctors' Association Ltd ([PRI0193](#))
- 197 The Health Foundation ([PRI0160](#))
- 198 The King's Fund ([PRI0191](#))
- 199 The Lift Council ([PRI0123](#))
- 200 The MDU ([PRI0237](#))
- 201 The Medical Protection Society ([PRI0235](#))
- 202 The Patients Association ([PRI0196](#))
- 203 The Practice Group ([PRI0106](#))
- 204 The Royal College of Emergency Medicine ([PRI0017](#))
- 205 The Royal College of Nursing ([PRI0063](#))
- 206 The Royal College of Radiologists ([PRI0079](#))
- 207 The Urology User Group Coalition ([PRI0159](#))
- 208 UCL Medical School ([PRI0223](#))
- 209 UK Public Health Register ([PRI0007](#))
- 210 Universities UK ([PRI0224](#))
- 211 Urgent Health UK ([PRI0076](#))
- 212 Urology Trade Association ([PRI0143](#))
- 213 Verumed ([PRI0055](#))
- 214 Vida Healthcare Partnership ([PRI0081](#))
- 215 Virginia Patania ([PRI0040](#))
- 216 Walgreens Boots Alliance ([PRI0150](#))
- 217 Weight Watchers UK ([PRI0121](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2015–16

First Report	Childhood obesity—brave and bold action	HC 465
Second Report	Appointment of the Chair of the Care Quality Commission	HC 641
Third Report	Appointment of the Chair of the Food Standards Agency	HC 663